To the Editors:

Attitudes on abortion among a group of Sri Lankan medical students

A study on attitudes on abortion for foetal anomalies, incest and rape was conducted among a group of 100 medical students of the Faculty of Medicine, University of Colombo, who had completed the medico-legal module and the forensic medicine appointment. In spite of a restrictive law on abortion, it is estimated that 44.7 per 1000 women aged 15 to 49 years have abortions each year in Sri Lanka [1]. This is a classic case of turning a blind eye to the obvious because it is too hot to handle. As medical professionals we face the ethical dilemma of having to offer abortions for genuine reasons. It has been made easy for the doctors by law, when the mother's life is in danger. But not so with other situations like foetal anomalies, incest and rape [2].

Among the students who participated in the study, agreement that abortion should be legalized in foetal anomalies, incest and rape, was 87%, 78% and 77%, respectively. In contrast only a minority wanted abortions legalized for cases of illegitimate relationships (27%) and as a family planning method (19%).

One may argue that the number of abortions done for foetal anomalies, incest and rape is small, (0.9%) [3], but what of the rights of the few and the dilemma these situations bring to the medical professional. In many instances, medical professionals are helpless in addressing the genuine reasons for abortions due to lack of legal support. Medical professionals should ask themselves just one question. What is my advice to anybody who comes to me for advice regarding a genuine reason for abortion? Will it be to advocate an illegal abortion and to suffer with our own conscience knowing that we have done right by the patient but violated the law of the land, or will it be to tell the patients that we can’t help them?

The medical students of this study have chosen to do away with the ethical dilemma. It is now the turn of the wider medical fraternity to do the same for the benefit of the public as well as the medical professionals.

References

K H Wickramasinghe¹, S I Wickramasinghe¹, K R Atukorala¹ and B Weerasundera²
¹Student, Faculty of Medicine, University of Colombo, Sri Lanka.
²Department of Forensic Medicine, Faculty of Medicine, University of Colombo, Sri Lanka.
Correspondence: KHW, e-mail <kumuduwick@yahoo.com>. Received 6 July 2008 and revised version accepted 9 October 2009. Competing interests: none declared.

To the Editors:

Vasopressin as an inotrope in refractory septic shock

Until recently vasopressin was commonly used as an antidiuretic to treat diabetes insipidus, and to control haemorrhage due to oesophageal varices. We report a woman with refractory hypotension due to severe sepsis whose blood pressure was maintained with vasopressin until the septic focus was drained.

A 64-year-old hypertensive woman was admitted to the intensive care unit with hypotension, tachycardia and dyspnoea of about 6 hours duration. She had undergone oesophagectomy for carcinoma of the esophagus 15 days ago. She also had high fever and neutrophil leucocytosis. Her heart rate was 142/minute and the blood pressure (BP) was 70/40 mmHg despite dopamine infusion. There were coarse crackles and reduced breath sounds in the lower zone of the right lung. Central venous pressure (CVP) and arterial blood pressure were monitored and she was ventilated. Although the CVP was 18-20 cmH₂O, her BP remained 75/40 mmHg despite infusions of dobutamine 20 μg/kg/min, noradrenaline 0.4 μg/kg/min, dopamine 20 μg/
kg/min and adrenaline 0.4 μg/kg/min, and intravenous hydrocortisone.

As her hypotension was refractory to the treatment given, she was started on a vasopressin infusion at an initial dose of 0.02 units/min, which was later increased to 0.04 units/min. Her blood pressure increased to 120/75 mmHg within 2-3 hours, and was maintained at this level for the next 24 hours. The mixed venous (CVP) oxygen saturation increased from 55% to 68%, and the base excess and urine output also improved. A chest radiograph showed a fluid collection in the right hemithorax, and a right minithoracotomy was performed to drain the purulent fluid. During the next 48 hours inotropic and vasopressor requirements declined, and were tailed off. She had no evidence of digital or coronary ischaemia during vasopressin infusion.

Vasopressin restores vascular tone in vasoplegic (catecholamine resistant) shock by at least four mechanisms: through activation of V1 vascular receptors, modulation of ATP-sensitive potassium channels, modulation of nitric oxide (NO), and potentiating adrenergic and other vasoconstrictor agents [1]. Studies show elevation of vasopressin concentrations in early septic shock, but with continued shock, concentrations decrease to the normal range in the majority of patients [2]. This is called “relative vasopressin deficiency”, because in the presence of hypotension, vasopressin levels can be expected to be high. A recent randomised, controlled trial (Vasopressin in Septic Shock Trial) comparing norepinephrine (noradrenaline) alone to norepinephrine plus vasopressin infusion at a dose of 0.03 units/min in patients with septic shock showed no difference in mortality at 28 days [3]. However, in patients with less severe grades of septic shock, the 28 day mortality was lower in the vasopressin group.

Our patient also had catecholamine resistant shock, as she did not respond to maximal doses of inotropic and vasopressor agents. Vasopressin was given at a dose of 0.04 units/min, and haemodynamic improvement was noted within 2-3 hours. Studies have not shown adverse cardiac effects related to low dose vasopressin. Our patient also did not have any evidence of coronary ischaemia during treatment with vasopressin.

References

B WP Habaragamuwa1, N Lamahewage1 and C AG S Piyasiri1
1Department of Anaesthesiology, Colombo South Teaching Hospital, Sri Lanka.

Correspondence: BWPH, e-mail <buddhikah@hotmail.com>. Received 12 October 2008 and revised version accepted 12 August 2009. Competing interests: none declared.