Adynamic Ileus and Nortriptyline

SIR,—In their short paper on this topic (2 April, p. 841) Drs. G. Milner and N. F. Hills assert that nortriptyline possesses more dangerous anticholinergic properties than do imipramine and desipramine. They do not produce any evidence about the relative toxicity of these drugs when administered in their normal dosage, but they did observe ileus when nortriptyline was given (1) in full adult dose to a child of 14½ years, (2) in the standard dose of 75 mg. daily to an 81-year-old admitted to hospital after having taken an overdose of barbiturates, and (3) when a standard dose was given in conjunction with 150 mg. daily of chlorpromazine to a woman complaining of abdominal pain.

The part played by nortriptyline in the induction of these patients' ileus is far from clear, but there is no doubt that nortriptyline is a potent drug with anticholinergic properties. It is to be used with discretion in the elderly, and is probably best administered to such patients in reduced dose initially.

The recommended adult daily dose is 75 mg., which may be raised to 100 mg. daily if necessary, above which level anticholinergic side-effects are likely to become troublesome. Drs. Milner and Hills state categorically that "the usual adult dose" is 150–200 mg. daily, but it is fervently to be hoped that their opinion on this point at least will be taken with reservation.—I am, etc.,

Dista Products Limited,
Liverpool 24.

W. H. LYLE.

Contact Lenses and Oral Contraceptives

SIR,—A 33-year-old short-sighted married woman who had worn corneal contact lenses uneventfully 12 hours a day for three years began sequential oral contraceptive therapy with Oracon, in which ethinyloestradiol, 0.1 mg., daily for 16 days, is followed by dimethisterone, 25 mg., plus ethinyloestradiol, 0.1 mg. daily for five days. After 10 days' therapy in the first cycle she noted improvement of acne vulgaris of her face and chest, but because she developed minimal ankle oedema, slight weight gain, fullness of the face and breasts, and increasing prominence of pre-existent mild varicose veins, she discontinued the drug. These effects were all probably oestrogen-induced; the side-effects diminished and the acne vulgaris relapsed after the oestrogen therapy was stopped.

A few days after stopping the ethinyloestradiol she began to notice photophobia in direct sunlight. After this had continued for three weeks, unaccompanied by redness of the eyes or lacrimation, she was examined by an ophthalmologist, who detected unilateral corneal oedema and superficial corneal opacities, staining with fluorescein. Her use of contact lenses was prohibited; the photophobia disappeared within 36 hours, and after three weeks slit-lamp examination of the cornea revealed complete recovery. She was then able to resume wearing her contact lenses for 12 hours a day uneventfully.

During the previous three years regular slit-lamp examinations had shown that her contact lenses were of a correct "fit," and no corneal staining with fluorescein had been detected. There was no obvious local cause for the attack of corneal oedema here described, which was coincident in time with side-effects due to fluid retention induced by

oestrogen. It would be of interest to know if oral contraceptive therapy has been associated with disturbances of contact-lens wearing in other patients.—I am, etc.,

G. A. CARON.

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Causes of Death in Primitive and Emerging Populations

SIR,—In the medical literature dealing with epidemiology, geographical pathology, environmental health, etc., regret is often expressed over our lack of knowledge of patterns of morbidity and mortality in primitive and emerging populations. Unfortunately, information in this field is likely to remain defective for many years. The reason is not far to seek. The following illustrates the difficulties prevailing.

In an attempt to assess the proportion of deaths of Johannesburg Bantu adults that could be ascribed to nutritional causes, death certificates for 1963 were examined. Of persons dying from 45 years and onwards it was dismaying to find that no less than 23% were attributed to senility or unknown causes (Classification B.45, 780–795). For the total Johannesburg Bantu population—that is, all ages—the figure was 21%. Yet in this city health services for non-whites are of a higher standard than any in Africa.^{1,2} Current Bantu infantile mortality rate is about 60, lower than that of any other city in this continent, and lower, too, incidentally, than current figures for Portugal and certain Central and South American countries.³ Why then is the cause of death of about every fifth Bantu uncertain or unknown? The proportion among the rural population, of course, is higher. To afford perspective it should be added that the corresponding percentages obtaining for total populations elsewhere are as follows: United Kingdom, 1.3; South Africa (Whites), 4.8; Greece, 18.0; Yugoslavia, 25.1; Ceylon, 22.4; El Salvador, 28.3.⁴

Locally (and presumably elsewhere) the salient reason for the lack of knowledge is that many Bantu die without the attention of a doctor in their terminal illness. This is by no means attributable wholly to poverty, but, at least in the case of adults, due rather to the tacit acceptance of the inevitability of death, which is part of their philosophy. It is conjectured that the proportion of adults dying from unknown causes could be reduced perhaps considerably by investigating from next of kin the antecedents of those who died in relation to hospital or other treatment prior to death. To throw light on this possibility we are seeking to assess the extent of the reduction possible by inquiring into the causes of death of 100 random adult Bantu stated to have died from senility or unknown causes.

The present situation, understandably, on the basis of death certificates precludes the making of satisfactory comparisons of prevalences of particular causes of death in Bantu compared with whites. At present it is therefore possible that diseases in Bantu believed to be common may be commoner than current figures suggest, and, moreover, that diseases deemed to be rare may be less so. For the study of inter-racial prevalence

of diseases valuable information is likely to accrue only from two avenues of approach—namely, from post-mortem studies of persons dying from traumatic causes and from clinical observations on truly representative groups, together with other appropriate examinations (x-ray, E.C.G., laboratory studies, etc.).—I am, etc.,

ALEXANDER R. P. WALKER.

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REFERENCES

- ¹ Fry, J., *Lancet*, 1965, 2, 381.
- ² Malkin, C., *ibid.*, 1965, 2, 1078.
- ³ *Epidem. vit. Statist. Rep.*, 1965, 18, 352.
- ⁴ *Ibid.*, 1964, 17, 532.

Battered Baby Syndrome

SIR,—I wonder how many doctors share Miss E. C. Sumpter's experience with these babies and their families (26 March, p. 800)? Our own, at the Whittington Hospital, differs considerably. We have certainly not found that the parents "usually seek immediate medical help and almost invariably appeal for the child's admission to hospital." On the contrary, the baby is sometimes not brought to the hospital until several days after the injury, and babies have been brought to our casualty department with a "lump" which turns out, on x-ray, to consist of well-calcified callus round a fracture. Nor, in our experience, are the problems "essentially different from those of the overtly neglected or ill-treated child." Several of the babies we have seen have been both neglected and "battered."

It is true that some of the babies seem otherwise well and come from apparently good homes, but we have been struck by the proportion of the families that are already known to their general practitioners, health visitors, and various social agencies as having many problems. What possible excuse is there for the consultant and social worker to confine their investigations within the hospital, as Miss Sumpter suggests, when these other professional persons are likely to have much relevant and important information?

Miss Sumpter finds the problem of whether to inform the police simpler than most of us. It may be true that "women police officers and C.I.D. officers are compassionate, well-informed people with considerable knowledge of human motivation" even off the television screen and without Miss Sumpter's rose-tinted glasses, but should doctors then be less compassionate? The N.S.P.C.C. has for years been involved in dealing with such families and pride themselves that they now very rarely prosecute. The doctor performs his civic duty perfectly adequately by informing the children's department of the local authority, which has quite specific responsibilities in such circumstances. Then inquiries can be made and decisions taken as matters, not of punitive justice, but of social case-work. The doctor, by contributing his specialized knowledge, can cooperate in the attempt to end the intolerable situation in which the baby and the parents find themselves.

I agree that these children are in "constant and mortal danger" whilst they are in their homes. The important thing, therefore, is for general practitioners, casualty officers, paediatricians, and others who may see them to know about the syndrome and to admit any

child to hospital if it seems possible that it has been deliberately injured, whether by parents or baby-minder or older sibling. The child is then in a "place of safety" and can be kept there, as the B.P.A. memorandum makes clear. But once it is there, the best interests of the baby and the rehabilitation of the parents are not contradictory aims: they are joint ones, and the apparatus for dealing with both is available.—I am, etc.,

Whittington Hospital,
London N.19.

SIMON YUDKIN.

Trusses for Femoral Hernia

SIR,—The facts of anatomy will not support even the very limited approval of femoral trusses expressed by Mr. R. J. McNeill Love (12 March, p. 673).

The sac of a femoral hernia descends at first vertically and lies between rigid structures—the pubic bone and the inguinal ligament. Here it is not susceptible to influence by any form of external truss. The sac is always elongated and relatively narrow in its first part. When it turns forward into the femoral triangle after escaping from under the inguinal ligament it may have a substantial globular fundus. More often it does not but remains a relatively small sac surmounted by a thick cap derived from the pro-peritoneal fat and fascia. Sometimes the fundus of the sac remains deep in the femoral canal, and the swelling, which can be seen or palpated, consists entirely of fatty cap.

When the hip-joint is fixed a truss can be made to exert continuous pressure on the femoral triangle and on any swelling in it, but from the foregoing it follows that no truss can prevent the first part of the femoral sac from being filled from above, and this precisely constitutes the danger of femoral hernia. A truss in this condition is as efficient as an inguinal truss, which presses on the external ring when the hernia has escaped from the internal ring—that is, it is totally inefficient.—I am, etc.,

Birmingham 15.

F. WELSH.

Umbilical Hernia

SIR,—At the first Commonwealth Medical Conference held in Edinburgh in October 1965 it was agreed that young doctors should be encouraged to undertake a tour of service in the developing Commonwealth countries. Apart from various emergencies such as injuries, together with other diverse sudden misfortunes, some more interesting cases face the young doctor, such as the one reported below—the most interesting of a number of

cases during my first year at this district hospital. Such cases are not uncommon, but I thought this one to be worth recording for the interest of prospective young doctors in the developing countries.

A 27-year-old Tumbuka female was admitted to this hospital with complaints of "swelling" of the abdomen since the birth of her third child five years before. She had borne two more since then. Her general health was good. There was a pyriform swelling 10 in. by 5 in. (25 cm. by 12 cm.) in the umbilical region (Fig.). The skin over it was stretched, obliterating the position and evidence of the umbilicus. The veins over the swelling were prominent (O), and there were trophic ulcers (X) on the most dependent part of the swelling. The swelling was soft and tympanitic. It reduced completely in the recumbent position, leaving a puckered ulcerated flap of skin.

The patient refused to travel the 400 miles to Blantyre for the attention of the surgical specialist.

A repair was performed as follows: The mass was reduced and the redundant skin clamped by means of occlusive intestinal clamps. An incision was made parallel to the rectus muscle on either side, and the redundant ulcerated sac excised, leaving an incision 6 in. (15 cm.) long with a gap similar to one in an ordinary midline laparotomy incision. The redundant sac had a capacity of 250 ml.

The recti muscles were defined; the right tucked under the left and their edges secured.¹ The skin was closed with interrupted sutures.

The patient recovered uneventfully, and was discharged 10 days later. She reported on 15 January 1966 for a check-up.

I wish to thank the Secretary for Health, Malawi Ministry of Health, for permission to publish this case, and the hospital staff for their assistance.

—I am, etc.,

District Hospital,
Mzimba, Malawi.

Y. H. MISOMALI.

REFERENCE

- ¹ *Rose and Carless Manual of Surgery*, 1960, 19th ed. London.

Serum Leucine Amino Peptidase Activity in Carcinoma of the Stomach with Metastases

SIR,—A modification of the method of Goldbarg and Ruttenburg¹ for the determination of leucine amino peptidase is described in the *Sigma Technical Bulletin No. 250*. Reference was found to the levels of serum leucine amino peptidase in various diseases, the highest values being found in carcinoma of the head of the pancreas, 450–1,270 G.R. units.

A man aged 65 years was admitted to this hospital with a history of confusion, vomiting, and back pain. A provisional diagnosis of carcinoma of the pancreas was apparently supported by a serum leucine amino peptidase of 1,000 G.R. units and an alkaline phosphatase of 44 K.A. units. The presence of metastases was suggested by the serum phosphohexose isomerase of 290 i.u./l. rising to 470 i.u./l.² The barium meal demonstrated an ulcer high up on the greater curve of the stomach, which at necropsy was shown to be malignant, with secondary deposits in the liver. The pancreas was normal.

It is interesting that in this case a greatly elevated serum leucine amino peptidase was found in the presence of a carcinoma not arising in the pancreas. The diagnostic

value of this enzyme may perhaps be limited.—We are, etc.,

W. H. S. GEORGE.
K. J. GURLING.
I. MACKENZIE.

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REFERENCES

- ¹ Goldbarg, J. A., and Ruttenburg, A. M., *Cancer*, 1958, 11, 283.
- ² Bruns, F. H., and Jacob, W., *Klin. Wschr.*, 1954, 32, 1041.

Home Treatment of Pulmonary Tuberculosis

SIR,—Dr. K. M. Citron's (12 March, p. 657) list of tuberculous patients unsuitable for home treatment can be reduced by at least one—namely, "Infectious patients with susceptible family contacts." Dormer and his colleagues¹ have shown that isoniazid is an excellent prophylactic for infants nursed by infectious mothers. It must be no less protective for other family contacts. My practice is to give isoniazid to all child contacts of infectious cases treated while remaining at work. Any children tuberculin negative six weeks after the start of prophylaxis are vaccinated with isoniazid-resistant B.C.G. under cover of isoniazid until conversion occurs.

Dr. Citron, in clearly setting out the undoubted merits of treatment at home and at work, regrettably repeats some traditional dogma concerning spread of infection. Infection is spread by airborne droplets, and there is no proof that bed linen, crockery, or dried sputum is ever involved. Disinfectants are as unimportant as rest, nutritious food, and fresh air.

A separate room is unnecessary. An adequate supply of handkerchiefs to cover the mouth during coughing should suffice.—I am, etc.,

Mullingar,
Ireland.

MICHAEL P. FLYNN.

REFERENCE

- ¹ Dormer, B. A., Harrison, I., Swart, J. A., and Vidor, S. R., *Lancet*, 1959, 2, 902.

Treatment of Sinusitis

SIR,—In his article on diagnosis and treatment of sinusitis (2 April, p. 834) Mr. J. D. K. Dawes does not mention nasal decongestants or steam inhalation.

Does this mean that he feels there is no value in either of these procedures?—I am, etc.,

Reepham, Norfolk.

A. S. GARRETT.

Post-vagotomy Neuroma

SIR,—In reference to your leading article on this subject (19 March, p. 694) a former senior house-officer of mine, Mr. E. J. Guiney, and myself reported a case of this condition in March 1960.¹

Our patient's major complaint was of dysphagia with a narrowed area demonstrable in the lower thoracic oesophagus; biopsy showed only inflammatory change. At thoracotomy the narrowing was found to be due to a small "stump neuroma" densely