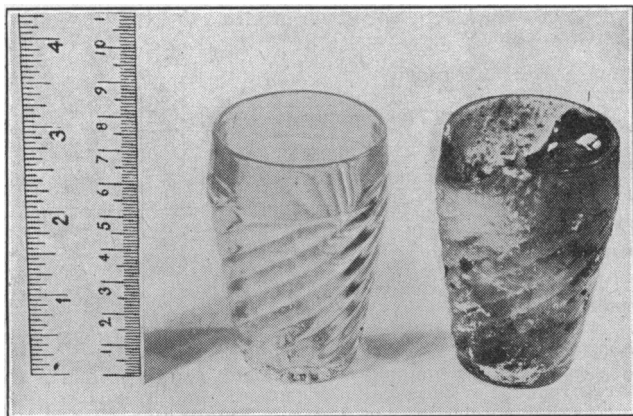


A Foreign Body in the Rectum

SIR,—I was most interested to read in your correspondence (September 16, p. 680) the letter by Mr. J. B. Prendiville, particularly as in the same week I was myself confronted with a similar case. Within the last nine months I have had to deal with two cases of tumbler in the rectum; apart from the age these cases are otherwise similar.

The first one was a married man aged 58 who gave a history of having slipped in the bathroom, "accidentally" sitting on a tumbler and causing the latter to become lodged in the rectum. Removal in this case was easily accomplished without assistance, using the orthodox technique of filling the glass with plaster-of-Paris in which a piece of wood was embedded to provide a hold.

The second case was a married man of 70 years of age with exactly the same history; he had exactly the same type of tumbler in the rectum; but he admitted having had a tumbler in his rectum on a previous occasion, which he had been able to remove himself. The patient was thoughtful enough to produce an identical tumbler for our inspection. The photograph shows the tumbler removed, with a portion of the rim broken off, and a second tumbler for detail.



This second case presented more difficulty on account of the broken rim, which rendered the rectum liable to laceration when the tumbler was pulled upon as it lay *in situ* in its inverted position; plaster-of-Paris failed to fill the gap and the technique employed in the first case failed. A laparotomy through a lower paramedian incision was performed and, with the assistance of a hand in the rectum, version of the tumbler was performed within the rectum and the tumbler delivered base first. No damage was caused to the rectum and the abdomen was closed without colostomy, a rectal tube being inserted for forty-eight hours. Convalescence was uneventful.

I am indebted to Mr. J. Jemson, consulting surgeon, for his help in extracting the foreign body in the second case.—I am, etc.,

London, S.E.13.

E. MORAGAS.

Rectal Thiopentone in Children

SIR,—Dr. Gordon M. Wyant (August 5, p. 368) is worried because Dr. J. Lorber (July 1, p. 21) does not stress the potential hazards of rectal thiopentone in children. The dosage the author recommends—1 g. per 50 lb. (22.5 kg.) body weight—was, I think, first suggested by Weinstein (Weinstein, M. L., *Curr. Res. Anesth.*, 1939, 18, 221), and I have used it myself as a premedication for children very satisfactorily for 10 years and have never met the "considerable respiratory depression" that Dr. Wyant says may ensue. My experience has been that the children are so lightly asleep that any undue stimulus in transport from the bed to the operating table may wake them up. I believe that theoretically the rectal route is less likely to cause laryngospasm than the intravenous, because the hypnotic concentration in the blood stream is reached much more gradually—and many anaesthetists believe that laryngospasm is more likely to attend rapid induction. As practical evidence of this I offer Dr. Wyant my 10 years' experience without a single case of laryngospasm.

From this distance in space and time I am prepared to accept Dr. Lorber's own diagnosis of "severe spasm of coughing and temporary cyanosis," but even if it had been a mild attack of laryngospasm, as Dr. Wyant prefers to believe, was it so very surprising that it fortunately resolved spontaneously? I am sure that an attempt to relieve a mild attack of laryngospasm with the aid of a laryngoscope and endotracheal tubes would only aggravate the condition—to say nothing of the danger of trauma to teeth, pharynx, and larynx from attempted laryngoscopy with inadequate relaxation of the jaw.

I have no means of knowing the dosage of atropine usually employed by Dr. Wyant, but to judge from most American publications it is the custom in that country to use much smaller doses in children than usually employed in England, and it may be that the threat of laryngospasm is more real in his experience for that reason. Dr. Lorber's case which aspirated vomitus (explained in his article as due to a nursing error in feeding the child immediately before rectal hypnosis) certainly does not bear out the suggestion that there is any increased tendency to laryngospasm with rectal thiopentone. There was not in this case even enough glottic reflex to prevent aspiration.

In parts of Europe it is held that the risk involved in any anaesthetic is too high a price to pay for tonsillectomy, and therefore the routine there is to remove children's tonsils and adenoids without any anaesthetic at all—a procedure given the approval of nursing staff who have not time to spare to nurse unconscious patients. To such lengths can the desire to avoid all risks take normally humane people.—I am, etc.,

Johannesburg, S. Africa.

F. W. ROBERTS.

Haematemesis from Leeches

SIR,—I had an experience similar to Dr. A. Cameron's (September 16, p. 679) when E.N.T. specialist at a stationary hospital at Kantara in 1917.

A private was admitted, and his brief notes were: "R.M.O.: bleeding from naso-pharynx; Field Ambulance: blood clot in naso-pharynx; C.C.S.: blood clot in naso-pharynx."

At that time my facilities for examining patients were still primitive in that I had to use the sun as my source of illumination. I had to be careful not to get the part examined at the focal point of the mirror and cause burning pain. This, however, did happen occasionally, and in this particular patient the "blood clot" wriggled. It was an enormously engorged leech, which I removed with some difficulty.

I learned later from an elderly missionary stationed for many years at Beersheba (or Hebron) that removal was easy if one first touched the region with a little weak cocaine solution.

I agree with Rokitansky's aphorism as quoted by Dr. Cameron, but suggest to him that he need not go so far back as Rhazes. He should investigate Hahnemann and his work, when he will find that he has not grasped the principle of the law of similars, and that, though the results from the application of the law are often surprising, they are not "magic" in the sense in which he uses the word.—I am, etc.,

London, W.1.

A. T. CUNNINGHAM.

Histamine Desensitization

SIR,—The appearance of a new drug urges us always to revise old treatments. This must be done in a careful manner not to discard helpful therapeutic aids for the sake of fashionable new drugs. The present status of the treatment of allergic diseases with antihistamine drugs challenges criticism of non-specific desensitization with increasing doses of histamine. Clinical and experimental literature on this matter was reviewed by Feinberg (1946). Since this time new indications have been described for this treatment (e.g., Atkinson, 1946; Paul, 1949)

Fabinyi and Szebehelyi (1949) recommended histamine desensitization and protecting the patient with antihistamines during the treatment. The following advantages may be expected from histamine desensitization over the use of antihistamines: permanent cure, or at least longer lasting effect; no side-effects peculiar to antihistamine drugs; effectiveness in conditions where antihistamines have no

effect. Besides certain diseases where the pathological role of histamine is questionable, antihistamines do not reduce histamine-induced gastric secretion (review: Loew, 1947) and do not prevent blood changes caused by histamine (Winter and Mushet, 1948).

On the other hand, histamine desensitization shows the following disadvantages as compared with antihistamines: it takes a long time to develop resistance to histamine—some authors even question whether this is possible in humans (Feinberg, 1946); side-effects of the treatment.

In recent studies we analysed experimentally the effects of histamine desensitization (Ambrus *et al.*, 1950). Gastric-secretion-inducing effect of histamine was decreased in guinea-pigs desensitized with very high doses of histamine over a long period. Spontaneous occurrence of gastric ulcers following pylorus ligation according to the method of Shay *et al.* (1945) was not significantly decreased in histamine-desensitized animals.

In further (hitherto unpublished) experiments we determined the duration of histamine desensitization in guinea-pigs. To test histamine resistance the animals were exposed in a glass chamber to a fine spray of 10% histamine solution, and the time in which symptoms of asthma developed was recorded. Protection by desensitization was maximal after the last application of histamine. It remained on this level for 24 hours, then started to decrease and disappeared completely within a few days. Protection by 2 mg./kg. "neo-antergan" lasted for 2-4 hours and by "phenergan" for 9-12 hours. On the basis of these experimental data there is no reason to prefer histamine desensitization to antihistamine drugs, although the effect of the former may last somewhat longer, but there is no permanent desensitization even toward the effects of histamine itself. On the other hand, it takes a long and difficult treatment to reach resistance. The use of histamine desensitization in the therapy of gastric ulcers must be studied further.

—We are, etc.,

Philadelphia, U.S.A.

JULIAN L. AMBRUS.
CLARA M. AMBRUS.

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Situs Inversus and Perforated Appendix

SIR,—The only reason for publishing the following case is its rarity. A search of the literature available revealed no similar case.

A schoolboy aged 17 was admitted into hospital with a three-day history of abdominal pains, generalized at first but later localized to the left iliac fossa. They were not severe and passed off with rest in bed. On the third morning of his illness the patient felt quite well and went to school, but the pain restarted two hours later and he cycled back home, a distance of about five miles. He vomited twice in the evening and his bowels opened once. During the night he felt feverish.

On admission there was tenderness over the lower abdomen, but more marked on the left side. Abdominal reflexes were sluggish in three quadrants and absent in the left inferior quadrant. The temperature was 103° F. (39.4° C.) and pulse 140. An enema resulted in the passage of some flatus only, but not faeces. The bases of both lungs were auscultated and found to be clear, but the front of the chest was not examined. The patient had never before been ill, and therefore never seen by a doctor.

If the pain had been on the right side, a diagnosis of acute appendicitis would have been made without hesitation. An inflammatory condition on the left side would have suggested diverticulitis of the sigmoid colon, but in view of the age of the patient this possibility was also ruled out. The possibility of it being a case of malaria was considered because the patient spent a night in a malarious district about one week before. An injection of quinine was consequently given and hot-water bottles were applied to the abdomen.

Next morning the patient felt slightly better, the temperature fell to 98° F. (36.7° C.) and the pulse to 100, but during the day the temperature and the pulse started to rise again. As there was no improvement in the physical signs it was decided to do an exploratory laparotomy. Under spinal analgesia a low median incision was made. On opening the peritoneal cavity some seropurulent fluid was found in the pelvic cavity. The right iliac fossa was searched, but no caecum or appendix was found. A loop of

the large intestine when traced downwards was found to end in the rectum. Perforation of a left-sided appendix was immediately thought of, and therefore search was made in the left iliac fossa. There an inflamed appendix was found covered with some fibrin, but completely free without any omentum in the neighbourhood. There was a neat perforation situated about 1 in. (2.54 cm.) from the tip of the organ. The appendix was removed, the stump buried with a purse-string suture, and the pelvic cavity drained. The patient was given 100,000 units of penicillin immediately and then 50,000 three-hourly. He also received 1 g. of soluble sulphamezathine every six hours for one week, during which time the temperature was about 1° F. above normal. After one week the drain was removed. Convalescence was otherwise uneventful, and the patient was discharged twenty days after the operation.

An x-ray examination was made before his discharge and it was found that all his organs were normal, but his heart, liver, stomach, and duodenum were completely transposed. The lesson to be learned from the above case is that in any obscure condition a thorough examination of the patient is necessary; had the front of the chest been also examined, the heart would have been found on the right side and immediately the possibility of a left-sided appendix would have been thought of.

My thanks are due to the Director of Medical Services for permission to publish the above case.

—I am, etc.,

Mauritius.

M. SHUN SHIN.

Dexedrine Poisoning

SIR,—To add to the previously recorded cases (see for instance *British Medical Journal*, 1949, **2**, 1394) of acute "dexedrine" poisoning, the report of a case in a boy aged 2 years may be of interest.

The child was said to have swallowed five 5-mg. tablets from his mother's handbag. He was given a saline emetic ten minutes later, but with no effect. He appeared well 30 minutes later and was given his breakfast. One hour later he became flushed and jumpy. He repeatedly picked up and dropped objects, and then ran to his parents, calling to them as if frightened. A few minutes later twitching movements of his arms were noticed. On admission three hours after taking the tablets he was delirious and threw himself violently around the bed, and, if restrained, repeatedly tossed his head from side to side.

Examination showed his pupils were dilated and only just responded to light; his tendon reflexes were not elicited; his plantar responses were flexor; and his temperature and pulse were slightly raised. Lumbar puncture showed a clear colourless fluid with a pressure of 190 mm. of water, and the cells and chemistry were normal.

His stomach contents were aspirated and consisted of semi-digested food. He was given 2 dr. (7 ml.) of paraldehyde (through a Ryle's tub passed nasally), and this was repeated four hours later. Subsequently, five doses of 1 dr. were given as the degree of narcosis decreased and the state of excitement recurred, but eventually he fell asleep and finally awoke 46 hours after admission, when he appeared tired but otherwise well.

—I am, etc.,

Christchurch, Hants.

S. T. LANGHAM.

Pernicious Anaemia and Gastric Carcinoma

SIR,—The article on gastric carcinoma and pernicious anaemia by Drs. J. Mosbech and A. Videbaek, like your editorial on the subject, appearing in the *British Medical Journal* for August 12, pp. 390 and 405, appears to me to fail to take into account one simple and obvious explanation of the fact that gastric carcinoma appears to be commoner among victims of pernicious anaemia than it should be: namely, that pernicious anaemia may be due in some instances to carcinoma of the stomach. To put it differently, not all cases of pernicious anaemia are truly cases of pernicious anaemia; some are cases of carcinoma of the stomach masquerading as instances of pernicious anaemia. If we could separate the "true" or idiopathic or agnotogenic cases of pernicious anaemia at the outset, we might find that they were no more subject to gastric carcinoma than the average person—or perchance even less so.

—I am, etc.,

Honolulu.

HARRY L. ARNOLD, JUN.