form of recent dental infection or manipulation. Our patient also had very poor dentition and valvar heart disease. Various combinations of antibiotics like penicillin and streptomycin, cephalosporin and streptomycin, penicillin, tetracycline and streptomycin have been successful in treating similar cases, however, at present high dose penicillin (>25 mU/day) in combination with an aminoglycoside for six weeks is favoured.

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3 Griffith JK, Daly JS, Dodge RA. Two cases of endocarditis due to lactobacilli species; antimicrobial susceptibility, review and discussion of therapy. Clin Infect Dis 1992; 14: 250–5.

Emergency blood test guidelines

Sir,
The audit study by AG Pennycook1 resulted in considerable savings (40%) on out-of-hours investigations in the Accident and Emergency department in Southampton. We carried out a similar study here seven years ago but achieved a smaller (22%) reduction in on-call investigations over the first few months only.2 Since then the on-call workload for the laboratory has increased steadily year-on-year, despite instruction of doctors in the Accident and Emergency department on the use of our guidelines. We are now reconsidering the wider use of emergency investigation guidelines and contacted the laboratory in Southampton to ask them about the effect of their guidelines on their workload. They were not aware of the audit study conducted in their Accident and Emergency department and their workload figures had not shown any reduction over the years. A possible explanation is that the reduced requesting in the Accident and Emergency department was compensated for by increased requesting for blood tests on patients admitted to other units in the hospital. We are therefore not yet convinced that significant costs savings can be made for the whole hospital by the use of such guidelines but intend to explore this further.

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Octreotide therapy for diarrhoea

Sir,
Intractable diarrhoea complicates systemic amyloidosis in a significant number of patients. The aetiology is thought to be either autonomic neuropathy or direct infiltration by amyloid of gastrointestinal submucosa. Therapeutic management is frequently unsatisfactory due to resistance to conventional antidiarrhoeal agents. Only two case reports exist to date in the literature describing successful symptomatic control with the long-acting somatostatin analogues octreotide acetate.3,4 We report the third.

Case report
An 80-year-old woman had a six-month history of weight loss, anorexia and unrelenting diarrhoea, unaccompanied by blood or mucus and resistant to all attempts at conventional treatment with codeine, loperamide and sulphasalazine. Routine biochemical and haematological investigations, stool cultures, gastrointestinal with biopsy, abdominal ultrasound and barium enema examination were all negative. Histology from rectal biopsies, however, stained with Congo red and confirmed a diagnosis of amyloidosis, immunohistochemistry demonstrating a monoclonal immunoglobulin light chain (AL type). Institution of octreotide therapy 100 μg subcutaneously three times daily resulted in immediate cessation of her diarrhoea. Transfer to another hospital unfortunately led to octreotide being discontinued with subsequent recurrence of diarrhoea, but re-challenge with the drug again achieved immediate symptomatic control.

This case represents the third reported where octreotide re-challenge resulted in immediate complete symptomatic resolution in a patient with hypereosinophilic diarrhoea due to amyloidosis. Successful antidiarrhoeal action has also been described with octreotide in patients with familial amyloidotic polyneuropathy.5 Hypermctatory diarrhoea in amyloidosis is an unlicensed indication for octreotide use, but further similar reports may strengthen the case for more generalised use of this agent in a distressing condition affecting predominantly elderly patients.

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1 Yamada M, Hatakeyama S, Tsukagoshi H. Gastrointestinal amyloid deposition in AL (primary or myeloma-associated) and AA (secondary) amyloidosis. Hum Pathol 1985; 16: 1206–11.

Oxtreotide therapy for diarrhoea

- reduces splanchic, portal and mucosal blood flow
- inhibits endocrine and exocrine secretions from somatostatin-containing cells in pancreas, stomach and intestine
- stimulates water and electrolyte absorption from gastrointestinal tract
- inhibits gallbladder motility and secretion
- slows gastric emptying and reduces postprandial in gastrointestinal tract
- inhibits hypothalamic–pituitary hormonal release
- inhibits gastrointestinal tract tumour

Oxtreotide: clinical indications
- bleeding peptic ulcer
- bleeding oesophageal varices
- gastrointestinal fistula
- pancreatic fistula
- acute pancreatitis
- short bowel syndrome
- jejunostomy diarrhoea
- diabetic diarrhoea
- chronic secretory diarrhoea (idiopathic, HIV)
- secretory tumours: pituitary adenomas, gastrointestinal, insulinaemias, vipomas, carcinoid syndrome

Oxtreotide: modes of action

Letters to the Editor

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