and illness durations of 8 and 17 months respectively. An Austrian patient without PSD survived 5 months from onset. 
Kimura et al. reported a patient with imaging unchanged throughout his illness, who developed PSD just 2 days before death, 13 months after onset of symptoms. The case described by Takashima et al., without PSD and with normal serial computed tomography (CT) scans, survived 17 months from onset. An American patient grafted with a Tutoplast patch survived 4 months from onset; imaging failed to assist diagnosis, while the EEG revealed only moderate to diffuse slowing. Interestingly, plaque formation was noteworthy in a number of these reports.  

Our case and the literature reports suggest that disease duration may be shorter in patients who do not show PSDs or in whom PSDs develop late. Subsets of graft-associated CJD may exist; this, together with host characteristics, might explain the differing clinical courses and disease phenotypes seen in graft-associated CJD.  

Conclusion  
Our report adds to the approximately 169 cases of dural graft-associated CJD. It supports the view that graft-associated CJD patients are younger than sporadic CJD cases, and are more likely to present with cerebellar abnormalities. Brain imaging without diffusion weighting may not always contribute to the diagnosis. We note an interesting association between delayed or absent PSDs and short illness duration. 

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Forensic laboratory applications

During evaluation of the Statscan at the Groote Schuur Trauma Unit, bodies suspected to contain bullets and other foreign bodies were referred from the Salt River Medicolegal Laboratory to the X-ray department at Groote Schuur Hospital by the Division of Forensic Medicine. The Statscan was found to be particularly useful in determining the presence of foreign objects such as bullets. The images produced greatly assisted the forensic pathologists in autopsy examinations, particularly by reducing the time taken to examine a body.

Large medico-legal laboratories admit up to 3 500 to 4 000 bodies per year for autopsy. In Cape Town half of these are due to murders (1 500 per annum) of which half again are caused by firearms. After a death due to gunshot injury, it is important to retrieve and mark all bullets found in the body. Each bullet must be carefully marked at its base, so as not to damage the rifling pattern along the side of the bullet, which is important for ballistic investigations. In cases of multiple bullets, where more than one firearm may have been used, it is also important to mark the site each bullet was retrieved from. Without a reliable X-ray facility the process of retrieving bullets may be lengthy and cumbersome, especially in cases where the bullet may have deflected against bone and changed direction. Correct location of bullets may be almost impossible to establish when they are lodged in bone. Standard X-rays require multiple fields to do a full-body survey. The use of a C-arm X-ray machine solves some of the problems, but requires the arm of the machine to be moved many times, with the danger of missing a bullet in the area between the settings. Both require films that have to be developed, and there is potential for high radiation exposure among staff.

The Statscan/Lodox system has clearly demonstrated the following advantages in a medico-legal unit.

Fig. 1 (left). Decomposed body on which some identification had been found. Cause of death undetermined. A Lodox scan revealed no bullets, but plate and screws in the right upper femur confirmed identification.

Fig. 3 (right). Firearm fatality with single bullet wound in the chest. The lower thoracic vertebrae were removed at autopsy in a failed search for the bullet. A Lodox scan revealed that the bullet had lodged in the lumbar vertebrae.

Fig. 2. Firearm fatality, multiple bullet wounds with difficulty in establishing entrance and exit wounds and defects (see sketch). Corresponding wound tracks were therefore difficult to establish. Retained bullets were suspected, but a Lodox scan revealed only two, in the right shoulder.
The Medicines Control Council alerts all health care professionals to safety information regarding the potential risk of interactions when domperidone is administered concomitantly with ketoconazole or possibly also with other medicines.

QT prolongation, ventricular tachyarrhythmias and sudden deaths have been reported following intravenous administration of domperidone in cancer patients. Domperidone has been shown to possess cardiac electrophysiological effects such as prolongation of cardiac repolarisation at normal doses.\textsuperscript{1,2}

The main metabolic pathway of domperidone is via the cytochrome P450 3A4 (CYP3A4) isoenzyme. In vitro data indicate that the concomitant use of medicines that significantly inhibit this enzyme may result in increased plasma concentrations of domperidone. Examples of CYP3A4 inhibitors include azole antifungals, macrolide antibiotics (e.g. erythromycin, azithromycin, roxithromycin, clarithromycin), HIV protease inhibitors (e.g. ritonavir) and grapefruit juice. Co-administration of ketoconazole with domperidone is contraindicated.

Studies in healthy volunteers have identified an interaction between domperidone and ketoconazole, showing a 3- to 10-fold increase in maximum plasma concentration ($C_{\text{max}}$) and area under the time-concentration curve (AUC) of domperidone. In one of these studies, ketoconazole was found to inhibit metabolism of domperidone by inhibition of CYP3A4-mediated first-pass metabolism, resulting in an approximately 3-fold increases in $C_{\text{max}}$ and AUC when compared with the administration of domperidone alone. A QT prolongation (about 10 to 20 milliseconds) was observed when domperidone (10 mg 4 times daily) was administered concomitantly with ketoconazole (200 mg twice daily) but not for domperidone alone at a dosage of 10 mg 4 times daily (Janssen-Cilag – Dear Health Care Professional Letter: Important information concerning the interaction of ketoconazole and domperidone and the risk of QT prolongation, November 2005). The QTc-prolonging effect of this combination (i.e. with ketoconazole) is not completely understood and cannot be explained solely by domperidone pharmacokinetic data.

The package inserts of domperidone products are in the process of being updated to reflect this important safety information.

Suspected adverse drug reactions associated with domperidone and other medicines can be reported to the National Adverse Drug Event Monitoring Centre, tel. (021) 447-1618, fax (021) 448-6181.

\textbf{References}
