Sir,

Whenever a physician falls sick, a decision has to be made whether to continue working or not. According to a British report, there was an increase in the proportion of doctors suffering from infections between the years 1993 and 2001. However, the majority continued to remain at work, with an average of only 2.9 days of sick leave per year per doctor. Furthermore, underutilization of occupational health services among physicians was also reported.1 According to another study enrolling 1476 Norwegian physicians, more than half the doctors had worked while suffering from an infectious disease. Most of those physicians practiced self-treatment whenever it was required.2 Although they preferred to be treated by a physician they did not have personal ties to, many contacted friends and colleagues when they needed help from another physician.2 In another study, more than 80 percent of all physicians enrolled in the study had worked while they were sick, citing cultural and organizational reasons behind their decision not to take sick leave.3

By increasing the incidence of nosocomial infections, this could potentially have serious implications on overall health of the hospitalized patients. Interestingly enough, doctors who avoid taking sick leaves actually advise their patients with a similar illness to take off from work, setting double standards in this way.2 Possible factors for physicians not utilizing their sick leave include their not wanting to look weak in front of their consultants, pressure by senior physicians and consideration for massive workload.1 Worldwide, nosocomial infections not only add to the suffering of patients but also pose an enormous financial burden on the health care. Not taking time off when a doctor is sick especially with an infectious cause (most acute diseases are usually infectious) can place the patients and other staff working in the hospital at an increased risk.1 This is a serious ethical issue, and must be addressed by the health care providers all over the world. Efforts to persuade doctors to utilize their sick leave might improve the management of their own health as well as that of their patients and staff members. At present, there is not sufficient data to assess the strength of association between under utilization of sick leave and incidence of nosocomial infections. More research will elucidate how much impact it has on the overall health status of patients.

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Spontaneous Paracentesis Through Umbilical Rupture in Cirrhotic Ascites

Sir,

The commonest cause of liver cirrhosis in Zaria is post chronic Hepatitis B viral infection.1 One of the complications of liver cirrhosis is ascites. There are various complications of the ascites such as umbilical rupture and spontaneous paracentesis which is rare and often fatal complication of cirrhosis with most reports coming from the western world. Only about 10 previous cases have been reported, with a fatal outcome in 7 of the cases. Three survivals were reported and large paracentesis have been reported to be associated with these complications and is responsible for the deaths in most cases.2 We report a case of spontaneous paracentesis through a ruptured umbilical hernia complicating cirrhotic ascites.

MA is a 45-year old farmer, who presented with a two year history of progressive abdominal swelling, weight loss, fatigue, anorexia, easy satiety, nausea and alteration in bowel habit. He had episodic epistaxis otherwise no gastrointestinal bleeding. His exercise tolerance had reduced drastically in the last 2 months. He was found to be wasted (Body Mass Index = 23 kgm-2), pale and dehydrated with peripheral stigmata of hepatic cirrhosis. His chest was clinically clear. He had a tachy-
cardia with a small volume pulse and blood pressure of 110/70 mmHg, apex beat displaced to the fourth left intercostals space in the mid clavicular line with normal first and second heart sounds. His abdomen was grossly distended, shiny with flat umbilicus that had foci of ulceration and necrosis around it. There were distented anterior abdominal wall veins draining away from the umbilicus, scratch marks, ballotable spleen of 4 cm. There was no asterixis.

His laboratory investigations confirmed anemia with thrombocytopenia, hypoalbuminemia with reversal of ratio in favour of globulins and positive HBsAg. There was gross straw coloured ascites with serum: ascites albumin gradient of 14. Abdominal ultrasound scan showed splenomegaly, shrunken liver and gross ascites without evidence mass lesion or lymph nodes.

Twenty four hours after admission to the ward, the umbilical wound burst open spontaneously, releasing about 20 liters of ascites.

Spontaneous paracentesis through an umbilical hernia is a rare but recognized complication of cirrhotic ascites which was first described in 1901, umbilical hernias, which are common in cirrhotic patients with ascites, develop as a result of a defect in the umbilical ring, allowing protrusion of peritoneum, fluid, omentum or bowel. The drainage is a result of a break in the hernia sac and overlying skin. Ulceration of the skin over the hernia is described before rupture in 81% of cases. Though a potentially fatal condition, the survival of the patient could be associated with the absence of circulatory failure, hepatic or renal failure or sepsis all of which have been associated with increased mortality. Massive ascites is common in liver cirrhosis and the possibility of umbilical rupture is real. Clinicians need to have a high index of suspicion and be proactive in instituting prevention in the form of paracentesis abdominis and diuretic therapy.

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