

Severe reaction to diphosphonate

The suggestion of Dr A T Elliott and colleagues that skin testing for sensitivity to diphosphonates should be considered before these drugs are used therapeutically—for example, in Paget's disease of bone—(3 September, p 592) is not well founded.

Including the clinical trial phases, the diphosphonate disodium etidronate has been given by mouth for the treatment of Paget's disease throughout the world for nearly 20 years without any reports of allergic reactions. More recently both this diphosphonate^{1,2} and other "second generation" diphosphonates, including dichloromethylene diphosphonate (clodronate),^{3,5} disodium aminohydroxypropylidene-diphosphonate,^{6,8} 4-amino-1-hydroxybutylidene-1,1-diphosphonate,⁹ and aminohexane diphosphonate,⁹ have been used extensively both orally and intravenously to treat Paget's disease, hypercalcaemia associated with malignancy, hyperparathyroidism, and osteoporosis without any serious allergic adverse effects. Even mild rashes, which may not have been a hypersensitivity reaction to diphosphonate, are rare and have been reported only in association with a particular formulation of disodium aminohydroxypropylidene-diphosphonate used by one investigator.⁶

It seems more likely that the allergic response reported by Dr Elliott and colleagues was a reaction to some other component in the injectable formulation of the radiopharmaceutical. At an incidence of allergic reactions of 4-50/100 000 skin testing before administration of radiopharmaceutical diphosphonates is questionable. It is completely unjustified before the therapeutic use of disodium etidronate, clodronate, disodium aminohydroxypropylidene-diphosphonate and the other new diphosphonates for Paget's disease of bone or hypercalcaemia associated with malignancy.

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Mediastinal haemorrhage complicating thrombolytic treatment

In their report Drs K P Suddes and R D Thomas make statements about the imaging of aortic dissections which are somewhat misleading (20-27

August, p 527). It is well recognised that a properly performed enhanced computed tomography scan is a more accurate method for detecting or excluding an aortic dissection than aortography. There is no reason for a patient who is suspected of having a dissection with a normal enhanced computed tomogram and a normal echocardiogram to then also undergo aortography. In patients who are ill and hypotensive, as described in this report, transfer to another hospital and the procedure of aortography, which requires multiple injections of large volumes of contrast medium, can only further aggravate their poor condition. It is not surprising that in this case aortography proved to be normal in view of the reported absence of a dissection on computed tomography.

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AUTHOR'S REPLY.—We should know that no test is 100% perfect; in a review a world authority on aortic dissection stated, "aortic angiography remains the most definitive method for confirming the diagnosis of aortic dissection. . . . The diagnostic accuracy of CT is in the range of 90%."¹ In our patient there was clinical suspicion of dissection as a cause of the sudden, spontaneous appearance of a periaortic soft tissue mass on computed tomography—presumably haemorrhage. After discussing the case with the regional cardiothoracic centre, at a consultant to consultant level, we thought further investigation was necessary.

Far sicker cardiac patients are transferred from district general hospitals to regional centres. Indeed, this is best done as soon as a diagnosis that suggests the need for urgent surgery is made. Delay for fear of aggravating the patient's condition is unnecessary and is likely to worsen the prognosis. Neither should aortography aggravate the condition; it is a procedure which "in skilled hands is well tolerated by even critically ill patients."²

On a more general note the question of which is the most appropriate diagnostic test for suspected dissection is important, but we did not make any statements about imaging the aorta. The test chosen depends on its availability and then, if possible, it should not be duplicated. This is the trouble with computed tomography, which appears to be slightly more sensitive than aortography (but "which is not without its limitations").³ Computed tomography is usually a 9 to 5 weekday service and it may not be available for acute cardiac emergencies. So 24 hour a day echocardiography in its various forms and aortography will continue to be needed.

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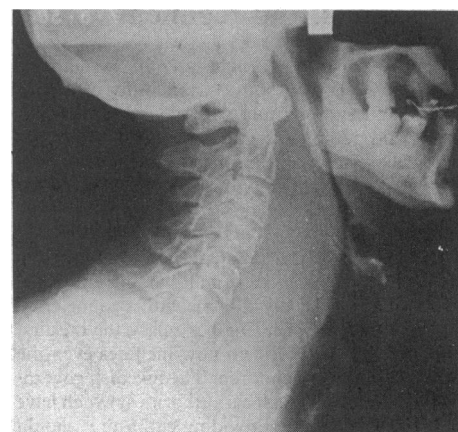
Drs K P Suddes and R D Thomas (20-27 August, p 527) encountered a rare complication, a mediastinal haematoma, in a patient receiving thrombolytic treatment for myocardial infarction. The diagnosis was based on a radiograph of the chest showing a widened mediastinum. They rightly point out that this complication may be more frequently encountered in the future, when myocardial infarction (and conditions mimicking it) are more widely treated by thrombolysis.

If the source of haemorrhage is the aorta urgent action is needed, but non-aortic haematomas are usually quickly absorbed even if they are quite extensive. It has also to be remembered that the anteroposterior view (taken on a portable x ray

apparatus) may produce a distortion that simulates a widened mediastinum. If penetrating films are also taken that outline the tracheal air shadow (which may be displaced) more valuable further information may occasionally be gained.

In a case of non-traumatic aortic rupture the supracarinal part of the trachea was displaced to the right to such an extent that the left main bronchus became its main continuation (instead of the right), though the cervical trachea was still central; in a lateral film the dense ovoid opacity was seen to spread upwards anteriorly.¹ The operation, however, was not successful and the patient died.

In a case of spontaneous cervicomedial haematoma the lateral film showed that the trachea was displaced forward by 6.4 cm by the haematoma, which extended up to the base of the skull (figure).² The haemorrhage arose in the visceral compartment of the cervicomedial fasciae, which excluded an aortic origin. The patient was discharged home after one week.



Spontaneous cervicomedial haematoma in penetrating lateral film of the neck. Reproduced by permission from the "British Journal of Surgery"

Taking penetrating films is a simple investigation that should be routine in such cases. The diagnosis is usually difficult and a high tech hospital may be some distance away.

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Community care: Italian style

The brief report on the 10 year anniversary of the Italian Law 180 (3 September, p 575) was a timely reminder of the lessons to be learnt from this most daring of moves towards community care in psychiatry. In fact, the story of this experiment predates the law by many years. In many places the sudden imposition of the law and the subsequent closure of hospitals without community support has been a disaster.¹ In at least one town—Trieste, where the late Basaglia and his group worked—it has, however, been a success.² Largely based on a theoretical reading of Basaglia, Crepet and Pirella argued that Psichiatria Democratica has established a radical, new psychiatry.³ Clinical practice, however, is in many ways similar to that in Britain. Psychopharmacological practice is much the same; the numbers of patients in institutions of one sort or another are broadly comparable. The difference in the new psychiatric service is both in the obvious dynamism of the practitioners who maintain a high