fibrosing ulcer in the caecum and terminal ileum, brushings from which showed for acid-fast bacilli. Biopsy revealed a chronic inflammatory granulomatous disease. She required 10 units of blood transfusion with anti- tubercular treatment and had an uneventful recovery. Review of the literature for the past 22 years revealed 13 cases of colonic tuberculosis which presented with massive rectal bleeding. Intestinal tuberculosis is associated with increased capillary vascularity and obliterator endarteritis which makes bleeding uncommon. All the reported cases required intestinal resection except one which was managed with transcatheter embolization. The reported case was managed conservatively as she was not willing for surgery and to our surprise she made a complete recovery.

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References

Bradycardia associated with fluoxetine in an elderly patient with sick sinus syndrome

Sir,

Selective serotonin re-uptake inhibitors (SSRIs) are a relatively recent class of drug introduced for treatment of depression and promoted as being largely free of serious side effects. In particular they do not have the quinidine-like activity of tricyclic anti-depressants.

However, a clinically non-significant slowing of pulse rate is recorded with SSRIs, and instances of cardiac side effects in patients with underlying cardiac disease have been reported. We report a patient who developed bradycardia whilst taking fluoxetine (Prozac) and who was subsequently found to suffer from sick sinus syndrome.

A previously fit 89 year old woman who had been started on fluoxetine 20 mg/day for depression 18 months previously, presented with dizzy spells and falls. Other medication was a small dose of amitryptiline of 25 mg/ day and occasional temazepam 10 mg nocte for insomnia. Both latter drugs had been taken for several years. There was no past history of cardiac disease.

Examination revealed a regular pulse of 44/minute, blood pressure 140/80 mmHg and a grade 2/6 ejection systolic murmur was heard over the left sternal edge. Central nervous system examination was unremarkable. Electrocardiogram (ECG) revealed sinus bradycardia at a rate of 40/minute, a chest radiograph was within normal limits.

All her medications were stopped and her pulse rate rose to 72/minute within 24 hours of admission. Her symptoms disappeared and she became independently mobile. An ambulatory 24 hour ECG recording was performed and showed features of sick sinus syndrome with pauses of over 3 seconds duration. A permanent pacemaker was therefore inserted prior to discharge home.

Although not absolutely proven since re-challenge was not considered ethical, we feel it likely that fluoxetine contributed to the bradycardia and symptoms in this patient. The low dosage and longer duration of use of other medication makes their contribution unlikely and the prompt resolution of the bradycardia on stopping medication suggests that the sick sinus syndrome alone was not responsible. It is also of interest that, although slowing of cardiac conduction is apparently a feature of all the SSRIs, previous case reports have implicated fluoxetine where cardiac side effects have occurred, as was the case with our patient.

We therefore suggest that SSRIs do carry a risk of cardiac side effects, particularly where cardiac disease and/or conduction defects are present. Awareness of this and appropriate assessment is therefore advisable before prescribing SSRIs, including ECG examination. This is especially important in the elderly where occult cardiac disease and conduction abnormalities are relatively common.

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