Letters

Nontraumatic Subcutaneous Emphysema

To the Editor:

We read with great interest the case report by Chu et al. regarding the rare occurrence of spontaneous subcutaneous emphysema in a cancer patient. It was interesting to note the assumption by the authors that there was no reason to suspect infection with a gas-forming organism in their patient. In nontraumatic subcutaneous emphysema secondary to lower gastrointestinal tract perforation, typical fecal flora is cultured, whereas in nontraumatic gas gangrene (spontaneous gas gangrene or clostridial myonecrosis), a different clinical entity that often presents with an occult onset but invariably untreated has a fulminant course, the bacteria are generally clostridial.

Samlaska and Maggio, in a review (241 references) of subcutaneous emphysema, emphasize the consideration of gas gangrene in the differential diagnosis of all forms of subcutaneous emphysema. They report that isolation of C. septicum from the blood is almost always associated with colon cancer or hematological malignancies and that the detection of nontraumatic subcutaneous emphysema of the thigh with or without erythema, tenderness or bullous lesions is associated with perforated viscus in a retroperitoneal location.

Nontraumatic gas gangrene is typically associated with colorectal carcinoma, leukemia, diabetes mellitus and drug-induced immunosuppression, as in those having received cancer chemotherapy. Ulceration of the intestinal mucosa caused by a carcinomatous lesion, cyclic neutropenia or necrotic colitis resulting from leukemia serves as the portal of infection for the clostridial organisms. Characteristic symptoms and signs include excruciating pain (or just a sense of heaviness), swelling of tissues, crepitance and bullous lesions, though a typical (non-classical) presentations could mimic subcutaneous emphysema. Early recognition of this entity is crucial to reduction of morbidity and mortality, including a multifactorial approach of surgical consultation, resuscitation, pharmacological therapy with high dose penicillin and hyperbaric oxygen therapy.

The fulminant course of the patient as reported by the authors, the presence of advanced colon cancer, unrelieved constipation, possible perforation at the anastomotic site due to local tumor recurrence, absence of microbial cultures and probable impaired immune defenses after recent chemotherapy and steroid therapy bring into question the differential diagnosis of atypical (non-classical) nontraumatic gas gangrene. Unfortunately, in this patient, a postmortem examination to determine a definitive diagnosis was not permitted.

While the authors point to the lower gastrointestinal tract and esophagus as potential communication sites, Walker and Mozes report a patient with massive diffuse subcutaneous emphysema resulting from perforation of the proximal jejunum, a previously unreported site. In a review of 79 reported instances of subcutaneous emphysema of gastrointestinal origin, the colon (26 patients) and rectum (16 patients) were the most common sites of perforation. Perforation of the stomach and duodenum were found in 12 patients. Subcutaneous air was more commonly found in the lower abdominal wall and thigh, and the more common causes were carcinoma of the colon and rectum and diverticulitis.

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References


Unwillingness to Fill Opioid Analgesic Prescriptions by Local Pharmacies

To the Editor:

Long-term opioid therapy for chronic pain would not be possible without ongoing and unencumbered access to legitimately prescribed drugs. A recent survey of pharmacies in New York City found that a large proportion did not stock the opioids preferred for the management of chronic pain; pharmacies in minority neighborhoods were less likely to stock these drugs than those in white neighborhoods. Prior to the publication of this survey, we noted that several outpatients treated in the ambulatory practice of the Department of Pain Medicine and Palliative Care of Beth Israel Medical Center reported difficulty in filling prescriptions. Beth Israel Medical Center is a large hospital located in the racially and ethnically diverse lower east side of Manhattan, New York. We subsequently surveyed 15 community pharmacies within walking distance of the hospital to assess their inventory of opioids, investigate their willingness to order opioids that were not in stock and accept emergency telephone orders, and clarify the difference, if any, between independent and chain pharmacies.

All 15 pharmacies stocked opioid combination products, but there was less uniformity for single entity opioids typically used to manage moderate to severe chronic pain (Figure 1). The independent pharmacies were found to stock more variety of opioids than the chain pharmacies.

Many of the pharmacists stated a willingness to order an opioid that was not in stock or to fill an emergency telephone order if they had a prior relationship with either the physician or the patient, or both (Table 1). In the absence of a prior relationship, however, only 33% were willing to order opioids, and only 6.7% would accept telephone orders. Ordering opioids from a supplier was reported to take an average of 3 days in independent pharmacies and more than 4 days in the chain pharmacies. The independent, owner-operated pharmacies were more willing to increase their opioid inventory and order new drugs in hope of establishing a referral relationship with a medical center.

Although limited, these data mirror other surveys in demonstrating that single entity opioids are often not in stock. Several days are required to order a drug, during which time a patient may have no access to the prescribed drug. The impact of this problem on the prevalence of unrelieved pain is yet to be determined.

More important perhaps, these data suggest a curious phenomenon. The pharmacies surveyed were often unwilling to order a drug if the patient and physician were not familiar. This could obviously pose a considerable burden on some patients, who may be turned away by pharmacists concerned about providing a drug to an unknown person. Similarly, the availability of an emergency supply through a telephone order would be compromised unless the pharmacist had a prior relationship with the physician or patient.