Correspondence

Pneumonitis in an elderly Bangladeshi man

The incidence of primary varicella zoster virus infection (VZV) in young adults and pregnant women has risen in recent years and is accompanied by a greater risk of serious complications. VZV disease in the elderly usually presents as shingles, as a result of secondary reactivation of latent infection, and can be treated successfully with early antiviral therapy. We report a case of fatal primary infection in an elderly man.

A 66 year old Bangladeshi man with fibrosing alveolitis and non-insulin dependent diabetes mellitus was admitted to hospital with increasing shortness of breath for one week. He was a smoker and had been well controlled on 25 mg of prednisolone daily for the previous two months.

On admission he was febrile (38.5°C), tachypnoeic (50 breaths/minute), and hypotensive (blood pressure, 85/60 mmHg), with severe mucosal candidiasis. An extensive maculopapular rash, present for three days, was noted and thought to be consistent with amoxicillin treatment, which had been started before admission. Coarse crepitations were heard throughout the chest, oxygen saturation was 80% on air, and blood gases showed type I respiratory failure (pH 7.3; partial CO2 pressure, 4.8 kPa; partial O2 pressure, 8.39 kPa; HCO3, 19.4 mmol/litre). Haemoglobin was 180 g/litre, white blood cell count was 8.5 × 10⁹/litre, serum creatinine was 180 mmol/litre, and blood glucose was 22.2 mmol/litre. Chest x ray showed right mid zone consolidation (fig 1). Broncho pneumonia was diagnosed; intravenous amoxicillin, clarithromycin, and fluconazole were commenced. After consultation with the virologists the patient also received aciclovir (10 mg/kg) intravenously.

He required intubation, ventilation, and inotropic support within 14 hours of admission. He remained persistently hypoxic despite 100% oxygen, positive end expiratory pressure, inverse ratio ventilation, and nebulised prostaclin. Oxygenation improved dramatically with prone ventilation. Renal replacement treatment was started on day 3.

On day 4 the rash was noted to be vesicular. Skin scrapings and respiratory secretions were then examined for herpes simplex virus (HSV) and VZV by immunofluorescence (Dako, Ely, UK) and were positive for VZV. IgM and negative for VZV IgG antibodies and a diagnosis of chickenpox was made. He received a single dose of normal immunoglobulin (Sandoglobulin; Novartis, Camberley, Surrey, UK; 200 mg/kg) and the aciclovir was continued for 14 days. Respiratory function gradually deteriorated despite 16 hours of prone ventilation each day and he died 23 days after admission.

VZV pneumonitis after primary infection is a severe disease with high mortality, especially in non-immune pregnant women, neonates, and the immunosuppressed. Smocking and previous treatment with steroids have been identified as independent risk factors. In the UK, pneumonitis in the elderly is a very unusual occurrence because there is almost universal seroconversion by early adulthood. In the tropics, seroconversion occurs at a later age, with seronegativity as high as 42% being found in rural Bangladeshi adults. It is interesting that although this patient had been resident in the UK for over 20 years he remained susceptible.

Intensive therapy unit (ITU) management of respiratory failure with ventilatory support is essential in varicella pneumonitis. retrospective analysis of patients treated with aciclovir has shown some benefit of treat- ment, especially when instigated early, but there has been no controlled randomised trial to date. High doses (10 mg/kg) are essential to obtain serum titres that are inhibitory to VZV (0.08–1.2 mg/litre). The use of steroids in varicella pneumonia is controversial, with one small trial showing a reduction in ITU and hospital stay, but no effect on overall mortality. Normal immunoglobulin (100–300 mg/kg) has also been given, with variable results. Prophylaxis using varicella zoster immunoglobulin (VZIG) has been successful in preventing or attenuating disease in non-immune contacts of primary cases after exposure. A live attenuated vaccine (Oka strain) has been used in some countries, but is available on a named patient basis only in the UK.

This is the fourth fatal case of adult varicella pneumonitis we have seen in six years, and the second in an elderly Bangladeshi man taking steroids for lung disease. Although a characteristic chickenpox rash can precede the onset of pneumonitis by three to five days,1 our experience in these patients is that it may not be present or may be atypical. Diagnosis is often delayed and initial treatment may sometimes be inappropriate. Varicella is a preventable disease and consideration should now be given to the identification and vaccination of seronegative individuals at risk of severe infection.

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Figure 1 Plain chest x ray taken on admission.
When should a coroner’s inquest be held? The Manchester guidelines for pathologists

I am grateful to Dr Roberts and colleagues for their important paper and argument to formulate guidelines on when to report a death to the coroner and decisions therefrom. The implications for practitioners in primary and secondary care. One particular dilemma is when to discuss with the coroner what appears to be a natural death, but where the cause is unknown or when it is well known to the practitioner, but has not consulted in the required preceding 14 days. This is compounded by the variation in attitudes of coroners and their officers to such discussions. It is indeed a “grey area” where general guidelines are required for doctors and coroners so that it can be determined more precisely when necropsies and inquests are required. To facilitate this process, death certificates and the second part of cremation forms could comprise specific additional questions. These should ascertain the extent to which the certifying practitioner, and the independent practitioner in the case of the cremation form (part 2; form C), are in agreement that the cause of death stated is beyond reasonable doubt, and so whether or not involvement of the coroner is required. In the case of cremation, where a body has been permanently disposed of, the use of a second practitioner who discusses the case with the first practitioner incorporates a double check into the process. This check is supplemented by a third practitioner acting as the crematorium medical referee.

It is well known that most medical diagnoses are made through clinical history, examination, and investigations, so that in most situations, unnecessary postmortem procedures and inquests could be avoided, although they may be required given the existing regulations.

Guidelines should be aimed at improving the specificity of the postmortem service as a research tool to be of benefit in three ways when the cause of death is unclear, namely: (1) educating the profession, (2) ascertaining where death is unnatural, and (3) most importantly, facilitating the grieving process of relatives. The latter could be facilitated by next of kin clinicians, who have been discussed in this journal, and which target the needs of families attempting to come to terms with the complications of a coronial investigation at a time of crisis, particularly in the situation of sudden death. Such changes should not only improve the quality of the service and its clinical effectiveness, but also be an aid to clinical governance in this area.

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Research

mentioned lymphoma subtypes, and to provide prognostic markers, should take into account immunobiological properties as well as clinical and histological features.

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Calendar of events

Full details of events to be included should be sent to Maggie Butler, Technical Editor, JCP, The Cedars, 36 Queen Street, Castle Hedingham, Essex CO9 3HA, UK; email: maggiebutler@pilotree.prestel.co.uk

Professional Standards of Pathologists in a Modern NHS Pathology Service 7 June 2001, Royal College of Pathologists, London, UK
Further details: Michelle Casey, Academic Activities Coordinator, 2 Carlton House Terrace, London SW1Y 5AF, UK. (Tel +44 020 7451 6700; fax +44 020 7451 6701; www.rcpath.org)

Recent Advances in Genetics 5 July 2001, Royal College of Pathologists, London, UK
Further details: Michelle Casey, Academic Activities Coordinator, 2 Carlton House Terrace, London SW1Y 5AF, UK. (Tel +44 020 7451 6700; fax +44 020 7451 6701; www.rcpath.org)

BSCC Annual Scientific Meeting 9–11 September 2001, Majestic Hotel, Harrogate, UK
Further details: BSCC Office, PO Box 352, Uxbridge UB10 9TX, UK. (Tel +44 01895 274020; fax +44 01895 274080; email lesley.couch@psilink.co.uk)

Infectious Hazards of Donated Organs 28 June 2001, Royal College of Pathologists, London, UK
Further details: Michelle Casey, Academic Activities Coordinator, 2 Carlton House Terrace, London SW1Y 5AF, UK. (Tel +44 020 7451 6700; fax +44 020 7451 6701; www.rcpath.org)

41st St Andrew’s Day Festival Symposium on Therapeutics 6–7 December 2001, Royal College of Physicians, Edinburgh, UK
Further details: Eileen Strawn, Symposium Coordinator. (Tel +44 0131 225 7324; fax +44 0131 220 4393; email 2.strawn@rcpe.ac.uk; website www.rcpe.ac.uk)

Current Concepts in Surgical Pathology 12–16 November 2001, The Four Seasons Hotel, Boston, Massachusetts, USA
Further details: Department of Continuing Education, Harvard Medical School, PO Box 825, Boston, MA 02117-0825. (Tel +1 617 432 1525; Fax +1 617 432 1562; email hms-cme@harvard.edu; web page http://www.med.harvard.edu/conted/)

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