Correspondence

Letter to the Editor

To the Editor,

I read with interest the report by Walk et al[1] cataloguing the impressive achievements of a 2009 humanitarian mission by the US Naval Ship Comfort. The authors took pains to point out the efforts to partner with host nation surgeons and medical doctors to provide appropriate screening and—when possible—postoperative follow-up, and mentioned the goals of incorporating education of local physicians. These efforts are laudable, but the authors failed to discuss a not-so-secret truth widely acknowledged in the humanitarian sphere: providing medical care under the aegis of a military is fraught with both theoretical and actual problems.

By virtue of its singular and virtually unlimited infrastructure and resources, and by its frequent involvement at the point of conflict, where local health resources are stretched or nonexistent, the military is often in a unique position to provide emergency medical care. Recent military medical experiences in the response to the earthquake in Haiti have been well documented (see Auerbach et al[2] as one example), and there is no doubt that such interventions filled a necessary gap in extreme crisis and need.

What is lost in the conversation, however, is an acknowledgement that militarization of humanitarian aid is in direct conflict with the precepts set forth by most major humanitarian organizations and transnational governmental agencies, including Doctors without Borders, OXFAM International, the International Rescue Committee, the World Health Organization, and others[3,4]. At the root of the philosophical struggle is that militaries, like their overseeing governments, have agendas, and these are rarely of the "strings-free" kind. This is not to say that non-governmental organizations do not have agendas of their own, but these may be more pure during medical decision making, abiding the principles of neutrality, impartiality, and independence.

One must also consider that in the very places where humanitarian medical need is at its greatest, local military forces are often the principal perpetrators of injustice. Providing military medical aid can blur the lines between right and wrong and sometimes lead to false trust among at-risk populations.

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References


Are Baveno V recommendations of any help in the management of extrahepatic portal hypertension in Latin America?

To the Editor,

Management of portal hypertension and particularly of variceal bleeding is controversial, and several meetings directed to establishing a consensus on these matters took place in the past in Groningen, the Netherlands (1986); Baveno, Italy (1990 Baveno I and 1995 Baveno II); Milano, Italy (1992); Reston, USA, (1996); Stresa, Italy (2000 Baveno III); again in Baveno (2005 Baveno IV); Atlanta, USA (2007); and Milano, Italy (2010 Baveno V). They all had some success and generated consensus reports on a few but not all points.

The key issues of discussion were the factors leading to bleeding, diagnostic assessment, management policies, and methodological requirements for future trials. The Baveno V consensus assessed the level of evidence of previous articles according to Oxford system (levels 1 [higher] to 5 [lower]) and degree of recommendation (A [strong] to D [weak])[1].

Noncirrhotic portal hypertension and particularly the prehepatic (PHPH) form were incompletely addressed in children, in whom it is the leading variety of PH. This was caused by the limited number of patients, their lack of
uniformity, and the absence of controlled studies in this age group. This is bothersome because PHHP has a particular physiopathology in children despite the preserved liver function. In fact, the Baveno V consensus addressed PHHP in developed countries where the etiology is heterogeneous and the clinical course usually benign [1].

However, this is not the case in most developing countries, including our own in which PHHP is often caused by portal vein thrombosis because of neonatal umbilical catheterization and in which access to modern diagnostic methods Doppler ultrasonography, angio-computed tomography, and angio–magnetic resonance imaging and to treatment by variceal endosclerosis or banding are far from being universally available. Most children in the world live in this particular setting.

Other controversial issues in the Baveno V meeting were the use of anticoagulation in prothrombotic states and the choice between endoscopic prophylaxis and β-blocking agents [1]. There is some preliminary evidence (level 2B) of similar results with both approaches, and this is relevant for developing countries where endoscopic treatment is not universally available. As regards to surgical treatment of children with PHHP, it was acknowledged as the best alternative in cases of failure of endoscopic treatment (level 2D). The Rex (mesenteric-left portal) shunt is probably the best option for reestablishing portal flow in these cases [2–5]. Biliary disease caused by PH was also addressed, particularly its mechanisms and eventually its treatment. Diagnostic algorithms and management policies for PHHP in children can hardly be based on weak or inexistent evidence and rather reflect expert opinions, like proposals for future studies [6].

The PHHP addressed in the Baveno V consensus corresponds to that of highly developed countries. That is certainly not the case in Cuba or other Latin-American countries with large populations of children. Further studies in this context are therefore necessary, particularly because expected survival in children is much longer than that of adults with PH and the possibilities of yet unknown complications indeed exist, particularly neurologic and psychiatric conditions. Irrespective of the relevance of the Baveno V recommendations, an effort should be made to tailor their application to the particular conditions of health systems and patients of each country [7].

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References


Tension pneumoperitoneum in a child

To the Editor,

It is with great interest that we have read the case report “Tension pneumoperitoneum in a child resulting form high-frequency oscillatory ventilation: a case report and review of the literature” by Hughes et al [1].

The authors describe a young child with severe respiratory insufficiency superimposed upon preexistent lung disease who developed air leak syndrome, in this case pneumomediastinum and pneumoperitoneum, after initiation of high-frequency oscillatory ventilation (HFOV) as rescue therapy. The authors conclude that the air leak syndrome resulted from HFOV. We disagree with this conclusion for several reasons. First, the air leak syndrome manifested after several days of mechanical ventilation. Second, and perhaps more importantly, the authors did not describe the ventilator settings used during HFOV, nor which strategy was applied. As a consequence, we argue that it is not HFOV in itself that has caused the air leak syndrome in this patient, but rather the coexistence of regions of low compliance with regions of higher compliance or, more specific, the coexistence of low lung compliance with preexistent bronchopulmonary dysplasia. Hence, it is not likely that the ventilator mode itself was the cause of the air leak syndrome. It is recognized that air leak syndrome occurs when inappropriate ventilator settings are used, especially when there is preexisting lung disease [2-4]. As a consequence, lung-protective ventilation is indicated (ie, low tidal volume and sufficient amount of positive end expiratory pressure (PEEP) to prevent repetitive opening and collapse of alveoli) [2-4]. This is exactly where HFOV comes into play [5]. However, good knowledge of the physiology of HFOV and its use in lung diseases is essential. The authors, in their explanation of the alleged mechanism, suggest that the

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