



Figure 1. Management algorithm for the nondeflating urethral catheter balloon.

tone, chloroform, or ether into a patient's catheter balloon or the catheter itself because of the potential dangers involved as cited by the article. I discussed this article with several other family physicians and several nurses who are well experienced in this sort of problem, and they also would never use these particular chemicals for this purpose.

To me, a more rational approach to deflating the balloon would be to drain the bladder completely through the Foley drainage port, then instill water in the balloon until it ruptures. With the bladder fully emptied, it seems that the chance of bladder rupture is minimal. Even balloon fragments that might remain in the bladder seem to be a lesser risk than that posed by acetone, chloroform, or ether in the bladder. Certainly finding retained balloon fragments could be resolved with cystoscopy if, when the Foley is removed, the entire catheter balloon did not appear to be present.

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The above letter was referred to the corresponding author of the article in question, who offers the following reply.

To the Editor: Thank you for the opportunity to reply to Dr. Baker's comments on our article (Shapiro AJ, Soderdahl DW, Stack RS, North JH Jr. Managing the nondeflating urethral catheter. J Am Board Fam Pract 2000;13: 116-9). Dr. Baker's central concern is with the chemical agents used for Foley balloon dissolution listed on the treatment algorithm. We mentioned acetone, chloroform, and ether for historical interest. We do not recommend their use and apologize for the confusion. We do believe, however, that mineral oil instillation is a viable option that can be considered. Perhaps to make the algorithm clearer, we could place a large X through the three chemical agents no longer recommended (as in the revised Figure 1).

Dr. Baker also proposes the technique of balloon rupture by overdilation with water in a fully emptied

bladder. We believe this procedure can cause undue pain and possible urothelial damage to the patient. If this technique is attempted, we recommend first completely emptying the bladder and then instilling 150–200 cc of saline. This fluid will act as insulation to prevent pain and potential bladder damage. Unfortunately, the balloon fragments must be dealt with cystoscopically to prevent the potential complications described in the article. We therefore suggest that an urologist be consulted before attempting this technique, as other methods using cystoscopy are often easier and less time consuming.

Thank you for the opportunity to clarify these points of confusion. We hope that we have provided the reader with several simple management options to consider before consulting the urologist in a case of a nondeflating Foley catheter.

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Toxic Hepatitis Caused by Herbal Medicine

To the Editor: In March 2000, a 39-year-old woman came to the clinic complaining of yellow discoloration of her eyes and very dark urine of 2 days' duration. She had been seen 18 months earlier because of postprandial epigastric pain. Although an abdominal sonogram at that time showed multiple stones in the gallbladder, she declined surgery. She was instructed to avoid greasy foods, and she continued to do well. A few months before this visit, a friend had recommended a herbal medicine to cure her gallstones. The patient purchased some unlabeled transparent capsules containing a greenish brown herb powder from a herbal medicine store in Mexico. She took one capsule by mouth twice daily for 10 days. Then she noticed yellow discoloration of her eyes and passage of dark urine. She stopped taking the capsules and reported to our clinic.

She drank alcohol rarely and had no history of intravenous drug use or blood transfusion. She denied ab-

dominal pain, nausea, vomiting, diarrhea, acholic stool, and pruritus. Except for icteric sclerae and skin, finding of her physical examination was normal. Her liver chemistry profile was alanine aminotransferase 364 U/L, aspartate aminotransferase 218 U/L, alkaline phosphatase 581 U/L, total bilirubin 4.0 mg/dL, and conjugated bilirubin 2.2 mg/dL; her urine urobilinogen was 4.0 EU/dL. Serologic testing for hepatitis A, B, and C was negative. During the next 4 weeks, her symptoms resolved, and her liver function tests returned to normal.

Cases of hepatitis caused by ingestion of herbal medicine have been previously described in the medical literature.^{1–3} The temporal relation between ingestion of the capsules and appearance of jaundice, the negative serologic tests for infectious hepatitis, and the paucity of obstructive features in this woman make toxic hepatitis caused by ingestion of herbal preparation the most likely explanation for her jaundice. Determining the toxic component in such herbal medicines remains a major problem, because the preparation is usually a mixture of herbs.³

As alternative medicine and natural healing become increasingly popular, physicians should be prepared to educate their patients about unconfirmed healing methods. Natural does not mean safe.

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