Spontaneous oesophageal rupture

Sir,

I would like to comment on the case report by Dr Mamum on spontaneous oesophageal rupture (Vol 59(12), 1998; p. 968). I fully support the contention contained in the report that we must retain a high index of suspicion of oesophageal rupture when collapse occurs whose features are a little unusual.

My case of some years ago illustrates both that and the importance of an accurate and full history of events immediately preceding the collapse. I was called to the local Nuffield hospital in the small hours of a Sunday morning at the urgent request of the nursing staff. The patient at risk was an elderly obese man who had had a hip replacement the morning before. I had not been involved. Apparently he had had 500 ml 70% dextran perioperatively as deep vein thrombosis prophylaxis and had been prescribed a further 500 ml some 18 hours later. He had been well postoperatively until, at 4am, the next morning the second bottle of dextran was commenced.

Within minutes, I was told, he reacted with pallor, followed immediately by giant urticaria, difficulty with breathing, tachycardia and hypotension. When I arrived he had all these features plus intense bilateral bronchospasm and was semi-conscious and cyanosed. I diagnosed an anaphylactic reaction, stopped the dextran and administered intravenous adrenaline and hydrocortisone, and oxygen by mask. The clinical features rapidly resolved, the man regained consciousness and was able to communicate rationally. I stayed for 15 minutes or so to confirm all parameters remained stable and then left for home (5 minutes away).

As I arrived home the telephone was ringing. It was the hospital to say the patient had collapsed again, this time without a rash. On my return to the hospital, the patient was fighting for breath, was deeply cyanosed, tachycardic and hypotensive. Now he had no bronchospasm, but there were no right-sided breath sounds, the right chest was hypertympanic and the trachea was deviated markedly to the left. I quickly inserted a right-sided chest drain and, to my absolute horror, faeculent fluid jetted out. Faeculent fluid continued to pour into the underwater seal bottle, although there was a good 'swing', the patient's dyspnoea and cyanosis disappeared, the trachea centralized, air entry was again detected on the right side and blood pressure improved, although not to normal, I obtained an anterioposterior chest X-ray. The chest drain was properly sited and the right lung had re-expanded. I inserted a central venous pressure line through the internal jugular and arranged transfer to the local intensive care unit.

On the way to the intensive care unit in the ambulance, I questioned in detail the nurse who was present at the patient's first collapse and ascertained for the first time, that the usual features of anaphylactoid reaction had been immediately preceded by a projectile vomit. This started my alarm bells ringing. On arrival in intensive care, therefore, I requested a barium swallow and the help of a gastrointestinal surgeon. The former outlined a large distal oesophageal diverticulum and showed dye in the right pleural cavity. At operation, a large tear was revealed in the sac which was repaired. The patient had a stormy postoperative course and unfortunately died some 30 days later.

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Infective endocarditis

Sir,

Infective endocarditis prophylaxis in children by Venugopalan and Worthing (Vol 59(9), 1998; p. 65) is an excellent review. The principle of antibiotic prophylaxis for infective endocarditis is the same in adult patients. Cardiac pacemakers do not require antibiotic prophylaxis but we would like to share our experience of a patient with a permanent pacemaker. This was an 85-year-old gentleman who was previously fit and well and had a permanent pacemaker inserted for Stokes-Adams attacks due to intermittent complete AV block.

One week following discharge, he presented with acute urinary retention and was admitted under the urologists. Following urethral catheterization, he was referred to our team for a medical opinion as to whether it would be appropriate to perform a TURP on him. We suggested that the procedure could either be carried out under antibiotic prophylaxis to prevent infection of the pacemaker pocket or the operation could be deferred for 6 weeks, thereby allowing complete healing of the pacemaker pocket. Antibiotic prophylaxis would then not be required. The urologist opted for the second option.

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Local anaesthetics

Sir,

I read with interest the recent article in your journal about local anaesthetics (Vol 59(11), 1998; p. 880). A useful method of drug delivery, including local anaesthetics, is iontophoresis (Banga and Chien, 1988). Iontophoresis uses a small external electric current to deliver water soluble charged drugs into the skin. An electrode with the drug to be delivered is placed on the skin with another electrode acting as a ground and a DC current applied. If the current carries the same ionic charge as the drug molecule the medication is literally pushed through the skin by the same principle as like-poles of a magnet repelling. Iontocaine® (Iomed's brand of lidocaine HCl 2% with adrenaline 1:100 000) delivered by this method can produce clinically effective anaesthesia in 10 minutes or less with a depth penetration of up to 10 mm (Ashburn et al, 1997).

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Ashburn M, Gauthier M, Love G, Basta S, Gaylord B, Kessler K (1997) Iontophoretic administration of 2% lidocaine Hcl and 1:100,000 epinephrine in man. *Clin J Pain* **13:** 1322–6

Banga AJ, Chien YW (1988) Iontophoretic delivery of drugs: fundamentals, developments and biomedical applications. *J Control Release* **7:** 1–24

Euthanasia: who needs it ?

Sir,

I read with interest the article *Physician-assisted suicide: issues facing doctors* by Professor Findlay (Vol 60(1), 1999; p. 4) which, like much of the euthanasia literature, is very subjective. I would like to make the following points:

- The author's position on the use of opioids seems to ignore the fudge that most health professionals live with, namely the principle of double effect.

As Wendell-Holmes observed in 1884 'perhaps logically it is difficult to justify a passive more than active attempt at euthanasia but certainly it is less abhorrent to our feelings'. To follow Professor Findlay's logic any patients who received too much morphine would receive naloxone if stopping morphine administration did not reverse the sedation (like regular postoperative patients). In terminal patients this would not be usual practice. If such patients die how can anyone be sure that the morphine did not hasten their death?

- There are always going to be a small proportion of terminally ill competent patients who wish to die, e.g. patients who are intolerant of opioids, those with severe neurogenic pain, those with severe dyspnoea or totally dependant patients.

We should not judge a patient's quality of life but according to Professor Findlay we should judge a patient's perception of their quality of terminal care. Surveys show that patients would like to have the option of euthanasia even though they would be unlikely to avail of it (Lee, 1996).

The euthanasia debate goes on.

Brian C Morrow
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Lee M (1996) Legalizing suicide - views from Oregon. *N Engl J Med* **334(1):** 310–5