

Complications of catheterization

Sir,

I am writing in response to the case report 'Acute abdomen following cardiac catheterization: a surprising outcome' (vol 62(11), 2001, p. 706). While agreeing with the authors that this was a pseudocomplication rather than a true complication, it is worth considering the indication for the original procedure. The patient underwent left and right heart catheterization for assessment of an ostium secundum atrial septal defect (ASD). While this is the traditional way to assess an ASD for potential surgical closure, allowing accurate shunt calculations, it is no longer widespread clinical practice.

The advent of transcatheter closure of secundum ASDs has necessitated accurate pre-procedure assessment with transoesophageal (or three-dimensional) echocardiography. Often in conjunction with transthoracic echocardiography, right heart pressures and shunt calculations (if need be) can be made non-invasively in addition to accurate ASD sizing. This allows a decision to be made regarding closure (surgical or otherwise) without invasive assessment. If the patient is suitable for transcatheter closure then any invasive assessment needed, e.g. coronary angiography, is done at the same sitting. If surgical closure is preferred then a coronary angiogram without full left and right heart catheterization is all that will be required. Complications should remind us of indications.

Gareth Morgan-Hughes

*Specialist Registrar
Cardiology Department
SouthWest Cardiothoracic Centre
Plymouth Hospitals NHS Trust
Plymouth PL6 8DH*

Obtaining informed consent

Sir,

Paice et al (vol 62(11), 2001, p. 699) audit preregistration house officers' (PRHOs) practice in gaining informed

consent from patients, reporting that 68% of respondents were obtaining consent for unfamiliar procedures.

We completely agree that it is inappropriate to expect PRHOs to obtain informed consent. The American College of Surgeons (2002) guide for patients undergoing surgery lists ten questions which should be answered fully when obtaining informed consent for that consent to be considered adequate.

1. What are the indications that have led your doctor to the opinion that an operation is necessary?
2. What, if any, alternative treatments are available for your condition?
3. What will be the likely result if you don't have the operation?
4. What are the basic procedures involved in the operation?
5. What are the risks?
6. How is the operation expected to improve your health or quality of life?
7. Is hospitalization necessary and, if so, how long can you expect to be hospitalized?
8. What can you expect during your recovery period?
9. When can you expect to resume normal activities?
10. Are there likely to be residual effects from the operation?

There is very little chance of any PRHO being able to answer these questions fully as they lack the necessary experience and hence knowledge.

We feel that the principle that someone who is able to perform the surgery obtains the consent is the safest. While PRHOs need to learn the concept of informed consent, it is inappropriate for trainers to expect their PRHOs to be performing this task. Furthermore it may expose trainers and PRHOs to unnecessary and unwelcome litigation caused by the inadequate consenting of patients.

Robert U Ashford/John Scollay/

Paul Harrington

*Specialist Registrar in Trauma and Orthopaedics/Senior House Officer in Trauma and Orthopaedics/Consultant Orthopaedic Surgeon
Hull Royal Infirmary
Hull HU3 2JZ*

American College of Surgeons (2002) Giving your informed consent. www.facs.org/publicinfo/operation/consent.html (accessed 24 April 2002)

Counselling patients before rectal examination

Sir,

I have been trained to carry out a digital rectal examination (DRE) in men as a part of their physical examination. I carry out a DRE in all men over the age of 40 years and all who present with urological symptoms. Over the years I have examined several men with no urinary symptoms and found abnormalities in their DRE results. Many of these men were subjected to prostatic biopsies, and in a proportion of these this confirmed presence of early prostatic cancer.

An abnormal DRE can lead to performance of prostatic biopsies, which have significant morbidity. The majority of biopsies will be negative, but a negative biopsy does not rule out prostate cancer. The best treatment for early prostate cancer is not known. Some treatments for early prostate cancer may cause more morbidity than the cancer itself, and treatment may not improve life expectancy. An abnormal DRE may cause a great deal of anxiety to patients, their relatives and their physicians.

We tend to counsel asymptomatic patients before a prostate specific antigen (PSA) test but do we similarly need to counsel asymptomatic patients before carrying out a DRE? An abnormal DRE is as likely to predict a prostate cancer as an abnormal PSA reading (Stamey et al, 1987; Richie et al, 1993). After having diagnosed prostate cancer in a series of asymptomatic patients (e.g. patients presenting with a hydrocoele, epididymal cyst or renal stone but no prostatic symptoms), solely because of their abnormal DRE findings, I now counsel all patients before their DRE.

Shiv Bhanot

*Consultant Urologist
King George Hospital
Goodmayes
Essex IG3 8YB*

Richie JP, Catalona WJ, Ahmann FR et al (1993) Effect of patient age on early detection of prostate cancer with serum PSA and DRE. *Urology* 42: 365

Stamey TA, Yang N, Hay AR et al (1987) Prostate specific antigen as a serum marker for adenocarcinoma of prostate. *N Engl J Med* 317: 909-16