Letters to the Editor

Thrombotic thrombocytopenic purpura in pregnancy

Sir,

We previously reported in this journal, the occurrence of thrombotic thrombocytopenic purpura in two sisters during their first pregnancy.¹ One of these patients had two subsequent pregnancies. Prophylactic low dose aspirin and periodic fresh frozen plasma infusion were administered starting in week 12 of the second pregnancy. This second pregnancy was uneventful with normal delivery of a healthy female baby. The patient also received prophylactic aspirin 100 mg daily without fresh frozen plasma infusion, during the third pregnancy. She did well until the 38th week of pregnancy when thrombotic thrombocytopenic purpura relapsed, manifesting as a mild purpuric rash, thrombocytopenia and microangiopathic haemolytic anaemia. Plasma exchange therapy resulted in a quick recovery. Labour was induced shortly after she recovered because pelvic ultrasound indicated possible growth retardation of the baby. She delivered a healthy male baby, although a blood count showed him to have erythrocytosis, indicating possible intrauterine hypoxia. The baby developed physiologic jaundice from which he recovered without complication.

This experience suggests the feasibility of pregnancy in patients with previous history of thrombotic thrombocytopenic purpura; prophylactic aspirin and plasma infusion appear to be beneficial in preventing relapse during pregnancy.

FAROUQ ALQADAH
Community Medical Center,
950 South Main Street
Celina, OH 45822, USA

1 Alqadah F, Zebeib MA, Awidi A. Thrombotic thrombocytopenic purpura associated with pregnancy in two sisters. *Postgrad Med J* 1993; 69: 229–31.

Legal aspects of venepuncture

Sir,

We write in response to an article previously published in this journal concerning the criminal liability of those who carry out venepuncture.¹ The authors argue that in Scotland the crime of assault can be committed recklessly. From this they conclude that careless venepuncture can lead to criminal prosecution. Yet, in Scotland assault requires an 'attack' and an 'evil intent' to attack (*HMA vs Harris* (1993, SCCR 559)). It requires the formation of an intention to do harm which is clearly not present in the case of venepuncture. If the intention of the doctor is to puncture a vein in the medical interests of the patient, no criminal liability can arise.

In England, battery can be committed recklessly although consent can remove liability

if some higher social purpose is present. Medical treatment is an example of this. Thus, if a patient continues to offer his or her arm for venepuncture (ie, consent), no criminal liability for battery could arise from such a procedure. In Scotland, it is the presence of intention to harm which renders an act criminal, not the absence of consent.

Individuals can bring a claim in damages for civil assault. One must prove, (a) 'touching', and (b) absence of consent. Venepuncture is clearly a 'touching', and in the case of *Chatterton vs Gerson* (1981, 1 All ER 257) it was held that, provided a patient is informed in 'broad terms' about the nature of a procedure, then an action cannot lie. Consent is vitiated only by fraud or error. Arguably then, if a doctor informs a patient that venepuncture is to be performed and the patient continues to proffer his or her arm, sufficient consent will have been obtained to avoid a civil action.

A negligence action can arise from failure to treat a patient with 'reasonable care'. 'Reasonable care' is determined thus: "did the doctor act in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in the particular art?" (*Bolam vs Friern Hospital Management Committee* (1957, 2 All ER 118)). This might require that an inexperienced doctor who has made several unsuccessful attempts at venepuncture seek assistance. Furthermore, a consultant who delegates responsibility for venepuncture to one not qualified to carry it out could also be negligent.

A doctor can be negligent as much for failure to obtain valid consent as for other careless acts. If, therefore, responsible bodies of medical opinion consider that certain details about the taking or testing of blood should be disclosed to patients (and there is no respectable contrary view), then such details must be disclosed. For example, the General Medical Council and the British Medical Association consider that patients should be specifically informed that their blood will be tested for human immunodeficiency virus. To fail to do so could lead to a negligence action. This does not, however, necessarily extend to other blood tests where it is common practice (and therefore accepted by responsible bodies of opinion) not to inform patients.

GRAEME T LAURIE
Faculty of Law, University of Edinburgh,
Old College, South Bridge, Edinburgh
EH8 9YL, UK

GRAEME P ADAM
Grosvenor House Surgery, Warwick Square,
Carlisle, CA1 1LB, UK

1 McConnell AA, Mackay GM. Venepuncture: the medicolegal hazards. *Postgrad Med J* 1996; 72: 23–4.

Splenic infarction related to cocaine use

Sir,

I am reporting a case of splenic infarction temporally related to cocaine use. A 30-year-old HIV-positive with a medical history of sickle cell trait was admitted to another hospital with severe pain in the left upper quadrant of abdomen of several hours duration. The patient denied any fever, nausea, vomiting or diarrhoea. Physical examination revealed a temperature of 99°F, pulse 100 beats/min, and blood pressure of 130/80 mmHg. There was marked tenderness in the left upper quadrant of abdomen. The rest of the physical examination was normal. The white cell count was $9.5 \times 10^9/l$ and serum electrolytes were within normal limits. Chest X-ray was normal. Computed tomography of the abdomen revealed a large splenic infarction. Two days later the patient was transferred to our hospital for further management. On further questioning, the patient denied use of illicit drugs, recent travel or exposure to high altitudes. His repeat white cell count, prothrombin time, partial thromboplastin time, blood cultures and cardiac echocardiogram were normal. Three days later in the hospital on repeated questioning, the patient admitted sniffing cocaine a few hours before the onset of pain. He was treated with intravenous fluids and analgesics and discharged one week later in stable condition.

Cocaine has been implicated in ischaemic injury to many organs. However, splenic infarction related to cocaine use has been described in only one patient in the literature and that patient had the sickle cell trait, interstitial lung disease and pulmonary hypertension. Our patient also had sickle cell trait but no lung disease.

Post-mortem examinations in patients who died from cocaine intoxication have shown highest concentrations in the urine, kidney, spleen, brain, lung, and skeletal muscles. We suggest that, considering high frequency of both cocaine use and sickle cell trait in the general population, physicians should be aware of splenic infarction as a possible complication of cocaine use in patients with sickle cell haemoglobinopathies.

ASHOK VAGHJIMAL
Infectious Diseases Division
Maimonides Medical Center
4802, 10th Avenue, Brooklyn
NY 11219, USA

- 1 Creglar I, Mark H. Medical complications of cocaine abuse. *N Engl J Med* 1986; 315: 1495–500.
- 2 Mathias D. Cocaine associated myocardial ischemia. *Am J Med* 1986; 81: 678–8.
- 3 Poklis A, Maginn D, Barr JC. Tissue disposition of cocaine in man: a report of five fatal poisonings. *Forensic Sci Int* 1987; 33: 83–8.
- 4 Novicilli KD, Chamber CV. Splenic infarction after cocaine use. (letter) *Ann Intern Med* 1991; 114: 251–2.