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Oesophageal rupture arising as a complication of acute appendicitis in a child

Kenneth Wong and Gerard Roy

TO THE EDITOR: Boerhaave's syndrome is a rare condition in which increased intra-oesophageal pressure associated with forceful vomiting leads to spontaneous oesophageal rupture. Although the condition mostly affects middle-aged men,¹ we present here a case arising as a complication of appendicitis in a child.

A 10-year-old boy presented with a 4-day history of abdominal pain, diarrhoea and bloodstained vomiting. He was febrile and tachycardic, with a mildly distended abdomen but no peritonism. Chest and abdominal x-rays were normal.

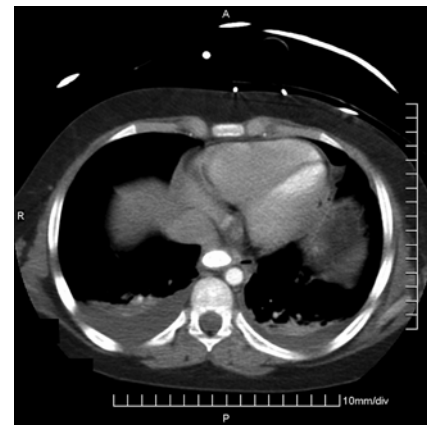
Over the next 6 hours, despite being given 4 litres of normal saline intravenously, the patient became hypotensive, oliguric and hypoxic, with increased abdominal guarding. A perforated appendix was suspected and an urgent laparotomy was planned. A preoperative chest x-ray revealed a large left-sided hydropneumothorax causing tracheal deviation. Insertion of an intercostal catheter immediately returned 600 mL of haemoserous fluid. At laparotomy, amid gross purulent contamination, a perforated appendix was removed. A subsequent computed tomography (CT) scan of the thorax showed contained mediastinal contrast extravasation with an associated air/fluid level from the lower oesophagus on the left side (Box), suggesting oesophageal rupture and establishing Boerhaave's syndrome.

Intravenous antibiotics and nasogastric and pleural drainage were instituted. A repeat CT scan of the thorax 3 days later showed no further mediastinal contrast extravasation. The child improved clinically until spiking high temperatures on the seventh day postoperatively. A chest x-ray showed a left-sided pleural effusion. Thoracoscopy revealed a loculated empyema. This was managed by a formal decortication via a left lateral thoracotomy. The patient was discharged after 2 weeks.

Vomiting is a common presenting symptom in acute appendicitis. Yet there is only one previously reported case of Boerhaave's syndrome secondary to acute appendicitis.¹ Therefore, this unusual complication of acute appendicitis may be missed. Without treatment, 100% mortality is expected.²

In retrospect, it was evident that our patient showed the classical clinical symptoms of Boerhaave's syndrome: a history of prolonged

Computed tomography scan of thorax



haematemesis, systemic compromise and a left-sided tension hydropneumothorax.^{2,3} As an initial chest x-ray may be normal, a repeat x-ray is worthwhile in any patient with prolonged vomiting. If clinical suspicion persists, a CT scan of the thorax, which is a more sensitive and specific test for detecting oesophageal rupture, is advisable.^{2,3}

The management of Boerhaave's syndrome involves initial resuscitation with broad-spectrum antibiotics, nasogastric intubation and pleural drainage.²⁻⁵ In recent literature, urgent operative intervention has been recommended to control communication between the oesophagus and mediastinum.^{2,3,5} In our case, we pursued non-operative management based on radiological evidence of a small, contained mediastinal collection and clinical improvement after pleural drainage. The present case highlights a rare complication of a common surgical condition and suggests that careful non-operative management may be successful.

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Doctors, prison torture and the "war on terror"

Niyi Awofeso

TO THE EDITOR: The arrest and imprisonment of 17 Australian-based suspected terrorists on 8 November 2005 underscores a need for Australian prison medical workers to implement strategies for either preventing or following up prison torture incidents.

The definition of prison torture is problematic, not least because modern prisons evolved to sequester torture practices from public view.¹ I define prison torture as custodial practices that: increase the likelihood of extreme deprivation in prison settings; facilitate traumatic stress on prisoners, resulting from beatings or excessive force used more as punishment than as restraint; result in inadequate or unaffordable health care; and/or expose prisoners to heightened risk of interpersonal violence and sexual assault.

Advocates of prison torture regard it as a means of quickly extracting information, humiliating prisoners to the extent of weakening their resolve, and sending a "tough on crime" message to potential terrorists. However, as the well publicised Abu Ghraib prison incidents in Iraq demonstrate, torture practices diminish the moral clout of implicated military physicians and governments.²

Physical and psychological scars from torture commonly lead to depression, major disconnection of victims from friends and family, and occasionally suicide. Confessions obtained under torture conditions are inadmissible in modern legal systems. Moreover, graphic torture incidents may be framed by terrorist organisations as recruitment tools.

The 1975 World Medical Association Declaration prohibits doctors' involvement in torture.³ Unfortunately, active medical complicity in prison torture did not end with the Nazi era.⁴ While Australian doctors have so far not been directly implicated in prison torture practices,⁵ the inability (or unwillingness) of Australian prison doctors to recognise and promptly speak out on such incidents in the past has been unfortunate. Prison torture practices in which doctors are actively or passively involved diminish the standing of the medical profession, whose members are expected to be advocates for people at risk of torture.

With a likely increase in the number of people imprisoned for terrorist activities in Australian prisons, medical workers need to be trained in the proper application of the Istanbul Protocol⁶ — a 1999 international guideline for the investigation and documentation of torture and its consequences — to enhance their skills in suspecting, documenting, and reporting prison torture incidents. It is also important that prison doctors are not placed in a “dual loyalty conflict” with regard to the treatment of terrorist suspects.⁴ Such risks may be minimised by administering prison health care through mainstream health departments, as well as by regular anti-torture training programs for frontline prison workers.

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Clinical outcomes after acute osteoporotic vertebral fractures

James L Mallows

TO THE EDITOR: I note with interest the findings of Diamond et al.¹ However, I would like to make some comments about the validity of the results presented.

The authors state that an intention-to-treat analysis was used. However, this was unusual as the intention was to treat everybody, with the control group being made up of patients who were offered the intervention but

refused it because of the lack of published data on the safety of the procedure.

There was a marked decrease in the pain scores at 24 hours in the intervention group. The methods state that all patients were offered similar analgesia titrated to individual need. However, there was no mention of how many of the intervention group (if any), compared with the control group, received parenteral analgesia. The intervention group may have tended to receive more parenteral analgesia than the control group, but this was not mentioned. Indeed, Predey et al² specifically mention this possibility in their review.

Diamond et al state that lower pain scores persisted in the vertebroplasty-treated group at 6 weeks. However, from the results given in Box 3, it seems that there was no clinically significant difference between the intervention and control groups at 6 weeks. I would have liked the report to have included pain scores at 1 week.

The decision to use means ± 1 SD instead of 95% CIs in the results is interesting. One SD will only include 66% of a normal population whereas a 95% CI would refer to the mean ± 2 SDs. More importantly, the size of the SD introduces the possibility of an enormous spread in the pain scores for both groups, which was not commented on in the Results or the Discussion.

Finally, it was unclear whether the patients were treated in the private or public hospital system.

Regardless of my comments above, I applaud any attempt to treat back pain in elderly people (especially that caused by osteoporotic crush fractures) in a time-expedient fashion. I look forward to the day when this therapy is first-line treatment for this disease and not something to consider 2 weeks down the track. The cost savings in reduced length of stay and the decreased morbidity associated with this treatment, as well as the reduced geriatric workload with the more rapid improvement in function, must outweigh the initial up-front costs.

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- 1 Diamond TH, Bryant C, Browne L, Clark WA. Clinical outcomes after acute osteoporotic vertebral fractures: a 2-year non-randomised trial comparing percutaneous vertebroplasty with conservative therapy. *Med J Aust* 2006; 184: 113-117.
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Terrence H Diamond, Carl Bryant, Lois Browne and William A Clark

IN REPLY: We thank Mallows for his constructive comments, and would like to reply as follows.

1. Intention-to-treat analysis is normally associated with randomised controlled trials (RCTs). Our study was not an RCT, as patients who refused vertebroplasty formed the comparison group.¹ We used intention-to-treat analysis to indicate that all patients who were assessed as eligible for our study at the outset were enrolled and were all included in the results presented, irrespective of subsequent events (ie, whether they were completely compliant, had died or were lost to follow-up). We thought it was important to make clear that the study was prospective, that all patients entered into the study were represented in the outcomes, and that patients had not been selected on the basis of later events or results.

2. A description of the analgesic requirements of a subgroup of the patients in our study has been published.² More than 90% of the vertebroplasty-treated cohort were either able to cease or reduce their analgesia dose by at least 50% within 24 hours after the procedure. Before the procedure, an intravenous injection of pethidine (50–100 mg) was the only parenteral analgesia given routinely and would not have affected the pain scores at 24 hours.

3. Pain scores at 6 weeks were statistically lower in the vertebroplasty-treated group compared with the control group. The clinical significance was not apparent, as measured by the changes in the Barthel indices. This indicator is only a crude assessment of patients' wellbeing, and a more detailed questionnaire of activities of daily living may have shown a difference. Pain scores recorded at 24, 48, 72 and 96 hours after the procedure would have been more sensitive, so that the additional pain, without vertebroplasty, could have been calculated from the area under the pain curve; the more data points, the more accurate the curve.

4. We elected to report the results as means ± 1 SD instead of 95% CIs. We used SDs to be consistent with our previous publications and other reports in this field. We agree that we could have used 95% CIs.

5. Patients were referred to Sydney Imaging Group from the inpatients and outpatients departments of St George public and private hospitals. All patients were treated without any out-of-pocket patient

expenses. Private hospital inpatients were billed according to standard Medicare fees and outpatients were bulk-billed, which was revenue neutral for the radiology practice.

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1 Diamond TH, Bryant C, Browne L, Clark WA. Clinical outcomes after acute osteoporotic vertebral fractures: a 2-year non-randomised trial comparing percutaneous vertebroplasty with conservative therapy. *Med J Aust* 2006; 184: 113-117.

2 Diamond T, Champion B, Clark WA. Management of acute osteoporotic vertebral fractures: a non-randomized trial comparing percutaneous vertebroplasty to conservative therapy. *Am J Med* 2003; 114: 257-265. □

Mifepristone (RU-486) and limits to abortion

Suzanne Belton

TO THE EDITOR: We now know the outcome of the parliamentary vote on mifepristone (RU-486), which restored responsibility for its use to the Therapeutic Goods Association (TGA). Politicians from both houses used their conscience votes to support the scientific scrutiny of medical abortion. van Gend will now be worried about Australian women “demanding” abortions.¹

However, abortion on demand in Australia does not exist. I refer van Gend to state laws which specify under what circumstances termination of pregnancy can take place. In no state can women “demand” an abortion whenever, wherever or however they wish. Regulations exist in all states and territories and, as a family doctor, van Gend must be aware of the multiple requirements. While there remains a lack of clarity about various state laws,² the current position in Australia is that termination of pregnancy is available under certain conditions and in particular cases.

The attempt by the Minister for Health Tony Abbott to influence women’s decisions about abortion by providing Medicare-funded, church-affiliated counselling for pregnant women³ has only further entrenched the view that the Minister is not able to speak for the majority of Australians. The previous situation whereby any Minister for Health, rather than the TGA, had the power to decide on the safety and efficacy of new medications before their

entry into the pharmaceutical market place was ludicrous.

Despite the endorsement of science over theology in health, and potential access to medical abortion, we still have the freedom of our own conscience. No one can force medical practitioners to prescribe mifepristone and no one can force women to accept medical (or surgical) abortions. Morals in Australia are a private matter and these decisions should be left to individuals and their families.

Who would decide the authenticity of the medical grounds for abortion, mentioned by van Gend — doctors or priests, or academic ethicists, or feminists? van Gend is clearly not in favour of women deciding.

I agree that more attention should be paid to the reasons for women stating they do not want to continue with a pregnancy, and, yes, we could do more to assist them. But I do not agree that excluding non-medical reasons is the answer — which, as van Gend points out, are financial hardship, relationship problems, single motherhood, and a completed family. To many, these appear convincing reasons to choose abortion. While this may not sit comfortably with van Gend’s medical paradigm, the “non-medical” reasons include the mental health of the woman (see the Menhennitt ruling which stipulates that an abortion is lawful if a doctor believes that the abortion is necessary to preserve her physical or mental health).⁴

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1 van Gend D. Mifepristone (RU-486) and limits to abortion [letter]. *Med J Aust* 2006; 184: 139.

2 de Crespigny LJ, Savulescu J. Abortion: time to clarify Australia’s confusing laws. *Med J Aust* 2004; 181: 201-203.

3 Opposition questions church pregnancy counselling plan. *ABC News Online* 2006; 19 Feb. Available at: <http://www.abc.net.au/news/newsitems/200602/s1573345.htm> (accessed Feb 2006).

4 Children by Choice Association. Australian abortion law and practice. Fact sheet. Available at: <http://www.childrenbychoice.org.au/nwww/auslawprac.htm> (accessed Feb 2006). □

David van Gend

IN REPLY: Belton is correct that “safety and efficacy of medications” is a matter for the Therapeutic Goods Association. The dispute was whether such limited criteria can meaningfully assess a drug designed to take life.

The government needed to consider higher criteria for RU-486 — its ethical and medical justifiability. Doctors needed to

advise the government on justifiable indications for RU-486, in contrast to the corrupt practice of abortion for non-medical reasons.

That advice was withheld. The Australian Medical Association advised only on the ethically neutral question of “. . . who is best qualified to scientifically assess the safety and efficacy of a drug”.¹

Such marginalisation of ethical concerns is consistent with the AMA’s earlier response in the context of late-term abortion: “There is no place for third parties — governments, over-zealous politicians and lawyers, hospital committees, or even the spectre of legal action”.²

This assertion of unchallengeable medical power over an unborn life is wrong. Belton’s notion that the morality of abortion is “a private matter” is wrong; neither parents nor doctors are above the moral and legal prohibition on intentional killing. “The law in this state has not abdicated its responsibility as guardian of the silent innocence of the unborn”,³ even if medical leaders have.

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1 Australian Medical Association. RU486 conscience vote — a vote for democracy and the safety of medicines. Media release. Canberra: AMA, 2006, 9 Feb. Available at: <http://www.ama.com.au/web.nsf/doc/WEEN-6LU2PL> (accessed Mar 2006).

2 Australian Medical Association. Australia needs consistent uniform national abortion laws. Media release. Canberra: AMA, 2005, 15 Aug. Available at: <http://www.ama.com.au/web.nsf/doc/WEEN-6FA4DU> (accessed Mar 2006).

3 McGuire DCJ. *R v. Bayliss & Cullen* (1986) 9 QLR 8 at 45. □

Health Workforce Innovation Conference

Gregory J Deacon

TO THE EDITOR: The report by Brooks and Ellis on the Health Workforce Innovation Conference held in November 2005 was, in my opinion, very misleading.¹

I was one of about five doctors who attended this conference; the other 200 attendees were non-medical health care workers. It was fortuitous I attended — no invitation was extended to the Australian Society of Anaesthetists. Not only was the audience nearly exclusively composed of people dedicated to the introduction of non-doctors to replace doctors, but the presentations themselves included nobody

expressing a contrary view. Such an unbalanced 2-day meeting therefore failed to truly examine medical task substitution. It failed to explore whether there truly is an inadequate number of doctors in Australia and whether the introduction of non-doctors to do medical work would actually save any money at all. In fact, the presentation by Sibbald indicated that nurse practitioners in the United Kingdom are no more cost effective: although they cost half as much, they take twice as long, so the overall cost is the same.

The issue of the quality of Australian health care and how that quality would be affected by the introduction of non-doctors to do the doctoring was not addressed at all.

There was also no examination of the consequences on the workforce of the rather illogical proposal to greatly expand the nurses' scope of practice into medical work when there are already too few nurses in Australia. Such a proposal would surely only worsen the nursing workforce problem.

Overall, the meeting was very disappointing, as it failed to approach the topic of medical task substitution in a balanced fashion, failed to justify why the proposal should be contemplated to begin with, failed to address whether there would be any improvement in health care delivery, failed to address whether there would be any reduction in health care costs, and absolutely failed to address how the proposed medical task substitution would not lead to an inevitable reduction in the quality of health care in Australia.

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¹ Brooks PM, Ellis N. Health Workforce Innovation Conference. *Med J Aust* 2006; 184: 105-106. □

Peter M Brooks

IN REPLY: Deacon has unfortunately missed the whole point of the Health Workforce Innovation Conference. It was about innovation — new ways of doing things. It was also about health, not medicine — a concept that some doctors might find difficult to accept, but is actually the reality. Deacon seems to suggest that we still need to debate whether there is an “inadequate number of doctors in Australia” — surely most of us have moved on from there. One of the consequences of the “rather illogical proposal to greatly expand the nurses' scope of practice” might be to retain nurses in the workforce. This, as most of us know, is a major issue.

The Health Workforce Innovation Conference was not necessarily about saving costs; it was about producing a more effective health system and trying to provide for those who cannot access services because they are not available or there are long waiting lists for procedures that could well be done by other health professionals.

A number of papers presented at the conference demonstrated that care could be provided by groups such as nurse practitioners or physician assistants without any reduction in quality, and it behoves Deacon (whom I assume is a believer in evidence-based practice) to present data to the contrary if he wishes to make those assertions. Deacon commented from the floor on a number of occasions, making the assertions that we would expect from an organisation which is dedicated to maintaining the status quo.

I really think the time has come to move on.

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Are meal replacements an effective clinical tool for weight loss? — a clarification

Garry J Egger

TO THE EDITOR: I would like to clarify several issues relating to the competing interests statement for my editorial in the 16 January issue of the Journal.¹

In my statement, I declared that I have used several meal replacement products in clinical settings and that I am not employed by, and do not receive benefit from, any companies producing these products.

By way of further information, I have used Optifast (Novartis) and Dr MacLeod's (Orfam) products in clinical work in the past. These were always sold at cost to patients, or patients were referred to a chemist, so there was no direct financial benefit to me. I currently use KicStart (Pharmacy Health Solutions) as part of the kit for “Professor Trim's weight loss program for men”. I purchase these in bulk at wholesale prices from the manufacturer and include them as part of the total program (which is much more than just meal replacement).

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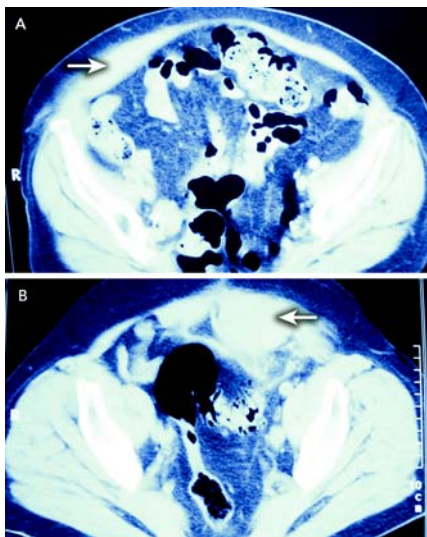
¹ Egger G. Are meal replacements an effective clinical tool for weight loss [editorial]? *Med J Aust* 2006; 184: 52-53. □

A marriage of inconvenience

Mark R Nelson

TO THE EDITOR: Reading the excellent Christmas edition of the Journal, I was struck by the symmetry of the computed tomography scans of rectus sheath haematomas in a husband and wife, reported by James and colleagues¹ (Box). I was wondering if the couple had not been involved in a minor car accident or incident of heavy braking several days earlier, where the lap-sash or buckle of a seatbelt might explain the mirror injuries?

Computed tomography scans of matching rectus sheath haematomas in a 62-year-old woman (A) and her husband (B).



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1 James D, Lawrentschuk N, Hii DO. A marriage of inconvenience. *Med J Aust* 2005; 183: 626. □

David James

IN REPLY: The rare and spontaneous nature of rectus sheath haematoma leaves its origins open to such interesting questions. Neither of our patients was able to recall a history of motor vehicle trauma, but minor braking trauma certainly remains a possibility, as does respiratory infection leading to protracted cough.

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The MP3 surgeon and the opera fan

Douglas N Gow

TO THE EDITOR: I found the recent letter to the Editor from Riley¹ fascinating, and the comment from Teo² depressing in the extreme. Of the many factors that drove me from anaesthetic practice and into the house-boat business 4 years ago, the selfish attitude of many surgeons towards our communal working environment was high on the list.

If all parties in an operating theatre wish to be "entertained" with music while operating on their fellow man, then I suppose it might be permissible (but one wonders what many patients would say if they knew).

However, it seems quite beyond the autocratic mindset of many surgeons to understand that auditory input is important to anaesthetists for monitoring the patient and for communication between the anaesthetist, surgeon and nursing staff. To impose music as background noise is unacceptable to many of us, especially as auditory discrimination decreases with age.

Riley's description of video as well as audio to distract from the primary function of surgery beggars belief. I note that Teo agrees with me here.

When are surgeons going to realise that surgery is only one part of the professional work that goes on in an operating theatre?

Douglas N Gow, Retired Anaesthetist

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1 Riley RH. The MP3 surgeon and the opera fan [letter]. *Med J Aust* 2006; 184: 255.

2 Teo C. The MP3 surgeon and the opera fan [comment]. *Med J Aust* 2006; 184: 255-256. □

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