The ROYAL HOSPITALS

THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

Medicines Control Agency
Market Towers
1 Nine Elms Lane
London SW8 5NQ

23rd October 2001

Medical Report. Re; Yellow card 433167 (RF)

Dear Dr Cheng,

Thank you for your correspondence of the 17th October. I enclose the answer to your questions as follows;

1. RF admitted to a large DGH with abdominal pain (no vomiting or diarrhoea) on 7/6/01 at 20.30. iv fluids commenced, serum sodium = 137 mmol/l
2. Appendicetomy (mildy inflamed) at 23.30 on 7/6/01
3. iv fluids in operating theatre (100 mls Hartmanns solution). Recommenced on 0.18% NaCl/4% Glucose at 80 mls/hour on return to ward.
4. Vomited 6-7 times on 8/6/01 from 12.30-13.00, complaining of headache. Sips of water allowed from 17.00 on 8/6/01
5. Seizures commenced at 03.00 on 9/6/01. Treated with diazepam 5mg PR followed by 10 mg iv.
6. Pupils fixed and dilated at 04.10 on 9/6/01. Intubated and ventilated for CT scan, which showed cerebral oedema. Serum sodium =118 mmol/l
7. Transferred to PICU at our hospital (RBHSC)
8. Brain Stem tests performed 10.00 on 10/6/01
9. Ventilation discontinued at 12.09 on 10/6/01
10. Coroner informed and postmortem conducted by Neuropathologist for Forensic.

Unfortunately I am not in a position to supply a postmortem result as it is a Coroners case. I have spoken to the neuropathologist who has confirmed that the cause of death was cerebral oedema leading to herniation. I have copied this response to both these men who I hope will supply you with further details of this important matter.
I am also conducting an audit of all infants and children admitted to the PICU with hyponatraemia. My initial results indicate at least 2 other deaths attributable to the use of 0.18NaCl/4%Glucose.

Yours sincerely,

Dr Bob Taylor, MA, MB, FFARCSI
Consultant in Paediatric Intensive Care

Dr Brian Herron, Consultant Neuropathologist, Royal Victoria Hospital, Belfast
Mr John Leckey, Coroner.

RF – CORONER