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Cardiac transplantation in severely ill patients

SIR,—Heart transplantation is one of the success stories of modern surgery. I have commented that the five year survival rate reported in the early 1980s was considerably better than that obtained by surgery for many kinds of cancer.¹ The investigation by health economists of the two British centres at that time reported that, taking account of both duration and quality of survival, heart transplantation was more cost effective than many procedures commonly carried out without hesitation.²

It is most unfortunate that this study, funded by the Department of Health and Social Security, was never published in a general journal—because it testified to the value both of heart transplantation and of economic appraisal. The reward for the surgeons who had the courage and confidence to allow their practices to be scrutinised by outsiders was that additional resources were made available for heart transplantation soon after the report was received by the department.

It appears from the recent paper from Harefield (19 March, p 817) that the selection criteria for transplantation have now been broadened to include patients with overwhelming cardiac failure, with or without multisystem dysfunction. Of 33 such patients, six died waiting for transplantation after an average of 34 days' intensive treatment; another five died within 24 hours of surgery and another one 10 days later (length of preoperative intensive care for these patients not stated). No fewer than eight different figures are given for success, mortality, and survival, leaving the average reader uncertain about how good the results really were. None the less, the authors claim that "the excellent results justify the expenditure and staffing requirements necessary to treat these terminally ill

patients." No costs are given and no mention even made of the previous economic appraisal of heart transplantation in this unit.

Some technologies become more cost effective as experience is gained. When, however, the selection criteria that led to early successes are later relaxed the opposite can happen. The original claim to cost effectiveness may not apply to the additional, differently selected, patients, who both incur greater costs and are less likely to benefit. The data in this paper are inadequate to judge whether that

Late abortions

SIR,—We write on the anniversary of the implementation of David Steel's Abortion Act, which legalised abortion under certain conditions. Since then over three million women in Britain and Europe have had operations which have become progressively safer over the years. In 1985 the *BMJ* published an article about the need for late terminations of pregnancy for reasons other than fetal abnormality, which was based on experience in Tower Hamlets.¹

We looked at the women who had been seen in 1987 to assess the effect of a change in the law to prevent abortions after the beginning of the 18th week of pregnancy. In practice this would prevent abortions after 16 weeks as doctors operate to a limit at least two weeks below the legal one.

We examined the records of 32 of the 37 women who underwent abortions after 16 weeks in 1987. They included seven women with fetal abnormalities, who had operations that would still be permitted under clause 2 of the proposed new law (which makes exceptions for the life of the mother,

is the case for the new constituency of patients now being considered for heart transplantation.

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1 Jennett B. *High Technology medicine; benefits and burdens*. Oxford: Oxford University Press, 1986.

2 Buxton M, Acheson R, Caine N, et al. *Costs and benefits of the heart transplant programmes and Harefield and Papworth Hospitals*. London: HMSO, 1985. (DHSS Research Report No 12.)

the likelihood of severe fetal handicap, and rape or incest under the age of 18). The 30 other women had operations for social reasons. These are often referred to in terms of "holidays in Spain," "beauty competitions," and "tennis matches," but in our experience the reality of these social problems is very different.

Our patients included a 26 year old single Somali woman with two children, living on social security, who spoke little English. Her two children were on the at risk register, the eldest was in hospital, which had delayed her from seeking advice, and she suffered from agoraphobia. She had just discovered that her boyfriend was married. She was unsure of her dates but was clinically 16 weeks when first seen and 17 weeks when her abortion was performed. Another was a 13 year old girl who had been referred promptly by her general practitioner when she realised that she was pregnant at 21 weeks' gestation. Clinically she was a little smaller than this, and ultrasound suggested a 19 week fetus. She refused to name the father, but the

pregnancy was probably not caused by incest or rape.

Even though the rate of late abortion was lower than the national average (4% v 6% in 1986), in one third of our patients there was a delay of two weeks or more between referral by the general practitioner and the operation. The underfinancing of the NHS has led to bed shortages and closure of the out-patient clinic over holiday periods. In two thirds of the women there was a discrepancy of more than two weeks between the woman's dates and gestation shown by ultrasound, a quarter had continued to menstruate for one or two months while taking the pill, and three women had irregular periods and did not realise they were pregnant until late.

Ignorance about the system, cultural change, poverty, homelessness, drug addiction, mental illness, violence from the male partner, youth and inexperience, and failed contraception in older women are associated with late presentation. These women would not be helped by any restrictive changes in the 1967 Abortion Act, which while not ideal, has helped many women, reduced the death toll and morbidity from illegal abortion, and allowed women and their doctors to discuss openly what was secret and hidden and thus deal with the problem safely.

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1 Savage W. Requests for late abortion—Tower Hamlets 1983. *Br Med J* 1983;290:621-3.

Strongyloidiasis

SIR,—Dr J A Hill (12 March, p 753) discusses the screening programme for *Strongyloides stercoralis* infection in ex-Far East prisoners of war. These patients are known to be at increased risk,¹ but *S. stercoralis* is endemic in several parts of the world.²⁻⁶ I present three cases of hyperinfestation occurring in patients of West Indian origin.

A 64 year old Jamaican man presented with a four year history of abdominal pain and weight loss. Stool parasitology had never been done. His eosinophil count was normal. Gastroscopy and colonoscopy showed lesions suggestive of Crohn's disease, and he was started on oral prednisolone. The biopsy reports, however, confirmed the presence of *S. stercoralis*. The steroids were stopped and he was started on thiabendazole. Twelve hours later he developed an *Escherichia coli* septicaemia and meningitis. He developed a cough, and live worms were isolated from his sputum. His treatment was changed to mebendazole and chloramphenicol, and he made a slow but uneventful recovery.

An 18 year old girl was admitted for investigation of weight loss and a low serum concentration of albumin. She developed clinical evidence of septicaemia and died. A postmortem examination showed hyperinfestation with *S. stercoralis*, and filariform larvae were found in the brain.

A 50 year old man was treated with thiabendazole after the organism was isolated from his stool. Within 12 hours he developed the clinical features of septicaemic shock and died.

S. stercoralis may be endemic among patients in Britain who have previously lived in the West Indies, and they are at risk of hyperinfestation. Other cases of hyperinfestation have been reported in Britain. Smallman and others reported two fatal cases in patients from the West Indies.⁷ A 29 year

old Jamaican woman was successfully treated,⁸ and two other fatal cases have been reported from the West Indies. These patients were all previously fit and three of them had not been back to the West Indies for more than 10 years.

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Sulphonylureas and hypoglycaemia

SIR,—The leading article by Drs R E Femeer and H A W Neil (2 April, p 949) omitted one aspect of hypoglycaemia developing with sulphonylureas—namely, this complication occurring with high dose sulphonamides, which are chemically related to the sulphonylureas. This has been observed in the last four cases of pneumocystis pneumonia we have treated by such therapy; we present here our most florid case. The other cases were less severe, but the patients did not have renal failure.

A 64 year old man was admitted with a five month history of general debility. Investigation showed renal failure (sodium 131 mmol/l, potassium 5.4 mmol/l, total carbon dioxide 12 mmol/l, urea 45 mmol/l, creatinine 837 µmol/l, creatinine clearance 3 ml/min). Biopsy showed active focal segmental glomerulonephritis. He was treated with cyclophosphamide 150 mg and prednisolone 60 mg orally per day. His condition deteriorated and he required haemodialysis and blood transfusion.

His chest radiograph showed progressive confluent shadowing of the left upper lobe. Suspected *Pneumocystis carinii* pneumonia was confirmed from bronchial washings. Treatment with co-trimoxazole 1920 mg intravenously four times a day was started, as recommended by Winston et al.² After initial improvement he relapsed and suffered an unexpected cardiac arrest, from which he was resuscitated.

At this time he developed hypoglycaemia and for the subsequent 48 hours his blood glucose concentration remained at 2.4 mmol/l despite an infusion of 10 g of dextrose per hour, repeated 20 g dextrose boluses, and on one occasion 100 g of dextrose in two hours. He recovered consciousness, but the response to treatment was not sustained and he died 48 hours later. The patient had received prednisolone 30 g, propranolol 120 mg, indomethacin 75 mg, flucloxacillin 2 g, calcium carbonate (Titalac 6 tablets), and danthron (Dorbanex 60 ml) daily. There was no evidence of liver or adrenal failure.

Necropsy showed an organising pneumonia, a quiescent glomerulonephritis, renal scarring, and patchy pancreatic necrosis. There was no evidence of an insulinoma.

We believe that accumulation of the sulphamethoxazole contained in the co-trimoxazole caused the hypoglycaemia. Hypoglycaemia has been recorded in cases of renal failure after much more modest doses of co-trimoxazole.^{3,4} This is clearly a rare complication but it is important to be aware of such a possibility in the increasing cohort of immunocompromised patients developing problems such as pneumocystis infection and requiring high dose sulphonamide treatment.

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Drug addicts and the GP

SIR,—The report from the Advisory Council on the Misuse of Drugs discussed by Dr Tessa Richards (16 April, p 1082) recognises the rapid spread of human immunodeficiency virus (HIV) among drug misusers which has overwhelmed the present arrangements for coping with them.

Among the proposals to contain misuse and combat the spread of AIDS are ones which affect the whole of general practice. For example, one proposal says: "We conclude that the advent of HIV makes it essential that all GPs should provide care and advice for drug misusing patients to help move them away from behaviour which may result in them acquiring and spreading the virus. Health authorities should ensure that appropriate support is available and that GPs are made aware of it."

As a result of this report considerable pressure will be put on all general practitioners to participate in combating drug misuse. Many, however, are reluctant to do so, although their response is based on practical reasons rather than the prejudice implied by Dr Richards. Their reluctance will be founded on lack of training; the expectation of lack of support, based on past experience of dealing with dependent groups; concern about demands on their time; and worries about their staff being exposed to patients who will bring manipulation and violence into the waiting room, where there is greater danger to staff than in hospital.

If any progress is to be made it will not come from rhetoric, reports, or the simple transfer of problems to general practice. Success can come only from a programme designed to train general practitioners and their staff to deal with this group and from effective support in the hospital and community.

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Early detection of visual defects in infancy

SIR,—Drs D M B Hall and Susan M Hall (19 March, p 823) do not analyse which visual defects screening programmes are likely to uncover. No claim to detect severe visual defects in the first weeks of life has ever been made. Myopia and refractive errors, by far the most common