

Letters

EMBOLIC STROKE AS A LATE COMPLICATION OF INFERIOR VENA CAVA THROMBOSIS

Editor,

We read with interest the article entitled “Inferior vena cava thrombosis in young adults – a review of two cases” by McAree *et al.* in the May 2009 Journal ¹. In addition to the complications they describe, we recently encountered an unusual and late complication of the condition.

A 73 year old male in sinus rhythm with history of 2 embolic strokes underwent trans-oesophageal echocardiography (TOE) after trans-thoracic echocardiography demonstrated an aneurysm of the inter-atrial septum, a finding often associated with patent foramen ovale (PFO). Of note, the patient had suffered two episodes of extensive deep venous thrombosis of the legs some 44 years previously and had stopped taking aspirin prescribed for cardiovascular risk just before the first stroke.

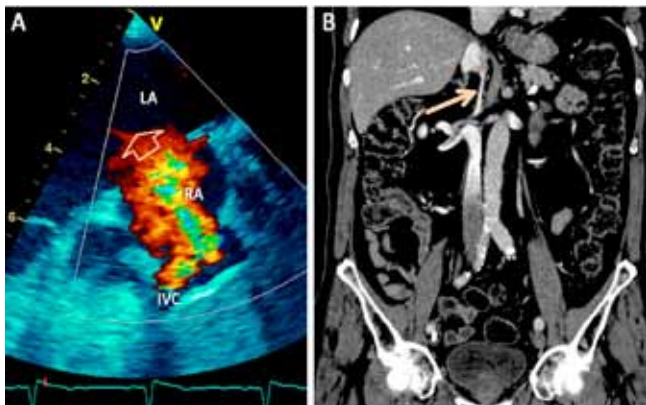


Fig 1. Panel A: IVC: inferior vena cava, LA: left atrium, RA: right atrium, Arrow: Jet crosses patent foramen ovale.
Panel B: Arrow: Inferior vena cava stenosis.

Initial TOE saline contrast study demonstrated a PFO with right to left flow. Colour Doppler interrogation revealed a high velocity jet (1.75ms^{-1}) entering the right atrium from the inferior vena cava (IVC). It impacted on the inter-atrial septum and crossed into the left atrium continuously via the PFO (Figure 1, panel A, arrow). The jet could be traced back for a few centimetres into the IVC before it seemed to disappear.

A computed tomography scan of abdomen showed a long stenosis of the IVC just above the right renal artery (Figure 1, panel B, arrow). There was accumulation of contrast in the IVC consistent with a severe stenosis. The remainder of the examination was normal.

The aetiology of the IVC stenosis was unclear; a congenital stenosis would usually be associated with prominent collateral veins that were not present in this case. A spontaneous thrombosis of the IVC is very rare as discussed by McAree *et al*¹. It seems most likely that the stenosis represented organised thrombus related to his previous extensive DVTs.

No other potential cause of embolic stroke was found. He was commenced on Warfarin after the TOE and remains well

PFO is a well recognised cause of cryptogenic stroke ² with paradoxical embolus being facilitated by an increase in right atrial pressure, in this case, the jet effect of the IVC stenosis. A MEDLINE search failed to find any other examples of this association in the literature.

We note that in their discussion, McAree *et al.* have listed pulmonary embolus as a recognised complication of the condition but PFO (present in up to 25% of the population) could potentially allow systemic embolisation of recent IVC thrombus or in our patient's case, potentially facilitate embolic stroke many years later in association with a jet effect from an IVC stenosis.

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SIR WILLIAM WHITLA'S FAMILY NAME

Editor

Information has recently been uncovered which merits a short foot-note to the biographical details of Sir William Whitla (1851-1933), a towering medical presence, twice President of this Society (1886 and 1901) and its greatest benefactor.

Sir William's first recorded ancestor was John **Whitly** (1680-1721) who lived in the townland of Drumnahuncheon, between Richhill and Kilmore, County Armagh. Sir William's father, Robert was born in 1817 by which time his family name was spelt **Whitley**. Due, reportedly, to a family feud, Robert and his father changed their name to **Whitlaw**. Robert **Whitlaw** went to live in Monaghan where in 1841 he married Anne Williams of a family long resident in the town. Shortly afterwards Robert changed his name to **Whitla**, and it was as **Whitla** that all twelve of the offspring were born. Such name changes were frequent at the time but those among Sir William's forebears have not previously been described.

(I am indebted to Mr Patrick Corkey, now deceased, a grandnephew of Sir William, for recently giving me this information which had been brought to light by Sir William's nephew, Commander James Whitla Gracey [1884-1969], but not reported.)

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COMPARISON OF PUBLIC PERCEPTIONS ASSOCIATED WITH HEALTHCARE-ASSOCIATED INFECTIONS (HCAIS) IN NORTHERN IRELAND FOLLOWING THE 2007/2008 OUTBREAK OF CLOSTRIDIUM DIFFICILE IN THE NORTHERN TRUST

Editor,

Between June 2007 and August 2008, an outbreak of the spore-forming anaerobic bacterium, *Clostridium difficile*, occurred within the Northern Health Trust, particularly associated with Antrim Area Hospital. During this period, there was sustained local media attention in its reporting via radio, newspaper and television. Following the outbreak, it was the aim of this study to compare public perceptions to and fear of healthcare-associated infections (HCAIs) of responders in Northern Ireland with responders elsewhere in the UK and worldwide.

An on-line e-survey was performed over the four month period, June through September 2009, hosted at the *Infection Free by Design* (IFBD) network site (<http://www.infectionfreebydesign.com/>), where IFBD was supported through an Invest NI facilitation grant. Twelve questions were asked to assess the public's perception of HCAIs and how these are being challenged. In total, 201 responses were analysed, originating from 53% males and 47% females, including 104 from persons with a Northern Ireland postcode, 75 with a postcode from Great Britain and 22 responders from other countries, including Australia (n=4), Germany (n=1), India (n=2), Malaysia (n=3), New Zealand (n=1), Republic of Ireland (n=3), South Africa (n=1) and the USA (n=7). Overall, the greatest fear of going into hospital in descending order was (i) fear of catching a HCAI (120/201 (59.7%) respondents ranked this their greatest fear, (ii) waiting lists (82/201 (41.0%) respondents ranked this as their second greatest fear, (iii) being away from home, (iv) hospital food and finally, getting to/from hospital. Within the Northern Ireland context, fear of catching a HCAI was also the greatest concern regarding going into hospital (62%), which was markedly higher than GB (56%) and where waiting lists ranked the second most significant anxiety/fear (49% in NI versus 33% in GB). Most responders described themselves as having a medium level fear of HCAIs (51.3%), whilst approximately one fifth of interviewees (18.1%) expressed having a high level of fear of HCAIs, whilst approximately one third of responders (30.7%) declared having a low level of HCAI anxiety. When questioned as to where this anxiety towards HCAIs originated, media reports were responsible for the majority (62.1%), followed by what one had seen when visiting a hospital (27.7%), stories from other patients (24.6%), practical/personal experience (22.1%) and finally

what one had seen as a patient (8.2%). Approximately three-quarters of responders (75.5%) did not feel that hospitals were doing enough to prevent HCAI-related infection. Three patients in Northern Ireland (2.9%) failed to keep a hospital appointment due to the fear of acquiring a HCAI during their visit to hospital. For two of these patients, the failure to attend a hospital appointment was on more than one occasion. Overall, in 2008/2009, there were 1,565,497 outpatient attendances recorded within DHSSPSNI (http://www.dhsspsni.gov.uk/volume_1_programme_of_care2pdf.pdf). In 10.8% of these scheduled attendances, the patient did not attend (7.4% of new referrals and 12.3% of review attendances). Therefore, if we attempt to estimate the total number of outpatient appointments missed in NI in the 2008/2009 period, potentially attributed to a fear of acquiring a HCAI, this crudely is 3,374 missed new referral appointments, which represents a significant cost to the HSC Trusts locally.

Unfortunately, we do not have any baseline data prior to the *Clostridium difficile* outbreak to make comparisons, although local rates appear to be higher, when compared to GB rankings. What is clear from these preliminary findings is that the fear of acquiring a HCAI from interacting with a HSC Trust is the dominant factor, ranking even higher than HSC waiting lists and that such anxiety is being driven by media reports. Statistically robust data is urgently required, particularly within the in-patient and out-patient setting, to inform policy, so that clear patient communication interventions are put in place to (i) communicate such risk to the patient in an informed and balanced manner, (ii) optimize patient management and (iii) avoid "missed" appointments by patients who fear attending a HSC Trust will result in a HCAI, thus saving the Trust valuable resources.

The authors have no conflict of interest.

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A THIRD STATUS

Editor,

As sometimes happens to asthmatic and epileptic patients, every now and then, a well controlled hypertensive patient also enters, for no apparent reason, a refractory hypertensive state that would demand urgent treatment with much higher doses of his usual medications and often with different and more powerful drugs to reverse it.

In line with the nomenclature used for the first two conditions,

i.e., status asthmaticus and status epilepticus, I suggest we use for this particular hypertensive state, the name 'Status Angiotensus', meaning a refractory state of tense arterioles.

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