Sir,

The authors of “Acute nontraumatic upper limb ischaemia: A protocol for management”. (Indian J Surg 2005;67:257-9), should be congratulated for achieving good results in the management of this condition. Their aim was to draw management guidelines from a retrospective review. However, their conclusion of “thrombolytic therapy can be the first modality of treatment in the ischaemic but viable limb”, is too simplistic for a problem whose management is controversial and still evolving. The authors did not state as to what selection criteria was applied in choosing the initial therapy for their patients, as there is clearly a subset in whom intraarterial thrombolytic therapy would be inappropriate and risky. The earlier the patient present with a thrombotic arterial occlusion, the greater is the chance of lysis with thrombolysis.[1] The authors have not disclosed whether, for example, patients presenting on day 3 were treated similarly to those presenting on day 12, with same clinical features. It is also unclear as to which lesions failed to respond to thrombolysis. A large series of 55 patients have expectedly shown that poor / modest results are obtained in the distal forearm and brachial artery lesions, compared to subclavian / axillary artery lesions.[2] Because stand-alone thrombolysis requires time to achieve recanalisation, only patients with sufficient collateral flow to maintain limb viability for at least another 12 hours, can be considered for thrombolytic therapy.[1] Clinical features of weakness, tingling or paraesthesia suggest that immediate flow need to be restored by thromboembolectomy, as failed thrombolysis can prolong ischaemic time and lead to limb loss. Obviously, it is necessary to exclude patients in whom the risk of systemic bleeding may be lethal (eg recent stroke, bleeding ulcer). Other factors that do not get equal attention but might affect the choice of first-line treatment are; compromised arterial access (obesity, calcific arteries), renal or hepatic insufficiency (causes platelet dysfunction), diabetic retinopathy (microvascular bleeding can be disastrous), atrial fibrillation and intracardiac thrombus (increased risk of embolization following thrombolysis).[3] It would be interesting to know, if attempts were made to unearth intracardiac thrombus by echocardiography, prior to a decision of thrombolysis and whether diabetics were excluded. Diabetics may not be good candidates for thrombolysis - in a multivariate analysis of 80 patients they fared worse than non-diabetics. It also showed that the ability to pass a guidewire through the occlusion during angiography and place a catheter within the thrombus rather than proximal to it, are predictors of positive outcome.[4] Although the choice of initial treatment would depend on the local expertise, the site of occlusion, time of presentation and associated conditions are the main determinants of the initial treatment. Thrombolysis as the initial modality in virtually “all comers” as a protocol, will gain widespread acceptance only, if the safety, efficacy and the speed of treatment can be substantially increased by combining with percutaneous mechanical thrombectomy devices, currently under evaluation.[3]

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