LETTERS TO EDITOR

MEDIA MANAGEMENT DURING DISASTERS MIGHT ALSO REQUIRE PROTECTING PATIENT PRIVACY AND RIGHTS

Sir,

Saxena and colleagues[1] commenting on the article by Supe and Satoskar[2] rightly point out the issue of media management being important at the times of disasters. However, I think an additional dimension needs to be highlighted while discussing ‘dealing with the various forms of media at the time of disasters.’ Overbearing media interest to present ‘breaking news’ could mean that there is pressure on hospital authorities to let the media have access to patients in wards, emergency rooms; to morgues; and take pictures or video footage of those who are injured or dead in the disasters; or get ‘sound bites’ from patients and their relatives. This often happens parallel to visits of politicians to hospitals post-disaster for meeting the patients and their families. Since there is frequently a competition between politicians for making visits, there is usually a continuous (and often over-bearing) presence of media personnel in the hospital area to cover the visits in the aftermath of disasters.

While the media plays an important role in providing information at the time of crises, like a disaster, it is also important to remember that patients and families of those admitted or who died as a result of disaster might be vulnerable as they have gone through a traumatic experience, might be in acute pain and distress and also in grief because of loss of loved ones, etc. Health care professionals and hospital administrators have an ethical duty to protect those in the hospital from media intrusions on their privacy and confidentiality, unless specific consent is given by the concerned patient and family for being willing to interact with the media. This issue has been highlighted as having been significant in the aftermath of the Asian tsunami in 2004 in an earlier paper.[3] Responding to the medical and social needs of patients and families should be the first priority of the hospital staff; and numerous media visits can affect their ability to provide the best possible care in the strenuous and high-pressure post-disaster circumstances. The media can be given regular updates by a senior hospital administrator so as to keep the public informed. Understanding how to handle the media, and, if needed, how to curb media coverage in the hospital precincts when needed should be part of disaster-preparedness training for health care professionals. Unbiased and comprehensive media coverage is definitely a need of democratic societies, but this should not automatically translate to free access within hospitals, especially in times of disasters.

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Sir,

Paraphenylenediamine (PPD), a derivative of paranitroanaline, is commonly used in several industries like oxidizable hair dye, dyeing furs, photochemical processes and tyre vulcanization. The first documentation of systemic PPD poisoning in 1924 described the case of a hairdresser who developed toxicity from handling the dye. [1] Many reports have followed since then, mainly from developing countries. We report a series of 10 patients admitted over a period of 1 year at a tertiary care hospital in south India.

Between January 2006 and February 2007, 10 patients (6 males, 4 females) of PPD (3.75%) ingestion in the form of hair dye, with suicidal intent, were admitted [Table 1]. It accounted for <0.1% of hospital admissions and 4.5% of acute renal failure (ARF) patients during the study period. Patients presented with features of severe hypersensitivity (itching, angioedema, asphyxia) and rhabdomyolysis (paresis of extremities, cola-colored urine, oliguria, markedly elevated creatinine phosphokinase and lactate dehydrogenase, hyperkalemia, hyperphosphatemia and hypocalcemia). ARF was observed in 8 (80%) patients.

Patients were treated with gastric lavage, intravenous fluids, antihistaminics and steroids initially. Eight patients required emergency airway (tracheostomy or endotracheal intubation) within 3 hours of ingestion, of which 7 patients required ventilatory support. Urinary alkalinization with mannitol and sodium bicarbonate was done for 4 non-oliguric patients. Oliguric patients presented with higher azotemia and potassium levels as compared with non-oliguric patients. Requirement of ventilation and dialysis was higher in oliguric patients. Mortality was also higher (83.3%) in oliguric patients as compared to non-oliguric (25%) patients. Seven patients underwent hemodialysis for a median of 5 sessions (3-9). Six of the 10 patients died (mortality, 60%) in this study; of these 6 patients, 2 died of sudden cardiac death preceded by arrhythmias, 1 developed sepsis after hospitalization and 3 patients had progressive deterioration of their hemodynamic status. The patients who survived had completely normal clinical and biochemical profile at 1-month follow-up.

PPD and its metabolites are allergenic, mutagenic and highly toxic. Clinical presentation of PPD intoxication is usually dominated by paresis, cola-colored urine, angioedema, asphyxia and oliguria. Our findings are consistent with those of published reports.[2-4] Asphyxia and respiratory failure are secondary to the upper respiratory tract and cervical edema and warrant urgent intervention. The demographic profile of the patients in our study compares favorably with that of the patients in earlier studies. A large cohort of 374 Moroccan patients was dominated by females belonging to the younger age group consuming PPD with suicidal intent.[5]