

Pulmonary emboli following oral contraceptive misuse and long air travel

Sir,

We read the article "oral contraceptive misuse as a risk factor for cerebral venous and sinus thrombosis" by "Saadat-niya *et al*," which has been published in the recent issue of your journal.^[1] It was a very interesting article. As it was emphasized in the article, taking oral contraceptives has been increasing to a great extent in Iran in recent years and more than 2/3 of women at fertility age do so.^[1,2] Although the main goal of taking such pills is to postpone conception and control population growth, these pills are also being used to postpone menstruation during the blessed Ramadan month and Mecca (Haj) pilgrimage.^[1] After the Advantageous Mecca pilgrimage (Haj-e-tamatto) of last year (2011), a 38-year-old woman with deep vein thrombosis of the left leg was hospitalized in the cardiology ward of Valli-e-asr hospital in Birjand. Misuse of oral contraceptives (two times the normal dose) for two months and long-time flight jounries were considered to be the underlying causes. On the second day, because of not taking complete bedrest, acute pulmonary emboli (PE) was occurred. PE was diagnosed timely and confirmed through transthorasic echocardiography and CT angiography. The patient was administered thrombolytic drugs and now, while she is feeling well, is using warfarin.

Misuse and taking without a physician's prescription of oral contraceptives, usually with over-normal dose, occurred and this intensified the side-effects of these drugs.^[1,3] One of the most important side effects of such pills concerns the cardiovascular system. The incidence of venous thromboembolism (VTE) in healthy women is 4-5/10000 per year, but the risk reaches 9-10/10000 women per year among those taking oral contraceptives; and if other risk factors like sedentary lifestyle are added the chance of thromboembolism further increases.^[4] Various studies have been conducted to explore the relationship between long flight journey and thromboembolism, in the majority of which such a relationship has been observed. This risk further increases if other predisposing factors such as sitting position of the passenger, inactivity, relative hypoxia, dehydration following taking diuretics like tea, and hot weather.^[5] Therefore, these factors should be considered in any long lasting trip.^[5]

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The necessity of stroke prevention in patients with systemic lupus erythematosus

Sir,

Systemic lupus erythematosus (SLE) is a chronic autoimmune disease affecting multiple organs of the body.^[1] Central nervous system (CNS) involvement has been considered one of the severe complications of SLE, which increases both morbidity and mortality rate in patients with SLE.^[2,3] Histopathologic and radiological studies demonstrated various brain abnormalities in patients with SLE, such as micro and macroinfarcts, cortical atrophy, parenchymal hemorrhage and

demyelination.^[1] These cerebral changes may present with headache, seizure, psychosis, cranial neuropathy and cerebrovascular attack (CVA).^[1]

CVA is an ominous event in SLE. About 3-20% of patients with SLE may experience an episode of stroke at some point during their course of disease.^[4,5] This event may be in the ischemic or hemorrhagic form. Occurrence of stroke in patients with SLE may reflect the influence of different factors such as hypercoagulable state, hypertension, cerebral vasculopathy, atherosclerosis, thrombosis, and emboli of Libman-Sacks endocarditis.^[3,6,7]

Some studies have implied that common cardiovascular risk factors cannot obviously explain accelerated rate of stroke in patients with SLE.^[8] However, in our practice, we encounter some factors which may predict or contribute in stroke in patients with SLE. These factors include presence of antiphospholipid antibodies, a history of systemic thrombosis, renal involvement with SLE, and also presence of Framingham cardiovascular risk factors.

It has been demonstrated that the risk for stroke in SLE is markedly higher among young patients.^[6] Moreover, presence of joint diseases, co-existing neuro-psychiatric disorders and the rate of stroke recurrence are the factors which restrain the recovery process and harden the rehabilitation. Therefore, stroke in SLE may hold more extended morbidities and impose great psychological and social burden.

Previous studies revealed that stroke in SLE have a significant tendency to occur early in the course of SLE.^[9] In fact, most cases of stroke in SLE occurred in first 5 years of the disease, particularly during the first year.^[4,5] This point puts emphasize on the importance of initiation of stroke prevention at the time of diagnosis of SLE.

Stroke prevention in SLE has different aspects. A valuable achievement is eliminating or controlling the risk factors which are contributing to the atherosclerotic process.^[10] It is suggested to assess the presence of hypertension, hyperlipidemia, obesity, diabetes mellitus and smoking in the first visits of patients with SLE.

Since low dose aspirin may reduce the risk of stroke in some patients with SLE,^[5] it is beneficial to recommend it for all new cases of SLE and patients in high risk groups. Anticoagulants are in the first line of stroke prevention in the patients with a history of systemic thrombosis. Several studies have revealed the effects of anticoagulants in the prevention of both occurrence and recurrence of ischemic stroke in high risk groups.^[5]

In conclusion, regarding to the higher risk of various subtypes of stroke in young patients with SLE, stroke prevention should be an early purpose and essential component of therapeutic strategies in patients with SLE.

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Re: Synchronous bilateral adrenalectomy by midline incision: A reliable method for treatment of hypercortisolism

Sir,

After I read the Letter to Editor^[1] (Synchronous bilateral adrenalectomy by midline incision: A reliable method for treatment of hypercortisolism) and Letter to Editor^[2] Re: Tabatabaee *et al.* in *JRMS*, I found some studies which may be useful in this regard..

Bilateral adrenalectomy either by open (BOA) or laparoscopic (BLA) approach remains a safe and definitive management for corticotrophin (ACTH)-dependent Cushing's syndrome.

Open adrenalectomy remains a consideration when concomitant intra-abdominal procedures are necessary in select patients with ectopic ACTH syndrome, or when laparoscopic techniques are either inappropriate or unavailable.^[3]

To date, there is a few published information that directly compares open and laparoscopic approach of bilateral adrenalectomy.

Laparoscopic procedure for adrenalectomy has become widely accepted since its initial description in 1992.^[1,2]

Although Propilia *et al.* (2004)^[4] and Acosta *et al.* (1999)^[5] found no difference in complications and in the length of hospital stay between BOA and BLA procedures, respectively, more numerous recent reports have demonstrated that laparoscopic adrenalectomy is associated with a shorter hospital stay, faster recovery, improved patient satisfaction, lower morbidity rate, favorable outcomes, and fewer perioperative complications (especially, wound related) than open adrenalectomy.^[6-17]

Additionally, postoperative analgesic requirements have been shown to be significantly less, following BLA when compared with BOA.^[3]

The overall rates for mortality and complications from the 12 series are 2.4% and 13%, respectively.^[18,19]

Hence, in experienced centers, BLA is safe and effective; more often avoiding problems associated with open approaches these being especially problematic in the patients with hypercortisolism.^[3]

This review indicates that BLA is gaining popularity and being done more commonly at institutions worldwide.

Although this report (Re: Letter to Editor) does not prove or disprove the use of BLA, it provides data for clinicians to use to weigh risks and benefits appropriately. It further provides strong data toward entertaining the possibility of laparoscopic approach for total adrenalectomy as the treatment of choice for ACTH-dependent Cushing's syndrome.

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Which uterine myomatous masses must be removed?

Sir,

Leiomyoma is the most common tumor of uterus and female pelvis. Leiomyosarcoma almost always arise de novo and almost it doesn't results from sarcomatous transformation of a leiomyoma. One of the most controversial concepts on the subject of uterine smooth muscle tumors is smooth muscle tumor of uncertain malignant potential (STUMP), a term first used by Kempson in 1973.^[1] These are a group of heterogeneous and uncommon uterine smooth muscle tumors which fulfill some but not all the diagnostic criteria for leiomyosarcoma. This makes them unclassifiable by currently available criteria as unequivocally benign or malignant.^[1] In these tumors, it is simply impossible with current tools to predict the behavior with certainty and this makes their management difficult.^[2] What makes the management more complicated is the difficulty in counselling patients with regards to the likely clinical behavior. However, data from literature suggest a low risk of recurrence and a generally good clinical outcome.^[2,3] Since recurrence of STUMP has been reported to be regional and resectable, surgical resection has been recommended as the primary modality for the treatment of recurrence.^[2] Recurrence rates have been similar for patients who underwent myomectomy and those who

underwent hysterectomy.^[4] Moreover, leiomyosarcomatous transformation likelihood is low and there is no evidence that adjuvant treatments improve long-term outcomes. As a result, most authors have recommended expectant management of STUMP in the form of close clinical observation in all patients.^[2]

Herein, we briefly report a case of 29 years nulligravid woman presented in 2011 with a two years history of menometrorrhagia and pelvic pain. Ultra sonography revealed a pedunculated subserosal myomatous mass measuring 65 × 50 × 50 mm as well as three small intramural myomatous masses with the greatest diameter of 17 mm. The patient underwent myomectomy. On pathologic examination, one of the small intramural masses was found to be STUMP. Since the gynaecologists frequently decide not to remove small myomatous masses during myomectomy procedure, the question is which myomatous masses should be considered for surgical removal. She recovered completely without complication. The problem becomes more challenging when considering the fact that the preoperative diagnosis of STUMP is usually leiomyoma.^[2] This question is open to more discussions and suggestions by experts in this field.

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