Atrial Fibrillation
During Flexible Sigmoidoscopy
To the Editor: The article by Bruehlman describes the occurrence of atrial fibrillation in a patient undergoing flexible sigmoidoscopy. Although this article is of great interest, the patient does not fit the high-risk criteria for which this procedure should be performed under cardia monitoring.

Also of interest is why flexible sigmoidoscopy rather than colonoscopy was offered in the face of two episodes of bright red rectal bleeding. Flexible sigmoidoscopy is an acceptable evaluation tool provided it is followed by a barium study. In this patient the question persists as to the origin or cause of the bright red blood coming from the rectum.

That the flexible sigmoidoscope was inserted to a depth of only 50 cm, which indicates visualization of only the sigmoid colon and rectum, is unusual in a young male patient. There could have been a lesion beyond the point of insertion that could have been the origin of the bright red blood.

Jay R. Varma, MD
Augusta, Ga

References

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

To the Editor: I agree with Dr. Varma that this 36-year-old man was not at high risk for sustaining a cardiac arrhythmia during sigmoidoscopy. He was placed on a cardiac monitor, not by direct physician order, but as part of a protocol applied to all patients undergoing treatment in the endoscopy suite of the hospital where the procedure was performed.

Passage of small amounts of bright red blood from the rectum is often caused by rectal conditions, such as hemorrhoids, fissures, or proctitis, all of which can be diagnosed by using the fiber-optic sigmoidoscope. The patient had no evidence of anemia or fecal occult blood, making questionable the more extensive bowel preparation and expense of colonoscopy. To date, he has reported no further episodes of rectal bleeding. Given the complication of atrial fibrillation during sigmoidoscopy, further lower gastrointestinal imaging would seem to be risky business.

A future dilemma: in view of his family history (both grandfathers had colon cancer), should screening sigmoidoscopy or colonoscopy be recommended as he ages?

Richard D. Bruehlman, MD
Pittsburgh, Pennsylvania

Reference
6. Lithium (which stimulates serotonergic neurotransmission by unclear mechanisms)

It is uncommon for serotonin syndrome to result from a combination of drugs that have the same mechanism of action, such as an SSRI plus meperidine.

Second, the patient’s condition in the case report was treated by stopping both medications and providing supportive care. A growing body of literature suggests the use of cyproheptadine (Periactin) as a direct antagonist of the high serotonin levels in the central nervous system that presumably cause the problem. Cyproheptadine is a nonspecific postsynaptic serotonin blocker. An patient I cared for who had serotonin syndrome responded dramatically to cyproheptadine alone.

The case report literature suggests using diazepam to reduce the muscular rigidity that creates fever and rhabdomyolysis and propranolol to treat serotonin syndrome, but for unclear reasons. It seems more sensible to use cyproheptadine to get to the root of the problem in the central nervous system. Methysergide (Sansert) is another nonspecific postsynaptic serotonin blocker. It might also be used to treat serotonin syndrome, but experience with it is limited.

Third, it is unnecessary to stop both offending medications. Stopping one is all that is necessary to prevent subsequent problems with serotonin syndrome. In the acute situation, this medication should be the one with the shortest half-life. It takes nearly 2 weeks to restore monoamine oxidase levels in the central nervous system to normal after stopping selegiline, an irreversible MAOI.

Fourth, the conclusion that we should use the “older generation of antidepressants” to treat depression in patients with Parkinson’s disease on selegiline is unfounded. All tricyclic antidepressants create some degree of serotonin reuptake inhibition and are likely to result in serotonin syndrome when taken with selegiline. The only antidepressant currently available that should be safe when taken with selegiline is bupropion (Wellbutrin), because it does not affect serotonergic neurotransmission.

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References