ADDRESS LETTERS TO

The Editor
Australian Family Physician
1 Palmerston Crescent
South Melbourne Vic 3205
Australia

FAX 03 8699 0400

EMAIL afp@racgp.org.au

Early management of meningococcal disease

Dear Editor

Recommending the early administration of antibiotics even in patients located in close proximity to hospitals is very commendable. This approach was vindicated recently in a tertiary care hospital in Delhi, India. During March 2005 to the beginning of July, there was an outbreak of meningococcal meningitis in Delhi. The cumulative number of cases during the outbreak period was 441 with 60 deaths, a case fatality rate of 13.6%.[1] We report two cases of meningococcal meningitis where prompt intravenous antibiotics administration was responsible for complete recovery in two adults.

During the first week of March 2005 and the last week of April 2005 respectively, two adult men aged 25 years were admitted to the Sant Parmanand Hospital, a 140 bed, private sector tertiary care hospital in Delhi. Both had high grade fever for 2 days. The first had headache and impaired mental status for a day, was drowsy and agitated with stiffness of the neck on admission. CSF showed protein levels of 300 mg/dL (3 g/L), glucose 3 mg/dL (0.166 mmol/L), cell count 11 000/mm, predominantly neutrophils only. A latex agglutination test using Pastorex Meningitis (BIORAD laboratories) was positive for group A meningococcus. The second patient was unconscious on admission. CSF showed protein 295 mg/dL (2.95 g/L), glucose 26 mg/mL (1.44 mmol/L), and cell count 25 800/mm, predominantly neutrophils. Latex agglutination test was again positive for group A meningococcus. In one case, CSF culture yielded growth of group A meningococcus, as confirmed by biochemical tests and serogrouping. Antibiotic susceptibility by E-test against penicillin, ampicillin, ceftriaxone, rifampcicin, ciprofloxacin, ofloxacin, gatifloxaciin, azithromycin and cotrimoxazole showed the isolate to be sensitive to all except ciprofloxacin and cotrimoxazole. There was no bacterial growth in the first patient's CSF and blood after 5 days incubation.

Both patients upon admission received intravenous ceftriaxone 2 g, antacids and infusion fluids. Further ceftriaxone was given twice a day for 2 weeks. Both patients improved remarkably and were discharged 9 days later.

The risk of meningococcal disease in contacts of a patient can be reduced by an estimated 89% by antibiotics known to eradicate meningococcus carriage.[2] Upon confirmation of meningococcal meningitis in the first patient, hospital personnel handling the patients or pathological specimens in casualty, wards and the laboratory were given ciprofloxacin 500 mg orally as a single dose. Chemoprophylaxis involved staff in the casualty department (132), intensive care units and other wards (83), and the laboratory (62). There has been no *Neisseria meningitidis* infection (cross or nosocomial) in the hospital premises. The practice was discontinued only following the fall off in Delhi's meningococcus disease outbreak.

The efficacy of ceftriaxone has been identical to long acting chloramphenicol in short course treatment during a meningococcal meningitis outbreak in nine health facilities in Nigeria.[3] In our recent experience, immediate intravenous ceftriaxone administration was associated with full recovery in two cases. Surely, instant response by clinicians at all levels with immediate antibiotics would be the most efficient therapeutic strategy. That alone would neutralise inimical effects of any delays in diagnosis and antibiotics administration in adults afflicted with meningococcal meningitis; both have been responsible for high adult mortality.[4]

Subhash Arya, Sunil Gupta
Sanjay Gupta, Lalit Mehta
Nirmala Agarwal, Shashi Khare
Delhi, India

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Bowel cancer screening

Dear Editor

I would like to comment on the excellent article by Dr Millard (*AFP* April). While pill enteroscopy is an excellent modality to examine the small bowel it is not designed to examine the colon and is not an alternative to colonoscopy. In the small bowel the pill enteroscope is aligned in the direction of the lumen and thus a full

examination is possible (allowing for battery time of 8 hours). In the colon, the lumen is larger and the cleared bowel without air insufflation lies with the mucosa flat on the mucosa of the opposite wall (like an empty inner tube). As a result the examination of the colonic mucosa in not complete which reduces the sensitivity to unacceptably low levels.

I agree the success of the upcoming bowel cancer screening program relies largely on the general practice input.

Andrew Bryant
Brisbane, Qld

Reply

Dear Dr Bryant. Thank you for your helpful description of pill enteroscopy using a micro-camera, often referred to as a 'pillcam'. This clearly is a valuable tool for investigation or surveillance of the bowel proximally but obviously its usefulness ends at the caecum. I apologise for any confusion in linking the micro-camera to 'virtual' colonoscopy, a term more frequently used to describe CT colonography. Trials of computer assisted software look promising in improving the sensitivity and specificity of colonography as a patient friendly screening and surveillance tool, but cost and exposure to radiation are likely to restrict its use for regular population screening.

Fiona Millard
Mackay, Qld

Mental illness and the law

Dear Editor

In the article 'Mental illness and the law' (*AFP* March), Dr Bird described a case in which a person charged with murder was acquitted on the grounds of mental illness. Important lessons were described.

This letter is to correct an often held belief that the person so acquitted goes free. This is not so under New South Wales law. The person is confined at the pleasure of the Minister and as a matter of practicality the confinement is in a gaol. Because of the indeterminate nature of the sentence the person is categorised by the Corrective Services Department as a person doing a life sentence. Just where the person is confined then depends on the department. In one case in which I was involved, the person spent some 6 years in Long Bay Gaol until it was decided he was no longer a danger.

RJ Burn
Yass, NSW

Ceasing warfarin

Dear Editor

In all states except Professor Kamien's own, Western Australia, there exists some doubt about the extent of the medicolegal risk that he warns of in relation to ceasing warfarin before dental extraction (*AFP* April). In the states which enacted Civil Liability legislation following the Commonwealth's Principles Based Review of the Law of Negligence (the Ipp Review), the standard of care for professionals is now defined (with some minor variations) in a way which does not make clear the extent to which quality evidence will bear on judgments of negligence. For example, Queensland's *Civil Liability Act 2003* states that a professional does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a way that (at the time the service was provided) was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice. Wide acceptance does not need to be universal. The only caveat to this standard is that peer professional opinion cannot be relied on if the court considers that the opinion is irrational or contrary to a written law.

Professor Kamien demonstrates through the evidence that the practice of ceasing warfarin before dental extractions is 20 years out of date. Whether the practice would be judged to be irrational is unknown because it is as yet untested. Professor Kamien's 'quick and dirty' epidemiology certainly suggests that ceasing warfarin before dental extraction remains a practice which is widely accepted by peer professional opinion. It is therefore unclear whether such an outdated practice would currently fail the test of the standard of care in the majority of Australian jurisdictions. It is hoped that in a case like the one Professor Kamien described, the courts would equate irrationality with a lack of good evidence, but this is by no means certain.

Malcolm Parker
Brisbane, Qld

Cooperation between GPs and psychiatrists

Dear Editor

I was intrigued by the remark in the article 'Item 291: Progress in cooperation between GPs and psychiatrists' (*AFP* March)... 'Other specialists are not paid extra to write back to me...'

It is stated, 'the item number (291) is ...a comprehensive report that requires the summary of history, a psychodynamic comment, opinion, and management plan that gives the GP a clear direction as to the diagnosis and management of the patient'. This is precisely what physicians provide in their reports back to GPs and other referring doctors, and yet, compared with psychiatrists, they are penalised by not being paid for this extra work, which, in my experience, usually takes 15–30 minutes.

I suspect that a GP preparing a proper summary of history, examination findings, and provisional diagnosis, would require a similar amount of time, which legally could be counted as part of an elongated consultation, and thus charged for by the GP. A consultant physician has no such luxury, and must absorb the time and costs of reports into his/her other expenses.

When looked at in this light, the GPs and psychiatrists are in a somewhat favoured position. I will not hold my breath waiting for physicians to be accorded the same financial reward for their time and expertise.

Ross Philpot
Adelaide, SA