Silent gall stones

SIR,—Professor I D Bouchier (9 October, p 870) must not allow his personal prejudice of leaving silent gall stones alone to spill over into orthodox teaching. All gall stones are “silent” until they give symptoms, and although many patients will pass through life without having symptoms from their gall stones a significant number of patients will develop painful and occasionally life-threatening complications. In my own practice some 40% of patients who come to cholecystectomy have presented with complications of gall stones that have necessitated emergency treatment.

Elective cholecystectomy in a patient who has not had acute cholecystitis or biliary colic is an easy procedure which can be carried out with minimal morbidity and mortality. In most cases the patients can be home within a week of operation. Alternatively, as Professor Bouchier states, patients admitted with acute cholecystitis may lie in hospital for some five to 10 days before operation and then have to undergo a procedure rendered technically more difficult by the presence of oedema, inflammation, and obstruction in Hartmann's pouch or elsewhere within the biliary tree.

Our aim should always be to prevent such complications and their associated pain, discomfort, and prolonged hospital stay. Thus, until adequate means of dispersing gall stones by drug treatment are found, cholecystectomy should be recommended to patients in whom investigation of other symptoms has incidentally shown the presence of gall stones. The low morbidity and mortality of elective cholecystectomy justify this policy despite the fact that a significant proportion of the patients so treated might never have developed symptoms. Common sense dictates that certain individuals should be excluded from this policy because of advanced age or severe associated illness.

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Oestrogens for menopausal flushing

SIR,—I am challenged by Drs G Mulley and J R A Mitchell (16 October, p 944) to produce evidence of a double-blind cross-over study in support of my contention that oestrogens reduce hot flushes in menopausal women. When preparing my article I was struck by the absence of such evidence and indeed this point was remarked upon in a recent review.¹ It is not disputed that such trials are a useful device for testing therapeutic efficiency, but they are not a sine qua non for clinical judgment. Oestrogens have been in use all over the world for several decades to treat menopausal symptoms. The fact that they reduce hot flushes has been attested in innumerable publications. It is possible, but improbable, that they are all wrong.

Whether or not a flush count is an objective way of evaluating treatment is a linguistic quibble rather than a point of substance. I meant no more than that it was a phenomenon to which a number could be put and as such gave evidence of a different quality from a patient's subjective assessment whether or not she was feeling better.

The therapeutic scepticism shown by Drs Mulley and Mitchell is to be recommended. Their conclusion that we should stop

prescribing oestrogens until there are “acceptable studies” which prove the superiority of oestrogens over placebo is not. In view of the dangers of oestrogens they should be used with nice judgment. I tried to say so. The distress caused by hot flushes, atrophic vaginitis, and osteoporosis can all be relieved by oestrogens. To refuse to do so is a failure of sympathy and therapeutic cowardice.

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¹ Utian, W H, “The scientific basis for postmenopausal oestrogen therapy,” in *The Menopause*, ed R J Beard, p 175. Lancaster, MTP Press, 1976.

Cervical hostility

SIR,—I was interested in your expert's answer to the query (9 October, p 865) about the treatment of “cervical hostility.” I have myself had one or two successes with patients using either a condom or a diaphragm plus spermicide for usually six months. My normal practice is to recheck at three months to see whether there is any improvement in the post-coital finding. Inexplicably, I have also had one or two successful cases where I have combined the use of vaginal douching with sodium bicarbonate, mid-cycle oestrogens, and self-insemination via an insemination cap. For these patients I am currently trying intra-uterine insemination of dilute buffered semen according to the technique described by Barwin.¹ The solution needed is Walton's buffered glucose, and the reason for its use is that intrauterine insemination of undiluted semen can lead to extremely painful uterine contractions. The pregnancy rate for these cases is not very high in my experience, but for very well motivated couples I feel that the treatment should not be withheld.

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¹ Barwin, B N, *Journal of Reproduction and Fertility*, 1974, 36, 101.

Acute abdominal pain in childhood

SIR,—No mention was made in your leading article on acute appendicitis in children (21 August, p 440) or in the article by Mr P F Jones under the above heading (4 September, p 551) of an important diagnostic feature—namely, vomiting—in the first few hours. This can be projectile in type with complete emptying of the stomach contents and occurs usually only once.

A girl of 3½ was put to bed on a Friday evening at 6.30 pm. She woke at 10.30 pm and was violently sick but made no complaint of pain. At 7 am no abdominal tenderness could be elicited and there was no diarrhoea, but she was content to lie in her cot, which was most unusual. At noon finger tip tenderness deep in the right iliac fossa was present and the pulse rate was 100/min. A consultant colleague saw her at 1 pm. At operation in the hospital at 3 pm an acutely inflamed appendix with a bulbous oedematous tip was removed. She made an uneventful recovery.

A schoolgirl of 17 complained early one Sunday morning of severe intermittent upper

abdominal pain and vomited once. By mid afternoon the pain had settled in the right iliac fossa. She was afebrile but resting pulse rate was 88/min. At operation a long acutely inflamed appendix tucked behind and adherent to the caecum was found. Convalescence was rapid and she left hospital five days later.

Both children were my daughters. Both were fortunate enough to have a parent hovering over them who knew of delays in early stages of acute appendicitis in children with, on occasions, tragic results. No doctor should put off seeing a child with acute abdominal pain, whether at its home or at his surgery. Time is not on the side of the GP in these cases, and the “let me know if he gets worse” approach should never be applied.

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SIR,—Dr D G Sims and Dr F W Alexander (9 October, p 880) raise the interesting topic of the delays which occur before children are admitted to hospital. This was not the subject of my recent paper (4 September, p 551), but we collected some information about parental opinions during the first six months of the survey.

Among the first 51 consecutive children with proved acute appendicitis the parents of 13 thought of acute appendicitis as a likely cause at the time the pain commenced, but by the time the family doctor was called in the parents of 40 children were suspicious of appendicitis. The time which elapsed before the doctor was called to the house varied greatly—within 6 hours in 20 homes, within 12 hours in a further 10, and within 24 hours in another 13. In the 8 families who delayed more than one day, 3 took 2½, 3, and 5 days to decide to call their doctor. One girl of 12 who had failed to persuade her parents that she was ill called the doctor herself by telephone after 24 hours of pain.

Once the family doctor had visited, 40 children were sent into hospital within a few hours, but in 11 there was a delay of more than 24 hours before admission was arranged, and 8 of these 11 children had a perforated appendix. It is interesting that all these 11 children were over 7 years of age and did not present special difficulty in diagnosis when admitted, although we do not, of course, know the picture when they were first seen.

It appears therefore that there is unexplained delay in sending for the doctor in 16% of families and delay in sending 20% of children to hospital. Dr Sims and Dr Alexander deplore this delay but give us little practical help in diminishing it. Television advertising time is widely used by Government departments to teach fire prevention and road safety drill, so there seems no reason why a well-planned one-minute programme should not be screened on the need to ask for medical advice when a child (or indeed anybody) has acute abdominal pain for more than six hours.

It was because we found accurate diagnosis of the acute abdomen in childhood to be at times so difficult that we made the studies reported in 1967¹ and last month. One of the major objects of both papers was to show the general practitioner how wide was the range of causes, the difficulties that might be met, the signs which can help to discriminate between surgical and non-surgical causes of abdominal pain, and the place of observation in the doubtful case. We concluded our 1967