CORRESPONDENCE

Correspondents are asked to be brief

Safety-pin Swallowers

SIR,—We expect that after the letter by Mr. J. A. C. Neely and Mr. A. Rhodes (12 December, p. 681) there will be a flood of reports of similar cases. May we then join in with the following account of a 21-year-old girl admitted to Guy's on 14 December?

She presented with a history of swallowing safety-pins "whilst dressmaking." There were several scars on the abdomen—some old, some of recent origin—for which various explanations (some plausible, some not so plausible) were offered. In addition there were multiple needle puncture sites in the upper and outer quadrants of each buttock—"from iron injections." Plain x-ray films of the abdomen confirmed the presence of two open safety-pins.

Bit by bit the true story emerged. She stated that she had had a partial gastectomy at the Northern General Hospital in Sheffield. On telephoning this hospital it transpired that they had received several inquiries about this girl's previous history from hospitals in Birmingham and London during the past few months. In fact the Sheffield operation was a gastrotomy for removal of pins—and she had later had a further laparotomy for a similar story. For the present two pins she has already had admissions to St. Mary's Hospital, in Paddington, and University College Hospital, each time taking her own discharge.

During her present admission we have watched the progress of the pins with serial x-ray films. One has passed on and now that the other appears to be approaching the rectum, she has now discharged herself.

Obviously these patients present a management problem. It seems that whatever one does they will continue to swallow pins. This being so they present as candidates for repeated enterotomies. If operation can be avoided then that is clearly preferable for both parties. The patient reported by Mr. Neely and Mr. Rhodes passes his pins per rectum without incident, and so it seems does this girl. Is this the general experience of other surgeons, we wonder? We cannot help feeling that the surgeon is obliged to admit these people in case an open pin should perforate the bowel. Can one state that treatment should always be expectant in the first instance and are manoeuvres such as enemas, rectal washouts, suppositories, and laxatives thought to be advisable?—We are, etc.,

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Gold for Rheumatoid Arthritis

SIR,—In recent years there has been a renewed interest in gold therapy, which has been accompanied by reports of adverse reactions, including blood dyscrasias. As the manufacturers of sodium aurothiomalate (Myocrisin), we should like to reiterate the recommendations of precautions to be carried out when it is used. For the treatment of rheumatoid arthritis and some related conditions gold is at least as safe as other therapeutic agents, but it must be used both with care and understanding. The "standard" course, in which the weekly dose rises to, but should not exceed, 50 mg, giving a total of 1 gramme, may cause some reactions. Attempts to predict such reactions through an estimation of gold serum levels, urinary excretion, or changes in erythrocyte sedimentation rate have had no success, and it has been suggested, but not yet proved, that the appearance of an eosinophilia may be an early warning sign. However, a sudden fall in the platelet level indicates that a marrow toxicity is developing. It is believed that the most likely time for a toxic reaction is during the period when 300-500 mg of gold has been given. Occurrence has seldom been reported during the later stages of the initial course and subsequent maintenance therapy.

Ideally, every patient receiving gold should have a full blood count with each weekly injection, and the result should be known before the injection is given. In practice a monthly blood count is all that may be possible, but whatever its frequency the request to the laboratory should always specify a numerical platelet count rather than an estimation. Probably the most important preventive measure is the assessment of the patient's condition before each injection. This should be carried out by the doctor personally and not delegated. The urine should be tested for albumin and evidence sought of malaise, rashes, and above all the occurrence of a sore throat or buccal ulceration. The patient should be instructed, preferably in writing, to report at once should any such effects arise between injections—particularly the sore throat, the onset of which will necessitate a full blood count (including platelets) followed by immediate action if there is any evidence of a thrombocytopenia.

If these precautions are adopted as routine the incidence of severe reactions will be minimized and the undoubted benefits of gold therapy realized.—I am, etc.,

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Abnormality in Mediaeval Femur

SIR,—The specimen described here was found at Carrow Abbey, Norwich, a mediaeval monastic foundation which flourished from A.D. 1146 to 1538. It was part of a chaotic medley of bones churned up by a bulldozer, but although remains of at least 16 persons could be identified in no case could more than about half a dozen bones be allocated to any one body. The fragment to be discussed (which is now in the Castle Museum, Norwich—Acc. No. 214,967) is unaccompanied by anything else that can be attributed to the same individual.

It consists only of part of a right femur proximal to the lesser trochanter (Figs. 1 and 2). Even this is incomplete, part of the greater trochanter having been damaged during excavation. This surviving fragment of what seems to have been a fairly large male thighbone, is grossly pathological. Its axis from the most lateral part of the greater trochanter to the fovea deviates from normal; an osteophytic outgrowth obscures the neck; the head of the bone is eroded and eburnated, has a heavy flange of new bone along its superolateral margin, and is severely distorted by craggy osteophytes around and below the fovea. The fovea itself lies at the base of an osseous tunnel about 13·5 mm deep, from which a smooth sulcus, impressed into the newly formed bone, marks the course of the ligamentum teres over about 40 mm.

It is unfortunate that as no trace of the corresponding innominate was found the

acetabulum cannot be examined. But there can be little doubt that severe limitation of function must have been present in this hip joint, probably with advanced osteoarthritis of the socket. The absence of the innominate, together with the impossibility

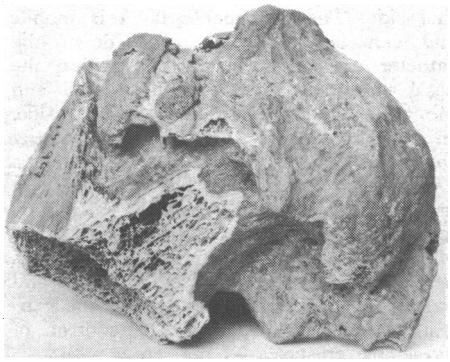

FIG. 1.—Anterior aspect of femoral head and neck. Note eburnated articular surface surrounded by craggy osteophytes masking part of the neck. The head has slipped downwards and backwards, shortening the distance between the fovea and the lateral surface of the great trochanter.

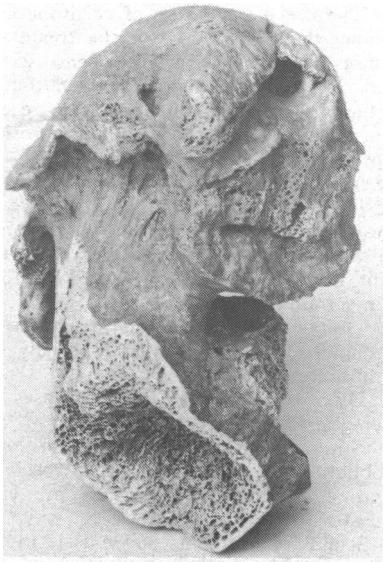

FIG. 2.—Inferomedial aspect of femoral head and neck. Note the groove made by the ligamentum teres which dips down into a deep tunnel towards the fovea. Note also the posterior displacement of the head.

of obtaining a clinical history, adds difficulty and interest to the diagnosis. The transverse diameter of the head of the bone is very close to 51·5 mm. In 12 normal mediaeval femora chosen because their femoral head diameters ranged from 50-53 mm the distance from the fovea to the most lateral part of the greater trochanter ranged from 98·3 mm to 117·6 mm. In the Carrow Abbey specimen this distance is only about 84·5 mm, which might suggest that the diminution is due to a fractured neck. There is no evidence of this, however; as far as can be seen the neck is nearly normal beneath its carapace of osteophytes.

The abnormality here seems to be primarily in the head of the bone, which has diverged posteriorly and downwards from its normal position. This is the characteristic feature of a slipped capital epiphysis spontaneously occurring in early adolescence, and there is little doubt that this accounts for the present lesion. It might possibly be a simple osteoarthritis, although this is extremely unlikely. Osteoarthritis is very common in mediaeval femora but its usual form is quite different from the specimen shown here.[1]

It is difficult to assess the age at which this person died. The epiphyses of the head and the trochanter had fused long before death and it is probable, from the severity and extent of the osteophytic reaction, that he was at least 30 years old. Be this as it may, the fragment seems to be highly typical of the late results of a juvenile slipped femoral epiphysis.

In contrast to fractures and osteoarthritis of the femur, this is an exceedingly rare condition in early burial grounds, if indeed it has ever been diagnosed. The fact that in the course of examining thousands of archaic femora I have never seen a similar specimen is, perhaps, sufficient justification for reporting this case.

My thanks are due to Mr. F. W. Cheetham, director, City of Norwich Museums, for permission to record this note.

—I am, etc.,

CALVIN WELLS

Castle Museum
Norwich

1 Wells, C., *Bones, Bodies and Disease*. London, Thames and Hudson, 1964.

Cullen's Sign in Perforated Duodenal Ulcer

SIR,—Mr. D. M. Evans (16 January, p. 154) records an example of Cullen's sign in a case of perforated duodenal ulcer. He quotes Cope[1] and Bailey[2] as stating that haemorrhagic staining at the umbilicus is pathognomonic of acute pancreatitis. In my experience it is more common in natural ectopic gestation and in spontaneous haemorrhage into the rectus sheath. The latter condition can be particularly deceptive as there is marked local tenderness and guarding.

It appears that in Mr. Evans's case there was no blood-stained abdominal free fluid. The possibility would seem to arise that in this case the blood staining at the umbilicus was due to a muscle tear.—I am, etc.,

S. C. RAW

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1 Cope, Sir Z., *The Early Diagnosis of the Acute Abdomen*, 12th edn., p. 89. London, Oxford University Press, 1963.
2 Bailey, H., *Emergency Surgery*, ed. T. J. McNair, 8th edn., p. 536. Bristol, Wright, 1967.

Unusual Cause of Varicocele

SIR,—We report a case of abdominal aortic aneurysm presenting as a left varicocele.

A 63-year-old man presented with a two-month history of aching and enlargement of the left side of the scrotum. Examination revealed a large left varicocele and an abdominal aortic aneurysm. The aneurysm had been symptomless, though on further questioning he admitted to a throbbing sensation in the epigastrium on occasions over the last two months. At operation the aneurysm arose 3 cm below the left renal vein. It was resected and a Dacron aortailiac bifurcation graft inserted. Two months after operation the varicocele was considerably smaller and symptomless.

Renal lesions, particularly hypernephroma, are known to present with a left varicocele. In this case the aneurysm probably caused the varicocele by obstruction of the left testicular vein or by stretching the left renal vein.—We are, etc.,

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Myocardial Infarction and the G.P.

SIR,—May I comment on the letter by Dr. R. D. Martin (7 November, p. 367), in which the use of procainamide as a prophylactic agent against ventricular dysrhythmias complicating myocardial infarction is advocated in general practice. The Boston study[1] concluded procainamide afforded highly significant protection against all types of active ventricular arrhythmias, markedly reduced the need for acute therapy of arrhythmias, and prevented death from active arrhythmias. Ventricular extrasystoles have been recorded in 80% and ventricular tachycardia in 27% of closely monitored patients.[2]

However, heart block has been reported to complicate myocardial infarction in 23% of patients.[2] Since procainamide reduces both the excitability and conduction velocity of the conducting system of the heart, any tendency towards impaired A.V. conduction may be exaggerated resulting in asystole. Since it is clinically impossible to exclude first-degree heart block, we consider that prophylactic therapy with procainamide should be delayed until E.C.G. evidence is available. Heart block of any type is a definite contraindication to the use of procainamide.—I am, etc.,

L. ADAMSON

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Twickenham, Middx

1 Koch-Weser, J., Klein, S. W., Foo-Canto, L. L., Kastor, J. A., and DeSanctis, R. W., *New England Journal of Medicine*, 1969, 281, 1253.
2 Lown, B., *et al.*, *American Journal of Cardiology*, 1967, 20, 494.

Vaccinia in a Patient with Acne

SIR,—Prior to proceeding on a Mediterranean cruise a 15-year-old girl requested vaccination against smallpox. This had not previously been performed. There was no family history of eczema and the girl was healthy apart from mild acne on the face and neck which at that time was not active. Primary vaccination was carried out on the right upper arm. Ten days after vaccination she developed primary lesions on the face and a temperature of 103°F (39·5°C). When first seen the original vaccination showed considerable but not excessive reaction. Four similar lesions were present on the face, two others on the trunk, and two on the other arm. All these lesions were superimposed on the old acneiform rash. Tetracycline was given to prevent secondary infection and by the next day a further four lesions had developed on the face and four more on the trunk. In view of this 2 g of antivaccinial gamma globulin were given by