Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within 3 weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

Splenic rupture

Editor – We read with interest the case of 'Spontaneous splenic rupture secondary to dabigatran' by Carey and Nelatur.[1] Drug related atraumatic splenic rupture (ASR) is well described and accounts for 9–33% cases with anticoagulants being the main group of drugs implicated.[2]

The presentation of ruptured spleen can be delayed and may occur even after trivial injury.[3] Could it be considered in this case?

Recently we saw a 20-year-old amateur boxer in Vanuatu who presented in the evening to the emergency department in shock. He complained of general weakness having collapsed getting off a bus. Initially he gave no history of trauma and had no abdominal pain. He had been training that afternoon using the heavy bag but not sparring. On examination he was afebrile, pale, pulse of 78 beats/min, blood pressure of 80/70 mmHg and oxygen saturation at 95%. Abdominal examination was unremarkable and rectal examination revealed no melaena. Shock secondary to concealed haemorrhage was considered. Further questioning revealed that he had fallen out of a tree and hit his left side one month previously. A diagnosis of ruptured spleen was made and was confirmed at laparotomy where he underwent splenectomy. He made a full recovery. The absence of tachycardia was initially attributed to his being a well conditioned athlete. However, relative bradycardia has been described in splenic rupture and is associated with poorer outcome.[4]

Conservative management of ruptured spleen is the preferred option particularly in malaria endemic areas. We have seen two cases of ASR complicating *vivax* malaria, both fatal. This is the single major cause of ASR worldwide. Over 80% require surgical management and it has a 22% mortality rate.[5] We have seen one case of ASR complicating tuberculosis in Australia successfully treated with splenectomy after a trial of conservative management failed.[6] ■

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Haematology: Multiple Myeloma

Editor – I wish to point out a significant and potentially harmful error in the CME Medical Masterclass article on multiple myeloma published in the January 2019 issue of Clinical Medicine.[1]

In the section on supportive care the authors state that 'Pain is common in myeloma and often requires opiate analgesia plus NSAIDs'. This is at odds with the current UK guidelines on supportive care in myeloma published on behalf of the British Committee for Standards in Haematology and the UK Myeloma Forum,[2] which state that NSAIDs should

> *be avoided apart from very short term use (eg 3–5 days) with acute severe pain, eg bone fracture. They should not be used in the presence of renal impairment, and used with extreme caution in myeloma patients in view of the risk of precipitating renal compromise.*

The Medicines and Healthcare products Regulatory Agency also issued a warning in 2009 highlighting the need for great caution when using NSAIDs in patients at risk of renal impairment, including those with myeloma.[3]

This practice of avoiding NSAID use is well-established in the haematology community because of the risk of precipitating acute kidney injury, but the risks may be less well-known amongst those in general medicine, to whom this CME series is directed. It is important that inappropriate use of NSAIDs in patients with myeloma is avoided to prevent renal damage in these susceptible patients. ■

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