Letters to the editor

Splenic injuries

Editor – I read with interest the case report by Carey and Nelatu titled ‘Spontaneous splenic rupture secondary to dabigatran: the last in a series of unfortunate events’ and postulate whether the splenic rupture was truly spontaneous or acute deterioration of an occult splenic injury sustained during the fall and worsened by direct oral anticoagulation (DOAC) therapy.

Blunt splenic trauma is common after falls and is usually elicited by history and examination, however, a negative history and unremarkable physical examination does not exclude splenic injury. For this reason, evaluation of the trauma patient should use focused assessment with sonography in trauma examination and computed tomography to assess the spleen.

The American Association for the Surgery of Trauma classifies splenic injuries as grade I–V; with I representing a ruptured capsular laceration less than one centimeter in depth. Subcapsular hematoma involving less than 10% of the surface classifies splenic injuries as grade I–V; with I representing a ruptured capsular laceration less than one centimeter in depth. For this reason, evaluation of the trauma patient should use focused assessment with sonography in trauma examination and computed tomography to assess the spleen.

Furthermore, in a multi-center cohort study, bleeding of a subcapsular hematoma occurred in 5% of non-operatively managed patients with splenic injury 4 days post diagnosis. Therefore, it’s difficult to classify a patient as having spontaneous splenic rupture secondary to DOAC, without confidently excluding occult splenic injury or subcapsular hematoma in an elderly patient with a mechanism of fall significant enough to cause bimalleolar ankle fracture.

EAMON P M C C A R R O N
Speciality doctor in general medicine, South West Acute Hospital, Enniskillen, Northern Ireland, UK

References

Subarachnoid haemorrhage

Editor – We read with interest the comprehensive article ‘Assessment of acute headache in adults – what the general physician needs to know’. The authors highlight that a minority of thunderclap headaches are secondary to a non-traumatic subarachnoid haemorrhage (SAH) and refer to a study showing that in routine practice up to 20% of SAH cases may be missed by computed tomography (CT) scan, without stipulating scanning parameters and then recommending cerebrospinal fluid (CSF) xanthochromia. In this retrospective study the diagnosis of SAH was made on clinical grounds plus the presence of CSF red blood cells. Only four of the 11 cases missed by CT scan were imaged by modern 64 slice technology, in none of these was xanthochromia detected and only two had a vascular cause for SAH identified by angiography. The authors acknowledge that the high prevalence of aneurysms means that aneurysm identification may be incidental if the CT has not confirmed a recent bleed. Additionally, the presence of xanthochromia in the CSF is not specific to SAH. A systematic review and meta-analysis concluded that the pretest probability for SAH has to be high to make lumbar puncture worthwhile, estimating the number of patients needing a lumbar puncture to identify one aneurysmal SAH amenable to treatment at anything from 250 to infinity. Though the risks are small, lumbar puncture is associated with minor morbidity (eg headache) and major morbidity (eg CSF infection, herniation). Samples for xanthochromia analysis are commonly rejected by laboratories (eg not protected from light) or uninterpretable (eg fresh blood from a traumatic tap interfering with bilirubin detection) and hospital admission is prolonged whilst results are awaited. We would therefore like to highlight the limited role of lumbar puncture over CT alone, dependant on scanning parameters, in the exclusion of SAH. However, as the authors state, although aneurysmal SAH is a rare cause of headache, lumbar puncture may enable other diagnoses. Consider carefully the requirement for lumbar puncture to rule out SAH in those having been imaged by a third generation or above CT scanner with appropriately sensitive settings with a low pretest probability of a subarachnoid haemorrhage.

KATE E SHIPMAN
Consultant chemical pathologist, Western Sussex NHS Foundation Trust, Chichester, UK

SATHEESH R RAMALINGAM
Consultant neuroradiologist, University Hospital Birmingham, Birmingham, UK

CHARLOTTE H DAWSON
Metabolic medicine consultant, University Hospital Birmingham, Birmingham, UK

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ZHAINEB A YASEAR
General medicine trainee, University Hospital Birmingham, Birminham, UK

References

Response
We thank Kate Shipman, Satheesh Ramalingam, Charlotte Dawson and Zhaineb Yasear for their comments and recognise there is ongoing debate regarding the additional benefit of the traditional CT-lumbar puncture (LP) algorithm vs CT alone in excluding subarachnoid haemorrhage. We agree that CT pick up of subarachnoid haemorrhage has improved significantly. It is however important to emphasise that studies reporting near 100% sensitivity and specificity were performed in routine practice, only 10% of patients were imaged within 6 hours of onset. In one recent UK study in routine practice, only 10% of patients were imaged within this timeframe. Sensitivity falls with increasing delay to presentation and the importance of considering lumbar puncture correspondingly increases. Furthermore, detection of subarachnoid haemorrhage on CT imaging remains operator dependent. In routine practice, scans are generally not reported by an experienced neuroradiologist as in the majority of the published studies but rather by a trainee general radiologist, often out of hours.

We would therefore strongly caution against false reassurance from a negative CT report in a patient with a suggestive clinical presentation and the importance of considering lumbar puncture with an exploration of test thresholds.

KRISHNA CHINTHAPALLI
Neurology specialty trainee, St George’s Hospital, London, UK
NIRANJAN NIRMALANANTHAN
Consultant neurologist, St George’s Hospital, London, UK

References

Mis-attribution of ectopic corticotropin-releasing hormone secretion (causing eutopic secondary adrenocorticotropic hormone secretion) to ectopic adrenocorticotropic hormone secretion?

Editor – In their Lesson-of-the-month, Kleining and Russell describe a case of adrenocorticotropic hormone (ACTH)-dependent Cushing’s syndrome, which they have ascribed to a metastatic small cell neuroendocrine carcinoma, presumed to have arisen through de-differentiation of a prostate adenocarcinoma. They describe this as a case of ‘ectopic ACTH secretion’ but in the abstractive and repeatedly in the main body of text. However, the complete absence of any ACTH labelling in tumour tissue points towards this description being both inaccurate and misleading. In the absence of tumour-ACTH immunostaining, the actual ectopic hormone secreted was almost certainly corticotropin-releasing hormone (CRH), with CRH being secreted eutopically in the pituitary gland. Lois et al reviewed the literature and identified no convincing case of directly-secreted ectopic ACTH (as opposed to CRH) secretion by prostate adenocarcinomas. Although the authors had no access to a CRH serum assay, nor CRH tissue immunolabelling, ectopic CRH secretion could easily have been confirmed at autopsy through demonstration of corticotroph cell hyperplasia by ACTH immunostaining of the pituitary gland itself.

RICHARD QUINTON
Consultant endocrinologist, Institute of Genetic Medicine, Newcastle upon Tyne Hospitals, Newcastle upon Tyne, UK

References

Response
We would like to thank Dr Quinton for his thoughtful and precise response to our case report. The possibility of our patient’s Cushing’s syndrome being secondary to CRH secretion is recognised and accepted. The dominant histology, however, of both the pelvic mass and metastatic lesions were of a small cell neuroendocrine tumour rather than adenocarcinoma. Prostate specific antigen level was normal, suggesting a quiescent adenocarcinoma component. When considering the possibility of CRH secretion, we reviewed the literature and found only one case of small cell cancer of the prostate releasing CRH, as opposed...