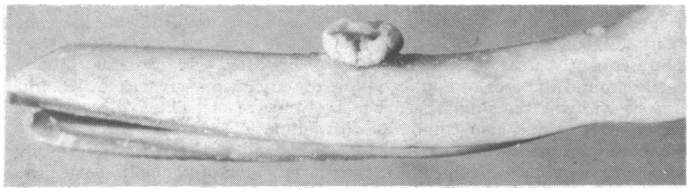

Photograph of T tube after removal. Some contraction of "blister" on cross limb has already occurred.

gram through the T tube track was normal. The patient was discharged and has remained well.

Comment

This was clearly an unusual occurrence that could probably be prevented by carefully inspecting T tubes and using them only when perfect. In this case the T tube, which had undergone autoclaving an unknown number of times, had almost certainly been distorted by handling with forceps during its insertion. Had we suspected that an abnormality of the T tube was causing the filling defect we could have confirmed this by pulling down on the T tube stem and showing that the filling defect moved with the tube. We report this case so that others may be made aware of this possibility and of how to confirm it.

We thank Professor R H Dowling and Mr J McIntyre for permission to report on this patient, who was admitted under their care.

[1] Burhenne, H J, *Radiology*, 1974, **113**, 567.

(*Accepted 7 April 1977*)

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Epidemic of Tietze's syndrome

The syndrome of painful swelling of one or more of the upper costal cartilages was described first in 1921 by Tietze.[1] Since then more cases have been recorded[2] and similar swellings of the sternoclavicular joints have been included in the syndrome.[3] The condition is relatively uncommon, runs a self-limiting course, and is of unknown aetiology. During mid-1976, six typical cases of Tietze's syndrome presented to the outpatient clinic of Nchanga North Hospital in Chingola, Zambia.

Case reports

Details of the six cases are shown in the accompanying table. Two of the patients had other illnesses at the time—a tuberculous spinal abscess in case 1, and secondary syphilis in case 5. Various anti-inflammatory analgesics were prescribed to all patients, but these were not of great benefit. All cases ran a benign course and slowly resolved.

Details of six patients with Tietze's syndrome

Case No	Age	Sex	Onset	Site	Duration (months)
1	38	M	3/4/76	Right 4th costal cartilage	6
2	25	M	13/4/76	Left sternoclavicular joint	2
3	30	M	3/5/76	Right 2nd costal cartilage	2
4	23	M	8/5/76	Left 2nd costal cartilage	1
5	38	M	15/5/76	Right 2nd costal cartilage	2
6	28	F	17/5/76	Right 4th costal cartilage	3

Discussion

All these six cases were typical of Tietze's syndrome[2]—that is, young adults were predominantly affected; the swellings were of the upper thoracic articulations; the disease was self-limiting; and it was largely unaffected by treatment. The aetiology of Tietze's syndrome is unknown, but trauma has been suggested, and various other conditions have been noted in association with it, including respiratory infections[4] and syphilis[5] (as in case 5 in this report). The association with spinal tuberculosis noted here in case 1 does not seem to have been recorded.

The patients in this series were all Black Zambians living in the town of Chingola and working for Nchanga Consolidated Copper Mines Limited, though none had any close social or work contact with one another. Moreover, the date of onset of all six illnesses was within a six-week period between April and May 1976. No other cases of Tietze's syndrome have been seen in recent years in Chingola, and at the time of writing (February 1977) no further cases have appeared. This clustering in time and space of such an uncommon condition suggests that environmental factors such as viral infection or exogenous toxins may be of importance in the aetiology of Tietze's syndrome.

[1] Tietze, A, *Berliner klinische Wochenschrift*, 1921, **58**, 829.
[2] Levey, G S, and Calabro, J J, *Arthritis and Rheumatism*, 1962, **5**, 261.
[3] Calabro, J J, and Marchesano, J M, *Journal of Pediatrics*, 1966, **68**, 985.
[4] Motulsky, A G, and Rohn, R J, *Journal of the American Medical Association*, 1953, **152**, 504.
[5] Vachtenheim, J, *Deutsche Gesundheitswesen*, 1966, **21**, 1387.

(*Accepted 25 March 1977*)

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Acute gastric dilatation in anorexia nervosa

Acute gastric dilatation, a rare complication of anorexia nervosa,[1-5] is probably caused by a rare combination of factors. The psychiatric diagnosis and difficult behaviour may direct attention from the physical nature of the complication. Delay in starting treatment may jeopardise the survival of an emaciated patient. On the other hand, anorexia nervosa should be considered in patients presenting with acute gastric dilatation.

Case report

A 17-year-old girl was admitted to the psychiatric unit with a six-month history of anorexia, loss of weight from 58 kg to 35 kg, feelings of despair, inability to cope, and vague suicidal thoughts after her grandmother's death. Grief reaction and secondary anorexia nervosa was diagnosed. She responded well to monoamine oxidase inhibitors, chlorpromazine, and social rewards for weight gain. She ate a 12·5 MJ (3000 Kcal) diet with additional biscuits and sweets. After eating most of a fruit cake weighing 1 kg in addition to her normal diet she complained of mid-abdominal, non-colicky pain of sudden onset associated with a swollen abdomen and nausea.

On examination her pulse rate was 112/min and BP 120/70 mm Hg. Her abdomen was tightly distended and a tender mass was felt in the upper abdomen. A plain *x*-ray examination confirmed a diagnosis of acute gastric dilatation. She was transferred to the medical unit where she was treated by "drip and suck." She settled quickly and within three days was back on a 12·5 MJ diet. Urea and electrolytes remained within normal limits throughout. Her subsequent progress was uneventful.

Comment

Acute gastric dilatation when treated promptly has few serious consequences. Delay in treatment may lead to stomach rupture, which has an 80% mortality rate.[2] In anorexia nervosa diagnosis of dilatation may so easily be delayed because manipulation, self-induced vomiting, and complaints of abdominal discomforts after eating are so common in these patients.