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Acute Hemorrhagic Edema of Infancy

Acute hemorrhagic edema of infancy (AHEI), a dramatic but benign and self-limiting small vessel vasculitis, was first described by Snow in the US in 1913(1).

A 7 month-old male was admitted with sudden onset edema of dorsum of hands and feet, multiple spontaneous ecchymotic spots over face and limbs and low-grade fever. Before he presented to us, the child had undergone incision and drainage of the dorsum of the foot on 2 occasions, the fluid drained was sero-sanguinous. Examination revealed edema of hands and feet (***Fig.*1**) and swelling of inter-phalangeal joints. Over the next 2-3 days edema and ecchymosis almost disappeared without any specific therapy. Another 4 days later, he again developed edema of the whole right lower limb and dorsum of left foot, restricted extension of the right knee joint and circinate skin lesions on the face. A clinical diagnosis of AHEI was considered at this stage.

FIG.1 *Edematous lower limbs with scars of surgery. Note also the swelling of the interphalangeal joints of the great toes.*

Laboratory investigations showed progressive anemia (hemoglobin 6.3g/dL), rising ESR (up to 60mm/h) with thrombocytosis ($13 \times 10^3/\mu L$). Other investigations to rule out mimicking conditions were normal. Skin biopsy from lesion on face showed luminal narrowing and destruction of the elastic lamina of the small and medium sized arteries. Parents were reassured and sent home without specific therapy. After a waxing and waning course over 4-6 weeks, the child improved.

AHEI is a distinctive cutaneous, small vessel leucocytoclastic vasculitis. It is common in males without racial predilection, usually benign and without sequel and with spontaneous recovery within 1-3 weeks(2,3). It presents at 4-24 months and occurs during winter(4,5). It is usually preceded by viral infections, drug intake or vaccination(2). Clinical findings develop rapidly over 24-48 hrs. The two primary features include (*i*) large cockade (rosette or knot of ribbons), annular or targetoid purpuric lesion found primarily on face, ears and extremities, and (*ii*) non-tender edema of the limbs and face. It may be asymmetric. Low-grade fever is common(2). Recurrent episodes may occur. Arthritis, nephritis, abdominal pain, GI bleeding and lethal intestinal complications are rare(2). The entity should be differentiated from erythema multiforme, HSP, and (iii) meningococcemia(2).

A slightly prolonged course of the disease with anemia, thrombocytosis and elevated ESR were unusual features in our patient.

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Medical Errors: Need Further Evaluation

We read the article by Parihar and Passi(1) with interest. It was a very good attempt to study an important aspect of clinical practice. However, there are some problems with the article. *First,* the authors report a medical error rate of 35.5%, which is very high. The authors have this figure by dividing the number of medical errors by total number of patients under evaluation. However, it would have been better, if authors used total number of prescriptions as the denominator to report the rate of medical errors. Further, it is possible that in many cases multiple errors would have occurred in a single patient. Hence, the figure of 35.5% appears to be an erroneous conclusion. *Second,* on the same issue, if we take to understand that total numbers of prescriptions in the intensive care units are more compared to other service areas, the figure of number of errors would come down significantly. The authors also report the percentage of errors between 8 am to 8 pm and from 8 pm to 8 am. Again these figures can also be significantly be affected by total number of prescription under evaluation, rather than the time frame alone. We know that in our practice, in most cases the clinical rounds are mostly held during the day time and possibly more number of prescriptions are written during the day time. *Third,* the authors have not mentioned anything about the blinding of clinicians and other staff who were under scanner. Because it is quite possible that if the clinicians and staff were aware about the study, then the reported rates would be less than the actual rates in clinical practice, because of being conscious about avoiding mistakes. *Fourth,* the alarming aspect of the study was the fact that more number of errors were committed by Senior residents than Junior Residents. If this fact is true (after taking total number of prescriptions as denominator for the each group), than it is very important to look at the training aspect. *Fifth,* the authors have not mentioned about the time of assessment, because it would give us important lead as to whether the erroneous prescriptions were intercepted or not. *Sixth,* it has been frequently shown in Western studies(2) that the numbers of errors correlate with level of stress and psychiatric morbidity in the residents. The study could have been strengthened by including such measures.

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