Case report: treatment of faecaloma of the colon

Sir

We read with interest on the above case report by Khera et al (*Hospital Medicine*, 66(4): 246). We wish to highlight that there appears to be an error on the colonoscopic pictures showing faecaloma.

Although it has been mentioned on the photograph about 'signs of fragmentation and softening by next morning', the dates on the photographs (03/15/03) contradict this, as the previous picture also shows the same date. We also feel that both photographs appear more or less similar.

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Response

Dear Colleagues,

Thank you for your interest in our article. The dates on both figures are due to calibration errors only in the camera set up. This is not under our control, our input was purely in the colonoscopy rather than the technical calibration of dates onto the camera screen.

This case reports actual factual events in the correct time frame and context. This case highlights a new approach in the treatment of faecaloma of the colon.

During this acute admission two colonoscopies were performed and a laparotomy was avoided. Indeed, during the first colonoscopy the faecaloma stubbornly proved resistent to all attempts of dislodging or disruption (*Figure 1*). Only after proximal decompression with a nasogastric tube, liquid paraffin injection and normal saline flushes overnight did the faecaloma begin to fragment (*Figure 2*).

We trust that this answers your queries.

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Management of non-thrombolysable acute coronary syndrome (ACS)

Sir,

The management of non-thrombolysable acute coronary syndrome (ACS) in patients who are already established on oral anticoagulants (OA) is unclear. This subgroup of patients present a challenge to clinicians as combined use of antithrombotics and anticoagulants could potentially cause adverse major bleeding. The results of the following study were presented at the 69th Japanese Circulation Society Annual Conference.

We examined the current self-reported clinical practice by sending out a short questionnaire to all cardiologists in UK asking 'In management of patients admitted with acute coronary syndromes (non-thrombolysable) who are already established on warfarin or other oral anticoagulant therapy, which of the following is your treatment of choice, apart from optimising other standard treatments?' followed by a list of choices. We also asked the respondents for their opinion on whether they think further evidence is required in such circumstances.

We received 349 responses (54% response rate) after a single mailing. We found that opinion was divided almost equally between continuing or stopping the oral anticoagulant in management of these patients. While 148 (42.5%) respondants said that they would discontinue the oral anticoagulant (OA) and put the patient on a combination of antithrombotics, 40.5% said they would continue the OA and add varying combinations of other antithrombotic agents.

Frequency distribution of the respondents' choices from the latter option are; continue OA, add aspirin and clopidogrel 44 (13%), continue OA and add aspirin 61 (17.5%), continue OA and add clopidogrel 21 (6%), continue OA and add LMWH 3 (1%), continue OA alone 12 (3%).

There were 14 (4%) who provided other responses in the free text space provided. Ninety-six respondents (27.5%) also made comments to suggest that their initial management strategy would depend on (a) the patient's INR on admission (b) the indication for anticoagulation and (c) the severity of the ACS and the need for percutaneous coronary intervention.

The majority(85%) agreed that more evidence is needed to guide the management of ACS in this setting. Although the overall response rate is modest at 54%, our findings suggest that there is considerable variation in practice among cardiologists is present and highlights the need for further evidence in this area.

The authors would like to thank all participating consultant cardiologists across the UK and Mr Ben Young and staff from James Paget Hospital Audit Department for their assistance with the project.

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