South African guidelines on venous thromboembolism

To the Editor: We commend the excellent work by Jacobson *et al*. on behalf of the South African Society of Thrombosis and Haemostasis in producing a very necessary set of local guidelines on the management of venous thromboembolism (VTE).[1] VTE is a major cause of morbidity and mortality, as highlighted recently by the United States Surgeon General.[2] One important nuance worth noting, however, is the fact that warfarin may be started together with low-molecular-weight heparin (LMWH) on day 1 of anticoagulation, and is supported by recent guidelines by the British Committee for Standards in Haematology and the American College of Chest Physicians (ACCP) who both agree that LMWH and warfarin should be started on the same day.[3,4] The ACCP gives this recommendation their highest level of evidence, namely 1A. Evidence for this suggestion includes data from a randomised trial by Mohiuddin *et al*. showing decreased cost and morbidity in the group started earlier on warfarin.[5] Leroyer *et al*. and Gallus *et al*. have both also shown decreased duration of hospitalisation with earlier initiation of warfarin.[6,7] The ACCP also recommends that the duration of LMWH should be for a minimum of 5 days v. the 7 days suggested by Jacobson *et al*. This is in part based on at least one randomised trial showing similar efficacy in both arms.[8] Although this may only result in a total difference of 4 doses of LMWH per patient, the long-term cost implications may be significant. Lastly, noting the narrow therapeutic window of warfarin, we believe that it is important to consider major risk factors for bleeding on anticoagulants, such as increased age, uncontrolled hypertension, alcohol, use of non-steroidal anti-inflammatory drugs, liver disease and peptic ulcer disease, before initiating therapy.[9,10]

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Professor Jacobson replies: On behalf of the authors, I thank Webb *et al*. for their valuable comments.

The initiation of anticoagulation with LMWH and delaying warfarin was done knowingly for the following reason: South Africa has a nursing crisis aggravated in the State sector where LMWH is often only dispensed as a Schedule 7 medication. This leads to delays in patients receiving their LMWH. In our experience, numerous patients are therefore given warfarin, and LMWH is only given by nursing staff 24 - 48 hours thereafter. As there is a serious theoretical concern that patients' thromboses – especially those with Protein S deficiencies – will be exacerbated, there was consensus that warfarin should only be started after the clinician was convinced that the LMWH had actually been injected rather than prescribed.

Regarding LMWH duration for a minimum of 5 days v. 7 days: this actually depends on when the patient is fully mobile, which we believe is far more important than looking at empirical days, especially as numerous patients are discharged early from hospital to recover at home.

Lastly, we fully agree that, when commencing any patient on anticoagulation, the risk/benefit needs to be assessed and individualised in relation to any contraindications for anticoagulation.

Olfactory reference syndrome in DSM-V

To the Editor: We read with interest Dr A Lawrence's recent *SAMJ* case report of a young man who presented with persistent preoccupation with personal body odour in the absence of any physical abnormalities.[1]

Dr Lawrence does not explicitly consider a diagnosis of olfactory reference syndrome (ORS). This condition, characterised by a preoccupation with the idea that one's body odour is foul or offensive to others, may be part of the differential diagnosis in patients with psychotic disorders (who may have olfactory hallucinations), in patients with obsessive-compulsive disorder (who may have concerns about contamination, and wash or clean repeatedly) and in patients with a social phobia spectrum disorder (who may have severe social anxiety because of fears of causing offence).

One of the reasons why ORS was not included in the differential diagnoses is that it is not formally included in the *Diagnostic and Statistical Manual*, 4th edition (DSM-IV). The

condition is briefly mentioned in the text on delusion disorder, somatic subtype and social phobia (given that some patients with taijin kyofusho (a condition related to social phobia) may suffer from concerns that their body odour is offensive).

Although we cannot be sure that a diagnosis of ORS might have been accurate or clinically useful for Dr Lawrence's patient, we would argue that this kind of discussion provides a good basis for explicitly including ORS in DSM-V. It is a well-described condition,[2] for which diagnostic criteria have been proposed,[3] and for which various interventions have been noted in the literature.[2,4-6] Including the condition in DSM-V would help to improve reliability of diagnosis and raise awareness among clinicians, and probably lead to further research on this entity.

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Cavernous sinus thrombosis – a possible lethal complication of facial abscess manipulation

To the Editor: We are concerned by two recent, similar cases. A 24-year-old man presented with facial swelling, an almost complete bilateral opthalmoplegia and chemosis, and a left dense hemiplegia of sudden onset. These symptoms followed expression of a facial abscess by a general practitioner. A brain scan showed an infarct in the right lentiform nucleus with involvement of the head of the caudate with marked sinusitis. He received high-dose intravenous antibiotics in intensive care after bilateral ethmoidectomies and antral washings. He was discharged after several weeks on a rehabilitation programme for the stroke.

The second was a 22-year-old woman who presented to a general practitioner with an abscess on the right cheek. An incision and drainage procedure was performed. Within days, she developed a severe frontal headache, fever, bilateral proptosis, conjunctival and eyelid oedema and a complete bilateral opthlamoplegia. A computed tomography (CT) brain scan showed proptosis with no obvious brain pathology. She was given high-dose intravenous antibiotics and recovered fully after several weeks.

Both patients presented with features suggestive of cavernous sinus thrombosis (CST), a known complication of facial abscess squeezing or surgical interference. Despite an improvement in mortality and morbidity with the advent of antibiotics, consequences of CST remain dire.[1] The causes of death include haemorrhagic brain venous infarcts and raised intracranial pressures from oedema. Pulmonary embolism via the internal jugular vein has been described.[2] Other complications include visual loss and carotid artery occlusion with a subsequent major stroke. The first patient had an arterial stroke as a sequel of the cavernous sinus thrombosis. Early diagnosis and management is therefore paramount, with the knowledge that a 'normal' CT brain scan does not necessarily exclude the condition in someone with suggestive clinical features.[3]

Incision and drainage of cutaneous abscesses (without antibiotics) is considered an appropriate intervention. However, double-blind, prospective, placebo-controlled randomised studies in this regard are absent.[4] Owing to their proximity to the cavernous sinuses, abscesses in the middle and upper face must be treated with special care. The infection may spread from the face via the facial venous plexus, which connects to the valveless emissary veins into the cranium.

These two patients provide a warning against a casual approach to suppurative facial processes. For even 'minor' incisions of facial suppuration, antibiotic cover and close follow-up are mandatory to avoid disaster. The early and aggressive use of antibiotics for a septic cavernous sinus syndrome can rescue an otherwise hopeless situation.

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