South African guidelines on venous thromboembolism

To the Editor: We commend the excellent work by Jacobson *et al*. on behalf of the South African Society of Thrombosis and Haemostasis in producing a very necessary set of local guidelines on the management of venous thromboembolism (VTE).[1] VTE is a major cause of morbidity and mortality, as highlighted recently by the United States Surgeon General.[2] One important nuance worth noting, however, is the fact that warfarin may be started together with low-molecular-weight heparin (LMWH) on day 1 of anticoagulation, and is supported by recent guidelines by the British Committee for Standards in Haematology and the American College of Chest Physicians (ACCP) who both agree that LMWH and warfarin should be started on the same day.[3,4] The ACCP gives this recommendation their highest level of evidence, namely 1A. Evidence for this suggestion includes data from a randomised trial by Mohiuddin *et al*. showing decreased cost and morbidity in the group started earlier on warfarin.[5] Leroyer *et al*. and Gallus *et al*. have both also shown decreased duration of hospitalisation with earlier initiation of warfarin.[6,7] The ACCP also recommends that the duration of LMWH should be for a minimum of 5 days v. the 7 days suggested by Jacobson *et al*. This is in part based on at least one randomised trial showing similar efficacy in both arms.[8] Although this may only result in a total difference of 4 doses of LMWH per patient, the long-term cost implications may be significant. Lastly, noting the narrow therapeutic window of warfarin, we believe that it is important to consider major risk factors for bleeding on anticoagulants, such as increased age, uncontrolled hypertension, alcohol, use of non-steroidal anti-inflammatory drugs, liver disease and peptic ulcer disease, before initiating therapy.[9,10]

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Professor Jacobson replies: On behalf of the authors, I thank Webb *et al*. for their valuable comments.

The initiation of anticoagulation with LMWH and delaying warfarin was done knowingly for the following reason: South Africa has a nursing crisis aggravated in the State sector where LMWH is often only dispensed as a Schedule 7 medication. This leads to delays in patients receiving their LMWH. In our experience, numerous patients are therefore given warfarin, and LMWH is only given by nursing staff 24 - 48 hours thereafter. As there is a serious theoretical concern that patients' thromboses – especially those with Protein S deficiencies – will be exacerbated, there was consensus that warfarin should only be started after the clinician was convinced that the LMWH had actually been injected rather than prescribed.

Regarding LMWH duration for a minimum of 5 days v. 7 days: this actually depends on when the patient is fully mobile, which we believe is far more important than looking at empirical days, especially as numerous patients are discharged early from hospital to recover at home.

Lastly, we fully agree that, when commencing any patient on anticoagulation, the risk/benefit needs to be assessed and individualised in relation to any contraindications for anticoagulation.

Olfactory reference syndrome in DSM-V

To the Editor: We read with interest Dr A Lawrence's recent *SAMJ* case report of a young man who presented with persistent preoccupation with personal body odour in the absence of any physical abnormalities.[1]

Dr Lawrence does not explicitly consider a diagnosis of olfactory reference syndrome (ORS). This condition, characterised by a preoccupation with the idea that one's body odour is foul or offensive to others, may be part of the differential diagnosis in patients with psychotic disorders (who may have olfactory hallucinations), in patients with obsessive-compulsive disorder (who may have concerns about contamination, and wash or clean repeatedly) and in patients with a social phobia spectrum disorder (who may have severe social anxiety because of fears of causing offence).

One of the reasons why ORS was not included in the differential diagnoses is that it is not formally included in the *Diagnostic and Statistical Manual*, 4th edition (DSM-IV). The