Letters

“THE ANALGESIC STEPLADDER - MISSING RUNGS.”

Editor,

“On a long enough timeline, the survival rate for everyone drops to zero.”

Risk is an inevitable aspect of medical care with recent studies illustrating the potential harm that can be done to patients using diclofenac with a cardiac history and codeine in paediatric patients. These studies apply in both cases to small subsets of each population however the implications have led health care bodies into disarray with the result that a large number of patients are no longer able to avail of these useful painkillers due to nationwide bans resulting in longer hospital stays and patients discharged on control drugs.

The background to the change in regulation of these two drugs is highlighted by The Medicines and Healthcare Products Regulatory Agency (MHRA) who have stated that diclofenac should not be used by people with underlying heart conditions or hypertension due to an increased risk of myocardial infarction and stroke. The use of codeine in children and adolescents has also been restricted after a European safety review was triggered by case reports of children who received codeine after tonsillectomy for obstructive sleep apnoea (OSA) and developed rare, but life-threatening adverse events.

A report, published in 2012, documented the cases of three children who died after receiving treatment with codeine after tonsillectomy. Although the number of documented cases of codeine-related deaths remains small, the complications and legal outcomes of tonsillectomy malpractice claims found that the incidence of codeine-related deaths was much higher than expected. Using data from the Lexis Nexis Mega Jury Verdicts and Settlements database from 1984-2010 it was found that 18 percent of death claims and 5 percent of injury claims resulted from the use of opioids rather than haemorrhage which would be expected.

Both medications are routinely used post operatively following a wide range of procedures in many specialities. While many of these patients are often well those with IHD other cardiovascular illnesses are encountered. Given the prevalence of children with OSA being less than 0.7% and those with CYP2D6 enzyme abnormalities (linked to abnormal codeine metabolism) being even less these patients are rarely encountered.

Our patients’ interest are first and foremost and providing them with adequate pain relief following surgical procedures is vitally important. Unfortunately we haveblanketing guidelines which fail to take into account the low risk to most patients and certainly fail to take into account both medical expertise and patient choice and sensibility.

Since the introduction of these restrictions data from the Northern Ireland Otorhinolaryngology audit suggests that complications have significantly increased in local hospitals specifically adhering to these policies. It is vitally important that a wide range of analgesic options are available to both adult and paediatric patients following what can often be painful surgery. While many new options are available the option to revert back to tried and tested analgesics should remain open to the clinician and be based on a balance of risk and benefit much like the option to operate in the first place.

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Philip R Bell
Robin A Adair

Department of Otorhinolaryngology,
Ulster Hospital,
Belfast,
Northern Ireland.

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ANTIPHOSPHOLIPID ANTIBODY SYNDROME: DIFFUSE ALVEOLAR HEMORRHAGE AND LIBMAN-SACKS ENDOCARDITIS IN THE ABSENCE OF PRIOR THROMBOTIC EVENTS

Editor,

Antiphospholipid antibody syndrome (APS) is traditionally characterized by the presence of circulating antiphospholipid antibodies (aPL) that lead to an increased risk of thrombosis and pregnancy morbidity.1,2 Considered rare, diffuse alveolar hemorrhage (DAH) is thought to be a non-thrombotic manifestation of APS, likely secondary to aPL induced pulmonary capillaritis.3 The diagnosis needs to be considered even in the absence of known thrombosis, as multiple recent case reports have identified DAH as the presenting symptom.4

CASE

A 35-year-old mother of four from El Salvador presented with a two day history of pronounced dyspnea and hemoptysis. Two years prior she had been diagnosed with adult-onset...
epilepsy and had undergone mitral valve replacement (MVR) for severe presumed rheumatic mitral stenosis. Pathologic evaluation of the resected valve revealed leaflet fibrosis with Libman-Sacks endocarditis. There was no previous history of thrombosis or pregnancy loss. She was afebrile and was able to speak in full sentences with a SpO2 of 92% on room air. Inspiratory crackles were auscultated bilaterally. No systemic findings of a connective tissue disease were present. CXR demonstrated extensive bilateral air space disease. Computed tomography of the chest identified bilateral groundglass opacities (Figure 1). Fiberoptic bronchoscopy demonstrated no endobronchial source of bleeding. Sequential bronchoalveolar lavage aliquots became progressively more hemorrhagic with microscopic evidence of hemosiderin-laden macrophages, suggesting diffuse alveolar hemorrhage (Figure 2). Laboratory investigations revealed the presence of a non-specific inhibitor, positive anti-cardiolipin IgG antibody, positive anti-dsDNA antibody, and serum thrombocytopenia and lymphopenia. Workup was negative for ANCA or anti-GBM related disease. A probable diagnosis of APS with suspected underlying systemic lupus erythematosus (SLE) was made. The patient underwent induction therapy with pulse-dose corticosteroids and IV cyclophosphamide with rapid clinical and radiographic improvement.

**DISCUSSION**

APS mediated capillaritis represents a rare cause of DAH. Although APS is traditionally defined by strict diagnostic criteria, recent literature supports the pathogenic role of APS in many non-thrombotic disease states. Non-criteria manifestations of APL include livedo reticularis, cardiac valve disease, thrombocytopenia, non-thrombotic neurologic manifestations, and nephropathy. Given our patient’s thrombocytopenia, recently diagnosed seizure disorder, and positive aPL on two occasions, a diagnosis of probable APS was made. Her valvular disease was not considered diagnostic, as while APS is a known cause of Libman-Sacks endocarditis, it typically causes regurgitant mitral valve lesions rather than stenosis, consistent with the previous diagnosis of rheumatic heart disease.

APS may occur as an independent disease entity – primary APS – or in the setting of an underlying disease, usually SLE. In our patient, comorbid SLE is suspected given the presence of anti-dsDNA antibodies, lymphopenia, and recurrent idiopathic seizure.

Given the morbidity of DAH, the high-risk of recurrence, and the suspected underlying SLE, the patient has been managed with cyclophosphamide and hydroxychloroquine. Her inflammatory markers have normalized and she has had no subsequent disease flare.

**Conclusion:** DAH can be the presenting manifestation of APS in the absence of traditional manifestations such as venous/arterial thrombosis or pregnancy morbidity.

Nathan Hambly MD, FRCPC, Suneet Sekhon MD, R. Andrew
Letters

McIvor MD, FRCP(C)
Department of Medicine, McMaster University, Ontario, Canada
Dr. Hambly is a Fellow in Respiratory Medicine, Dr. Sekhon is a fellow in Rheumatology, and Dr. McIvor is a Professor of Medicine at McMaster University, Hamilton, Ontario, Canada.

Authors have no conflict of interest.

T2127 Firestone Institute for Respiratory Health
St. Joseph’s Healthcare, McMaster University
50 Charlton Ave East
Hamilton, Ontario, L8N 4A6. Canada
Email: amcivor@stjosham.on.ca
New to Twitter Follow me at @MacCOPD
Like My Facebook Page https://www.facebook.com/MacCOPd
Phone: 905 522 1155 Ext 34330
Fax: 905 521 6183

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WHAT BECOMES OF THE BROKEN NOSE?
Editor,

Nasal fractures are the most common facial injury, frequently associated with aesthetic, functional and psychological complications. Closed reduction of fractured nasal bones is first line treatment commonly employed by Otolaryngologists and Plastic Surgeons, however some patients require open septorhinoplasty1.

In our practice the incidence of fractured nasal bones appears to be rising from approximately 100 cases in 2008 to 170 cases in 2012. For 95 percent of cases closed reduction of fractured nasal bones led to satisfactory results. However an increasing numbers of patients are being seen, following closed reduction of fractured nasal bones, who are unsatisfied with the result and are requesting further surgical intervention. Our review of 700 patients from 2008 to 2012 has shown a rise in those undergoing either rhinoplasty or septorhinoplasty from 1.9 percent to 8.4 percent.

Seventy percent of patients with fractured nasal bones were male with an average age of 31 years, of which approximately 50 percent sustained nasal injury secondary to alleged assault. SIMON (Single, Immature, Male, Overly expectant and Narcissistic) is an acronym commonly used to identify patients who are likely to be unsatisfied with the outcome of nasal surgery2. We appear to be seeing an increasing number of patients fitting the SIMON criteria who are ‘unsatisfied’ with the outcomes of a procedure that in general provides satisfactory results. Alternatively there maybe a legal motivation for those pursuing open surgery considering that almost half of our patients reported injury secondary to alleged assault3.

Complex nasal injuries are frequently associated with high failure rates, following closed reduction of fractured nasal bones. These include grade III fractures involving the nasal septum and patients with previous nasal fractures1,4,5. Septal involvement is frequently underestimated by physicians when assessing and managing nasal fractures1,4,5. Our study showed many discrepancies between findings documented at the time of clinic compared to at the time of theatre, particularly in relation to the nasal septum. If closed reduction of fractured nasal bones is conducted without addressing a septal fracture, the septum will in time move the nasal bones back towards their deviated position1,4,5. Moreover, our results showed that approximately 25 percent of patients who had an unsatisfactory outcome reported previous nasal fractures.

Fractured nasal bones are successfully treated by closed reduction in the vast majority of cases, however a rising number of patients are now undergoing open surgery. We believe the reason for this increasing trend is multifactorial. Our results suggest that there is an increasing number of SIMONs within our society who are frequently unsatisfied with the result of cosmetic surgery or surgery following assault or injury. Furthermore factors such as status of the nasal septum and previous nasal injuries have to be considered if initial treatment is to be successful. Finally it is the authors experience that increasing numbers of patients with nasal fractures are being booked for septorhinoplasty at the outset rather than nasal bone manipulation if this is felt acceptable at the time of consultation and we predict that this trend will continue.

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Mr Gary Ferguson
Mr Philip R Bell
Mr Samuel J Hall.

Department of Otolaryngology, Southern HSC Trust, Craigavon, Northern Ireland.

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