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A chest wall swelling in a young girl

Parvaiz A Koul, Abdul Wahid, Ghulam N Lone and Tariq A Bhat

To the Editor: Humans may serve as intermediate hosts in hydatid disease, a parasitic infection caused by the tapeworm *Echinococcus granulosus*. They are infected through contact with infected dogs or by ingestion of tapeworm eggs in contaminated food, water, or soil.[1] The larvae form cysts in body organs. Although the liver is the most common site, lung cysts are seen in up to 30% of cases of hydatid disease. Lung cysts are generally asymptomatic, but symptoms occur if the cysts rupture.[2] Here, we describe an adolescent girl with a lung cyst that ruptured *across* the thoracic cage into the subcutaneous fascia, presenting as a breast swelling.

A 14-year-old girl had had left-sided pleuritic chest pain, a high-grade fever, and marked swelling of the left breast for 10 days, which did not respond to antibiotics (oral amoxycillin and parenteral amikacin). Clinical examination revealed a slender, febrile and tachy-pnoeic patient with a tender swelling of the left mammary region. The swelling had a tense cystic feel, and transmitted impulses were felt when she coughed. A diffuse pleural rub was heard anteriorly, with reduced air entry.

Investigations revealed a neutrophilic leukocytosis of 12.7×10^9/L. Chest x-ray showed diffuse opacification of the left hemithorax, and a computed tomography scan revealed a cystic, low-attenuation lesion in the left hemithorax extending into the submammary region (Figure A). On anterolateral thoracotomy, an infected ruptured cyst was seen in the left upper lobe of the lung, with degenerated membranes and pus extending across the chest wall into the submammary space. The cyst was removed, capitonnage of the residual cavity was performed, and pus and laminated membranes were removed from the submammary space. Small communications seen between the pus cavity and the bronchi were closed. After the operation, parenteral antibiotics (vancomycin and amikacin) were administered for 10 days and albendazole for 4 weeks. Casoni's skin test was positive and antihydatid antibodies were detected in serum. Surgically obtained pus revealed nonviable scolices of *E. granulosus* (many degenerated), and the histopathology of the surgical specimen was consistent with hydatid membrane (Figure B).

Pulmonary hydatid cysts can rupture; however, rupture into the pleural cavity is rare.[1-3] Although spontaneous rupture of a cyst into the pleural cavity, or rupture after trauma, has been reported,[4,5] a rupture across the pleural cavity into the submammary fascial tissues has, to our knowledge, not been reported previously.

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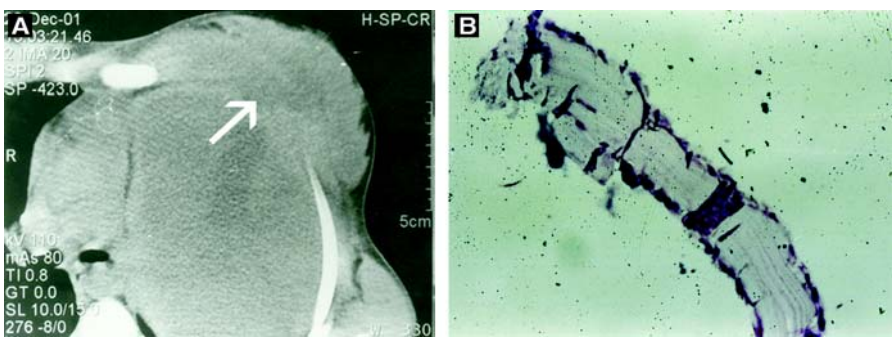

A. Computed tomography scan showing a cystic lesion in the left hemithorax, extending into the submammary region (arrow). B. Degenerated hydatid cyst membrane (original magnification x 200). ◆

Convulsions associated with an overdose of St John's wort

Dharshi C Karalapillai and Rinaldo Bellomo

To the Editor: St John's wort (SJW) (*Hypericum perforatum*) is a natural medicine commonly used for treating depression. We recently encountered a case of an overdose of SJW leading to serious manifestations in the patient.

A 16-year-old girl presented to the emergency department with seizures and confusion. She was intubated and admitted to the intensive care unit. The only relevant history was of febrile convulsions at the age of 4 years. There had been no head trauma.

Results of a computed tomography brain scan and cerebrospinal fluid examination were unremarkable. Electrolyte levels were normal, and standard drug toxicological screens were negative. An electroencephalogram (EEG) confirmed diffuse spike wave activity consistent with generalised epileptic activity.

On further questioning, it was found that she had taken large quantities of SJW — up to fifteen 300 μg tablets a day in the 2 weeks leading up to admission and an additional 50 tablets just before presentation — for a recent "depressive episode". Depression had not been formally diagnosed, and the tablets had been obtained "over the counter" from a local pharmacy.

A provisional diagnosis of seizures due to an overdose of SJW was made. High performance liquid chromatography was not performed to quantify hypericum extract in serum and urine, as these tests are not available in our hospital. A repeat EEG at discharge on Day 6 was normal, and there were no further seizures in the following 6 months. Psychiatric assessment during the patient's hospital stay revealed a likely suicide attempt following recent social stresses.

There is some evidence for the efficacy of SJW in treating depression.[1] In the United States and Australia it is available without prescription, but in Germany, where it is prescribed more frequently than fluoxetine for depression, it is available by prescription only.

The reported incidence of adverse drug reactions to SJW is 0–5.7%.[2] Although these are usually minor and transient, more serious adverse reactions (such as serotonin syndrome) have been reported.[3] SJW was implicated as a likely, but unproven, cause of seizure-related events in a recent review,[4]

but our case appears to be the most severe reported so far. Adverse reactions are thought to be more common if SJW is taken in conjunction with selective serotonin reuptake inhibitors, but have also been described when SJW is taken alone.[5]

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The "therapeutic footprint" of medical, complementary and alternative therapies and a doctor's duty of care

Craig S Hassed, Vicki Kotsirilos, Marie Pirotta and Avni Sali

To the Editor: Sanderson et al provide an interesting viewpoint about how the community, including medical practitioners, have embraced complementary and alternative medicine (CAM).[1]

However, if we were reviewing this article for publication, we would ask the authors to:

- make a valid distinction between those complementary and alternative therapies promoted as curative versus those considered palliative;
- define how they decided which therapies belong to one or other side of the arbitrary CAM boundary;
- review and justify the boundaries for the "therapeutic footprint" in a more evidence-based and rigorous way;
- locate specific therapies inside the footprint;
- locate where chemotherapy lies within the footprint, in light of the recent review showing, for the vast majority of adult malignancies, its marginal survival benefits considering its high costs, both monetary and healthwise;[2]
- emphasise that there are relatively few recorded adverse events for CAM compared with conventional cancer care (Therapeutic Goods Administration Medicine Summary reports 2003, 2004, 2005 — Dr K Mackay, Acting Director, Adverse Drug Reactions Unit, TGA, personal communication); and
- vigorously question the marketing of conventional medicines, such as trastuzumab (Herceptin, Roche), to vulnerable patients and an uncritical public when the evidence suggests huge expense and little, if any, survival benefit.[3]

Perhaps a distinction also needs to be made between CAM therapies, many of which provide proven symptomatic relief, and those lifestyle interventions, such as exercise,[4] dietary change,[5] and social support, which provide symptomatic relief and may also confer a survival benefit. It does not serve the profession well when many cancer patients and their carers have to go outside the medical system to access information, advice and therapies which they should have easy access to within the system. In fact, we might even question how helpful these arbitrary boundaries are when all that patients and doctors want is to use what works and what is safe.

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Christine R Sanderson, Bogda Koczwara and David C Currow

In reply: We would like to thank Hassed and colleagues for their comments on the "therapeutic footprint" and their questions about locating specific therapies within the model. While it was outside the scope of our article to critically analyse different treatments using the model (as benefits and risks will vary from patient to patient), we would like to direct Hassed et al to a more detailed consideration of the risks and benefits of chemotherapy.[1]

We do not see our model as a tool to categorise or economically appraise specific treatments, but rather as one to help conceptualise the key issues to be considered when proposing treatment — the evidence for benefits *and* risks, contextualised according to treatment goals. The model provides a basis for comparison, taking us beyond arbitrary and unhelpful arguments about the distinctions between complementary and alternative therapies and their boundaries. We hope that the model will encourage evaluation of evidence for *all* therapies and support critical evaluation not only of drugs, but also lifestyle interventions that may benefit patients. The primary or essential purpose of the model is to encourage the posing of questions like those articulated by Hassed and colleagues to any therapist — whether they identify as medical, complementary or alternative.

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The doctor's dilemma

David E Smith

To the Editor: In *From the Editor's Desk* in the 20 November 2006 issue of the Journal, Van Der Weyden acknowledged the 100th anniversary of the first performance of George Bernard Shaw's play *The doctor's dilemma*, and the fact that both society and medical practice have since changed dramatically in the ensuing century. He then asked: "...what is the modern doctor's dilemma?"[1]

Contemporary Australian medical practice faces challenges posed by changes in community and government expectations, free market policies, workforce shortages and infrastructure changes, so this question should not be regarded as rhetorical. Answers to it will depend to some degree on the type of medical practice under consideration and where it is situated geographically, but to get the ball rolling, I suggest that in respect of general practice anywhere in Australia, a significant set of dilemmas surround notions of responsibility.

Traditionally, general practitioners have held responsibilities primarily to individual patients. With increasing emphasis being placed, appropriately, on preventive and screening activities, to what extent should GPs' responsibilities be extended to the community as a whole, and how should any such extension be resourced? Given that the interests of individuals and communities will not always be in accord, how might the resulting conflicts of interests best be managed? And, to increase the complexity of such considerations, to what extent ought responsibility *to* patients extend to responsibility *for* patients?

Another dilemma for doctors in respect of responsibility relates to identifying the boundaries between altruism and martyrdom. To what extent should health care professionals be expected to put the interests of their patients or of the community before those of themselves and their families?

To extend the notion of responsibility further, and with the GP's role as patient advocate particularly in mind, to what degree should health care professionals be active against social injustices which impinge on their patients' health?

I know that in responding to the Editor's question I have posed another set of questions, none of which are easily answered — if they could be, they would not be dilemmas. However, acknowledging and clarifying these questions is the first step towards answering them, and also towards preventing much community misunderstanding.

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1 Van Der Weyden MB. The doctor's dilemma [From the Editor's Desk]. *Med J Aust* 2006; 185: 529. ❑

The demise of professional courtesies: *cui bono*?

Max Kamien

To the Editor: I am one of the septuagenarians described by Arnold in his *cri de coeur* over the demise of professional courtesies.[1] In my medical student days, my teachers extended the courtesy of free medical treatment to my parents. I have continued this tradition, in the certain knowledge that this will be the only situation in which medical students save their parents money.

Such professional courtesies are still the norm in Western Australia. But, with the exception of medical colleagues, I have only once, in the 30 years of operation of Medibank/Medicare, had a bulk-billed patient realise that he has received a discount. I recently asked a picture framer/patient for a 40% discount and he laughed. When I explained that by bulk-billing I was effectively giving him a 40% discount, he was incredulous, but he did reciprocate.

In the 1970s, Australian Medical Association spokesmen and medical educators often confused etiquette (a code of desirable behaviour between doctors) with ethics (a more important set of moral principles underlying a person's general behaviour). This is no longer the case, and etiquette has disappeared from undergraduate and postgraduate medical curricula. I think it is time to reintroduce the topic into the education of both our future doctors and our patients.

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1 Arnold PC. The demise of professional courtesies: *cui bono*? *Med J Aust* 2006; 185: 670-671. ❑

A dangerous truth

Peter C Arnold

To the Editor: There would be few medical students who have not had drummed into them the tautological aphorism, "Common things occur commonly!" And few practising clinicians who have not come across or read about a serious adverse event arising from the actions of a colleague or nurse who thought, "It was only X, which is so common at this time of the year/around these parts/among these people. I didn't think it was anything serious." The patient might have been a child with meningitis sent home with a diagnosis of a winter

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upper respiratory tract infection or a very anxious young woman with an intracranial haemorrhage discharged with a diagnosis of tension headache.

Guided by this aphorism, we doctors will almost always make the correct diagnosis, and nurses an accurate assessment of a patient's complaints, and we will glow with professional satisfaction. But how does this boost to our professional confidence measure up against what should be our paramount concern — the safety of each patient in our care?

When assessing junior colleagues, we must, above all else, be seeking reassurance that patients will be safe in their hands. We do not want to hear a junior doctor brushing aside a commonly occurring symptom or clinical sign as of little importance merely *because* it is common. But we do want to know that he or she has considered, "What is the most serious condition that this could be?", followed by relevant enquiries into the patient's history, appropriate clinical examination and warranted laboratory or other investigations. Knowing that the doctor has checked that there is no suggestion of a serious illness, we can be reasonably assured that the patient will be safe.

An excellent candidate would make the correct diagnosis sooner and perhaps with less pain, discomfort and inconvenience for the patient, and at less cost to the health care system, than a less able colleague. But the patient will be safe with either doctor, as a dangerous, perhaps life-threatening, illness has been excluded. All that remains is for the correct diagnosis to be made and appropriate treatment administered — a burden for the patient perhaps, but not a disaster.

I suggest that readers of the Journal, in their role as teachers, advise their students to abandon that inane and dangerous "commonness" tautology, and replace it with: "Exclude the worst possibility and then assist Nature in its healing processes".

Acknowledgements: I thank Drs Irene Rotenko and John Raftos for discussing this proposition with me.

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