hypothyroidism is an important distraction and a possible cause of various symptoms, perhaps including the chest pain.

In Scotland (population about 5 million), only 258 women under 45 had coronary heart disease diagnosed in 2004.⁴ If these women were evenly distributed, an average general practitioner would only see one presentation every 20 years or so. But they are not evenly distributed. I have colleagues from parts of Glasgow who would not in the least be surprised by the correct diagnosis. The likelihood of coronary heart disease is much higher in deprived communities, independent of traditional risk factors.⁵ For general practitioners in different places, our experiences—and consequent diagnostic practices—are quite different.

We don't know how Mrs Patel's general practitioner responded to her chest pain and hypothyroidism. We know she received treatment for a presumed musculoskeletal cause, but I wonder if her thyroxine treatment was cautious (25 µg is an unusually low dose) because coronary heart disease was also being considered.

Not unusually, Mrs Patel re-presented with chest pain six months after angioplasty. A clinical diagnosis is now even more difficult. Even for "experienced" angina patients, it can be impossible to differentiate types of chest pain, causing some patients disabling anxiety and others to delay presentation with critical ischaemia. This time the pain was not related to exertion and, thankfully, investigations were normal.

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Lesson of the week

Parental suicide after the expected death of a child at home

Dawn E Davies

Doctors prescribe opioids and other controlled drugs to make patients in a variety of states of disease more comfortable. Once in the community, these drugs are not monitored or audited, and patients and their families are responsible for handling them safely. Recently, end of life care has received greater international attention, and the field of palliative care is emerging strongly. This, in turn, has often changed the setting in which palliative care services are provided from hospital to home. The two cases that follow show a potential hazard in the current system.

Case reports

Case 1

A boy with congenital rhabdoid tumour of the face received palliative care at home for progressive disease. The tumour grew to involve almost half of his face, with inferomedial displacement of his palate. He presented with pain seven weeks before his death. Initially the pain was controlled with codeine and simple analgesics, but it eventually intensified. He was then treated with morphine. The dose was gradually titrated upwards to relieve his pain. He stayed normally alert and interactive as the dose was increased.

Two days before his death, he developed sudden signs of obstruction to his airway, with stridor and respiratory distress. He had been prescribed lorazepam in anticipation of such an event. This was titrated until it helped. He was sleepy but could be roused, and he no longer seemed anxious, despite visibly laboured breathing.

A paediatric palliative care nurse saw him two hours before he died. At that time, he had an increased

respiratory rate but was cyanotic. Although he still had laboured breathing, he slept peacefully. He died the day before his first birthday. His mother refused to have his body removed from the home the night of his death and declined to have a nurse come to the home to help. The next day, in a lengthy visit, a paediatric home care nurse tried but failed to have the parents release the body to a funeral home. Encouragement to return the baby's drugs to the pharmacy was again unsuccessful. The parents repeatedly denied any plans of suicide, and they said that they would later return the drugs. The paternal grandmother and aunt were present, and they supported the parents' decision.

The involved oncology and palliative care doctors, the managers of the home care nursing, the crisis unit, and the coroner were contacted. A decision was made not to intervene again until the next day. They particularly decided not to try to admit the mother to hospital against her wishes, given her denial of suicidal intent or plan, and not to force removal of her son's body from the home. It seemed important to the mother that her baby's body was there on his birthday.

The mother was found unconscious the next morning by her partner and was pronounced dead upon arrival at hospital. Toxicology tests at autopsy showed high concentrations of opioids and benzodiazepines, presumed to be her son's drugs. But a review of the drugs found in the home after her death did not find any discrepancy in the amounts predicted remaining after the baby's treatment. The previous visual review of the boy's drugs was two days before he died.

Editorial by Raphael

Bereaved parents occasionally take their dead child's drugs to end their own lives

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Case 2

An 8 year old girl received palliative care services at home for advanced metastatic Wilms's disease. She had multiple painful bony metastases. Escalating doses of morphine eventually had minimal effect, and she was therefore changed to enteral methadone, which gave better analgesia. As her condition deteriorated, she became unwilling to take oral drugs. Therefore, after telling her family the analgesic options, we decided to get a pharmacist to prepare methadone for parenteral use. We controlled this via a central venous catheter, with a continuous background infusion and patient controlled boluses. She remained alert until she died.

Days after her death, her mother was found unconscious at home. She had taken the child's enteral methadone. The family had been advised to return all drugs to the pharmacy on the day that their child died by the home care nurse who visited them. The parents had stopped answering telephone calls from the palliative care nurse and home care nurses after the child's death. The mother was first admitted to a hospital's intensive care unit, and she survived.

Discussion

We highlight attempts of parental suicide after the expected home death of a child, by taking opioid drugs prescribed for the child. The literature on suicide in bereaved parents in general is scant; that which exists focuses on suicide in parents whose children died a violent death, specifically suicide, unintentional injury, or homicide.¹

A recent Danish population study showed twice as many deaths by suicide in bereaved mothers compared with a matched cohort of mothers who had not lost a child.² The data did not, however, relate the mother's suicide with her child's cause of death. A similar study further evaluated the relation between parental status and suicide.³ Generally, being a parent protected against suicide. But the death of a child strongly affected parental suicide, and the impact was greater when adjusted for other risk factors. Death of a young child (1 to 6 years) was correlated with more suicide in parents, and the risk was highest the month after the death of the child. Other studies have also shown increased morbidity and mortality due to natural and unnatural causes in bereaved parents.⁴⁻⁶

The extent to which opioids are used to control pain in the community has changed markedly recently. The widespread development of palliative care and home care services has allowed more and more dying

patients to stay at home. A recent study showed increased medical use of four common opioids from 73% to 402% in six years.⁷ The author cautions that if the misuse of opioid analgesics increases, the sources should be "addressed directly" without interfering with the drugs' availability, patients' care, or legitimate medical practice. This is vital to providing effective community palliative care.

These cases were in the context of providing palliative care for children. But the surviving relatives of dying adults may be similarly at risk. Literature exists that considers the safety of providing palliative care at home,⁸⁻⁹ the monitoring of opioid prescriptions,¹⁰ and the diversion and misuse of drugs.¹¹⁻¹² Neither law nor policy contain much guidance, however, on handling any remaining opioid drugs in patients' home after they die, beyond reminders to families to return them for safe disposal. Given this, families may rarely use these residual drugs for self harm, despite denial of suicidal intentions, and in the absence of legislation that would ensure these drugs were removed.

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The red sticker

We were scrubbed, in theatre, waiting for the anaesthetist to finish with the patient so that we could begin the operation. There was a young future medical student with us, who was trying his best to soak up the clinical atmosphere before attending his medical school interview the following week.

My consultant pointed at a large, round, bright red sticker on the patient's forehead and asked the youngster what he thought it was for. The anaesthetists at our hospital had started to place this sticker on patients' foreheads routinely after intubation as a

reminder that there was a mouth pack inserted, as some junior anaesthetic trainees in the past had forgotten to remove the mouth pack after extubation.

The bright young lad, representing the hopes of doctors of the future, puffed out his chest and confidently proclaimed, "Not for resuscitation, sir."

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