that are felt to be primary in nature. If autopsy examination is delayed, air in the venous system may be resorbed, contributing to the difficulty in diagnosis.

The symptoms of VAE are variable and non-specific. These include alteration of sensorium, chest pain, dyspnoea and dizziness. Physical examination may reveal tachycardia, tachypnoea, and signs of elevated right heart pressure. A ‘mill wheel’ murmur produced by movement of air bubbles in the right ventricle is the only specific sign, but it is rare, transient and a late finding.

Precordial low-frequency Doppler ultrasound is the most sensitive method for detection of venous air. Other useful indicators of VAE include helical CT, echocardiography, transoesophageal echocardiography, and aspiration of air on an indwelling central venous catheter.

Prevention and early detection are the best approaches to VAE. Because of the non-specific signs and symptoms, a high index of suspicion in the appropriate clinical setting is important, since prompt recognition and institution of treatment, including immediate placement in the left lateral decubitus position, can be life-saving. Other measures designed to restore blood flow include removal of air through a central venous catheter or direct needle aspiration and external cardiac massage. Measures designed to increase absorption of air include the use of 100% O₂ and early institution of hyperbaric oxygen.

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Isolated microscopic haematuria

Sir,
I read with interest the paper by Chow et al.1 (‘Long-term follow-up of patients with asymptomatic isolated microscopic haematuria’). The title of the paper is somewhat misleading, as in pure isolated microscopic haematuria, the urine protein excretion rate is <100 mg/day (<0.1 g/day),2 but in this study the authors also included patients with microscopic haematuria and minimal proteinuria (>0.2 g/day) and, as expected (as shown in Table 1 and Figure 2), the majority of the patients in the latter group had adverse events, because of the higher baseline protein excretion rate, possibly suggesting an underlying nephrological process. This paper re-iterates the well known fact that patients with minimal proteinuria are increased risk for disease progression.2 We shouldn’t mix apples with oranges, and then conclude that a small amount of oranges would give apples a sour taste. The title ‘Long-term follow-up of patients with microscopic haematuria, with and without minimal proteinuria,’ might have been more appropriate for this paper, which highlights the significance of ‘even minimal proteinuria’ and the need for long-term follow-up of such patients.

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Norethisterone-induced cholestasis

Sir,
Combination oral contraceptive steroids are (rarely) associated with cholestasis that resembles intrahepatic cholestasis of pregnancy. The incidence of cholestasis due to oral contraceptive steroids is approximately 1:10 000 women exposed in Western Europe, but as high as 1:4000 women exposed in