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Childbearing and menstrual psychoses

Ian Brockington

University of Birmingham, UK

In my early career, as a cardiologist working in tropical Africa, I experienced the value of single cases supported by a multilingual literature review: Two cases were sufficient to indicate that an idiopathic disease (endomyocardial fibrosis) was a complication of eosinophil leukocytosis. Since 1975, I have studied the psychoses of childbearing in the literature over 4,000 cases, of which 30% in the English language, plus a personal series of 320 mothers. The study of 600 recurrent cases has shown that the problem is more than the eruption of a psychosis shortly after childbirth: There is a group of reproductive triggers; prepartum, post-abortion (including mole pregnancies), early and late postpartum (onset 1-2 weeks and 4-13 weeks after the birth), after weaning and at two phases of the menstrual cycle. The history of individual patients demonstrates associations between all of them. Since 1981, I focused on menstrual psychosis; several hundred cases in the literature and 60 of my own. Periodic monthly psychoses occur before and at the menarche during phases of amenorrhea, in the early months of pregnancy, after childbirth, after the menopause, in men and (in one remarkable observation from Japan) without a pituitary. Everything worth knowing about childbearing and menstrual psychoses comes from case description and indicates involvement of the gonadorelin neuronal network (2000 neurons) in the anterior hypothalamus (a needle in the haystack!).

i.f.brockington@bham.ac.uk

Acute myeloid leukemia in Jehovah's Witnesses

Joseph Butterworth

University Hospital Coventry and Warwickshire, UK

To induce disease remission and cure in acute myeloid leukemia (AML) requires highly myelosuppressive chemotherapy. Treatment typically necessitates supportive measures including blood product transfusions during the marrow aplasia associated with treatment. The refusal of Jehovah's Witnesses (JW) to accept transfusions makes the application of intensive chemotherapy a practical and ethical challenge. Within the remit of acute leukemia there is a variable need for blood product support. Acute lymphoblastic leukemia or acute promyelocytic leukemia (APL) are responsive to less myelosuppressive therapy such as vincristine and prednisolone or all-trans retinoic acid, respectively and their treatment in JWs incurs less risk than treating a JW with acute myeloid leukemia. Such cases and cases of JWs with AML treated with individually tailored less myeloablative regimens are reported, however, there remains no documented case of AML where complete remission (CR) has been achieved with standard intensive chemotherapy without blood product support. We present the case of an 18 year old female Jehovah's Witness diagnosed with de novo AML who achieved and maintained CR following intensive induction chemotherapy and three subsequent cycles of consolidation chemotherapy without blood product support.

joebutterworth@doctors.org.uk