The symptoms of hydatid cysts may be related to local and mechanical effects depending on the location and nature of the cyst but hydatid fluid can be irritating, due to toxic reaction. In our group there were 2 patients with toxic reaction. Other patients presented with abdominal pain, icterus, ileus and fever. Various incidence rates of direct rupture have been reported (1.75–8.6%). The clinical signs and symptoms of hydatid cyst rupture are not always severe, but hydatid fluid can irritate, which can cause peritonitis as occurred in our series of patients, all of whom had acute abdominal signs. In the study of Patel and Butt, 76% of the patients with ruptured hydatid cysts had abdominal pain. In our series, this rate was 100%. Thus, the clinical presentation of hydatid cyst rupture is not always silent. The severe clinical presentation and infrequency of hydatid cyst perforation has been held partially responsible for the misdiagnosis by the clinician. The use of diagnostic imaging studies can be helpful. Ultrasound is widely used with an acceptable sensitivity and specificity for diagnosis and specificity of 90% with rupture. Compression and displacement of the biliary ducts are frequent. At the point of contact with a biliary duct, a rupture may occur. In frank rupture daughter vesicles and fragmented membranes escape into the biliary tree causing obstruction, cholangitis or septicemia.

Mechanical bowel obstruction is an uncommon clinical presentation for hydatid disease, although intestinal obstruction due to rupture or fistulization of a hepatic, splenic, pancreatic, mesenteric, or retrovesical cysts into the gastrointestinal tract has been reported.

In conclusion, in endemic areas, complicated hydatid cysts should be included in the differential diagnosis of acute abdomen. Ultrasound is an extremely helpful diagnostic aid.

Hayrettin Dizen, MD
Fifth Department of Surgery
Ankara Numune Training and Research Hospital
Ankara, Turkey

Ibrahim İbilî, MD
Emergency Department
Ankara Numune Training and Research Hospital
Ankara, Turkey

Barış Zulfikaroğlu, MD
Mesut Tuz, MD
Mahmut Köç, MD
Fifth Department of Surgery
Ankara Numune Training and Research Hospital
Ankara, Turkey

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Can My Severe Sepsis and Septic Shock Patients Wait Any Longer?

To the Editor:
We appreciate the attempt of Maryn McKenna to write a balanced non-peer reviewed article entitled “Controversy Swirls Around Early Goal-Directed Therapy in Sepsis: Pioneer Defends Ground-Breaking Approach to Deadly Disease.” However, we were concerned that the closing summation of the article does not adequately reflect the current status of the literature and practice guidelines.

“Should I be doing this (early goal-directed therapy) across the US, and across the world, based on 250 people in Detroit?” is the query posed at the end of the article. The answer is “Yes,” based not only upon the single randomized controlled study in Detroit, but upon similar mortality reductions in over 5,000 patients at 50 hospitals with similar baseline mortality risks.

Clinicians should feel confident that early goal-directed therapy can save 1 life for every 6 treated while remaining cost efficient. To date no studies have demonstrated harm from early goal-directed therapy. Many hospitals have demonstrated mortality reductions by adopting early goal-directed therapy as standard care without publication. Several have been awarded quality and safety improvement awards by The Joint Commission on Accreditation of Healthcare Organizations for adopting early goal-directed therapy (Christiana Medical Center 2007, Carolinas Medical Center 2008). Early goal-directed therapy continues to be supported by the American College of Emergency Physicians and over 14 professional societies with the Surviving Sepsis Campaign. According to a recent survey of emergency department (ED) directors, only 16% reported lack of agreement with early goal-directed therapy and over 70%...
The decision to perform early goal-directed therapy confronts providers on a daily basis regardless of hospital location. Disproportionally, nearly 60–75% of severe sepsis patients present through the ED averaging 150–400 patients per year with stays of 4-5 hours.\(^6\) Assuming a 16% absolute mortality risk reduction and an estimated 571,000 septic patients presenting to the ED per year,\(^6\) choosing not to perform early goal-directed therapy may result in an additional 91,000 lives lost per year. While logistical and professional challenges regarding early goal-directed therapy implementation exist, these are similar and were overcome in the evolution of care for trauma, acute myocardial infarction and stroke. Despite the challenges, the common theme is that “time is tissue” and delayed recognition or suboptimal treatment of organ failure and shock states adversely impacts morbidity and mortality.

Prior to the early goal-directed therapy study and the Surviving Sepsis Campaign, one could reasonably argue that there was no standard of care for severe sepsis, especially in the early setting. Future studies are likely to refine our understanding of which care path elements are most essential and less invasive methods of resuscitation protocols may emerge. In the meantime, given the prevalence and lethality of this disease coupled with the time-critical benefit of early goal-directed therapy, the question no longer becomes, “Should I be doing this across the US...” but rather, “Can my patients afford to wait any longer?”

Christopher V. Holthaus, MD
Division of Emergency Medicine
Washington University School of Medicine/Barnes-Jewish Hospital
St. Louis, MO

Chad Cannon, MD
Department of Emergency Medicine
University of Kansas Medical Center
Kansas City, KS

Ronald Elkin, MD
Division of Pulmonary and Critical Care Medicine
California Pacific Medical Center
San Francisco, CA

H. Bryant Nguyen, MD, MS
Department of Emergency Medicine
Loma Linda University Medical Center
Loma Linda, CA

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Corticosteroids for Acute Bacterial Meningitis

To the Editor:

We are writing in response to the systematic review abstract entitled “Corticosteroids for Acute Bacterial Meningitis”\(^4\) and associated commentary in the September 2008 issue of Annals. We applaud the authors for tackling this important topic in an organized and concise manner. However, we disagree with some of the conclusions they draw. Both sets of authors, as a result of the review, advocate corticosteroids for all adults and children with suspected bacterial meningitis. While undoubtedly correct in the era before the H. influenzae vaccine, we feel this recommendation may not be the current best course of action for pediatric patients. We reference the paper by Arditi et al in which pediatric patients with pneumococcal meningitis who received dexamethasone trended towards a worse outcome.\(^2\)

This was a retrospective study, but dexamethasone still showed no benefit when adjusted for severity of disease. Peltola et al also showed no benefit for dexamethasone treatment in children with non-H. influenzae bacterial meningitis (however, it interestingly did show a benefit for oral glycerol therapy).\(^3\) In addition, the Infectious Disease Society of America (IDSA) (www.idsociety.org) weighs in on this subject in one of their practice guidelines by referencing, in their conclusion, the Committee on Infectious Diseases of the American Academy of Pediatrics (AAP): “For infants and children 6 weeks of age and older, adjunctive therapy with dexamethasone may be considered after weighing the potential benefits and possible risks. Experts vary in recommending the use of corticosteroids in pneumococcal meningitis; data are not sufficient to demonstrate clear benefit in children.”\(^4\) They also conclude that


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