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Response

We agree entirely that HIV infection is an important secondary cause of immune thrombocytopenic purpura, and list it as a cause in Table 1 and refer to HIV testing as a baseline investigation under 'Clinical evaluation of the cytopenic patient'. Thank you for highlighting the NICE guidance further. ■

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Established endocrine practice

Editor – Pre-operative preparation with alpha receptor antagonists before phaeochromocytoma resection is established endocrine practice.[1] We therefore read with great interest the report by Faloon *et al*[2] detailing circumstances which precluded this. We congratulate them on the successful outcome of the case and for highlighting the ongoing absence of parenteral preparations of alpha blockers in the UK. This has significant implications for the management of a phaeochromocytoma crisis given the uniformity with which these agents are recommended in society guidelines.[1,3]

The established mantra of alpha followed by beta blockade, whilst correct and widely held, is not achievable in the situation described. A range of alternative intravenous anti-hypertensive agents have been used in the management of phaeochromocytoma. Indeed, some units do not use alpha blockers even when available, but utilise the dihydropyridine calcium-channel blocker nicardipine[4] which acts by preventing catecholamine-stimulated calcium influx into arterial smooth muscle. The combined $\alpha 1$ and β antagonist labetalol has also been used[5] and has the advantages of familiarity with acute care physicians and accessibility in the emergency department. However, like all beta blockers, concerns exist regarding the risk of paradoxical hypertension in spite of its $\alpha 1$ activity and adverse events have been reported.[6] Other drugs that also have a role are magnesium,[7] sodium nitroprusside and glyceryl trinitrate.

Use of these agents may be limited by profound hypotension as they were in this case and this serves as an important reminder that patients with phaeochromocytoma are severely volume contracted due to alpha-mediated vasoconstriction. Volume expansion is therefore a key component to acute management and significant hypotension may follow successful tumour (and therefore catecholamine) removal.

We would like to remind readers that alternative parenteral treatment agents for this rare but life-threatening clinical situation are available in the UK. ■

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Mechanical circulatory support such as extracorporeal membrane oxygenation is indicated in phaeochromocytoma crisis with sustained hypotension

Editor – Faloon and colleagues describe a 26-year-old man who developed phaeochromocytoma crisis following blunt abdominal trauma and attempted embolisation.[1] The patient had a phase of sustained hypotension giving rise to multi-organ dysfunction. Ischaemia of the colon was treated with emergency laparotomy without alpha blockade. Emergency adrenalectomy was performed intraoperatively for a ruptured phaeochromocytoma and retroperitoneal haemorrhage. It is to the credit of the team that this patient survived the episode despite the high mortality associated with this condition.[2]