LETTERS TO THE EDITOR

Abdominal thrusts are not recommended for infants with foreign body airway obstruction

To the Editor—We read with interest the editorial by Pak and van Hasselt.[1] They correctly warn of the danger of foreign body airway obstruction (FBAO) and the need for urgent intervention. This should not include abdominal thrusts in infants however.

The following advice is based on current guidelines for the management of the choking child from the European Resuscitation Council[2] and American Heart Association[3]:

If the FBAO is mild, encourage the child to cough and observe. If the FBAO is severe, such that the child cannot effectively cough or make a sound, then immediate intervention is necessary. Cardiopulmonary resuscitation should be performed if the child is unresponsive, looking in the mouth before delivering breaths. If a foreign body is identified it should be removed under direct vision; blind finger sweeps should not be performed. For a conscious child over 1 year of age, the Heimlich manoeuvre is appropriate. For infants however, abdominal thrusts are no longer recommended because of the much higher risk to upper abdominal viscera. Instead, five back blows are alternated with five chest thrusts until the object is expelled or the victim loses consciousness.

Giles N Cattermole, MA, FCEM
Colin A Graham, MD, FHKCEM
Timothy H Rainer, MD, FHKCEM
E-mail: thrainer@cuhk.edu.hhk
Accident and Emergency Medicine Academic Unit
The Chinese University of Hong Kong
Trauma and Emergency Centre
Prince of Wales Hospital
Shatin, New Territories
Hong Kong

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Breast-conserving surgery in young Chinese patients

We read with interest Yau et al's article,[1] which concluded breast conservation treatment (BCT) is a reasonable option for suitably selected young Chinese women. In our review the breast conservation rate is 21.9%.[2] For a median follow-up of 34 months, six (4.0%) of the patients with BCT had local recurrence. We expected the local recurrence rate would be higher with longer follow-up. This was observed in Yau's study, which had a 10% local recurrence rate after a follow-up of 6.5 years.

Despite adherence to guidelines for adjuvant therapies, a substantial proportion of patients with BCT suffer local recurrence during long-term follow-up. Hence careful selection of patients who are suitable for BCT is important. Both young age and family history should be taken into account, particularly for those who carry the BRCA1 or BRCA2 mutation, since they have a high risk of in-breast tumour recurrence (IBTR) as well as contralateral breast cancer.

Whether BCT is appropriate for BRCA-associated breast cancer remains controversial.[3] Most studies report that in patients with mutations, the short-term risk of IBTR after BCT is not significantly greater than that in others. However, with long follow-up, rates of metachronous ipsilateral cancer are higher.[4-6] The substantial risks of late ipsilateral metachronous primaries as well as contralateral cancer can result in mutation carriers deciding to choose bilateral mastectomy instead of BCT, though the impact of such drastic interventions on survival still needs more large-scale studies.

The availability of genetic testing before surgery can benefit patients who may need to consider prophylactic surgery at the same time, if they are confirmed to carry the mutations. Since 2007, genetic testing for clinical purposes and research has been introduced in Hong Kong, with the establishment of Hong Kong Hereditary and High Risk Breast Cancer Programme (www.hrbcp.org). A Risk Assessment Clinic has been established in our centre and patients and families at high risk of developing breast cancer (based on age, family history, and breast cancer pathology) are invited to participate in the genetic testing. This should assist better selection of patients, especially young patients suitable for BCT.

Dacita TK Suen, MB, ChB, FRACS
Ava Kwong, MB, BS (LON), FRCS (Edin)
E-mail: akwong@asiabreastregistry.com
Division of Breast Surgery, Department of Surgery
The University of Hong Kong Li Ka Shing Faculty of Medicine
Queen Mary Hospital and Tung Wah Hospital Breast Centre
Hong Kong

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