Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Abdominal Wound Dehiscence

SIR,—We think that Mr. H. A. Kidd (July 15, p. 173) has been mistaken in finding so simple an explanation for his cases of wound dehiscence as an inferior brand of catgut. Our own experience is at variance with his; and in one of our units the incidence of wound dehiscence during an 18-months period (October, 1959–April, 1961) was 1.8% (16 cases in 879 major laparotomies). In the majority of these there was an obvious cause (malignant cachexia, post-operative infection, post-gastrectomy pancreatitis, chest infection, paralytic ileus); in some, no doubt, the surgical technique also may not have been impeccable. Throughout this period we relied solely on Ethicon, and in no single instance could the wound disruption be attributed to the suture material.

We have no doubt that catgut as good as Ethicon is manufactured; it may even be that, as Mr. Kidd implies, London Hospital catgut is as good—or better—than Ethicon, but the important point is that if Ethicon is as poor as Mr. Kidd records—in which case many of us might wish to discontinue its use—we would like better evidence than that given by Mr. Kidd.

We naturally sympathize with Mr. Kidd in his own predicament. It is distressing to have to report an incidence of 12% of "burst" abdomens—and to find in the "black" months that even silk (presumably Ethicon's) is an unreliable friend. His deduction is a serious one, however, and those of us who know the care and precision with which Ethicon sutures are manufactured and the constant research that has gone to its perfection, and who appreciate the enterprise and the co-operation that have been so readily at the disposal of all surgeons, are unable to accept it on the basis of the information given in his letter.—We are, etc.,

Department of Clinical Surgery, University of Edinburgh.
JOHN BRUCE.
WALTER MERCER.

SIR,—My recent experience would appear to support the contentions of Mr. H. A. Kidd (July 15, p. 173) about fraying and too early absorption of Ethicon catgut. It has so happened that in recent weeks I have had to re-open four abdomens. Brief particulars were as follows:

(1) Male, aged 75. Intestinal obstruction, bands, etc., July 2. Reopened for recurrent obstruction fourth day and intubated jejunostomy[1] performed. Catgut fragmented.

(2) Male, aged 46. Combined excision of rectum, July 1. Not well eighth day, burst abdomen eleventh day. Firm adhesion of small bowel to rectus sheath made it obvious that the deep layers of the wound had parted two or three days previously. Catgut fragmented and largely absorbed.

(3) Female, aged 41. Pyloroplasty, etc., July 4. Oedema of pylorus; reopened seventh day to pass Ryle's tube through pylorus. Catgut fragmented.

(4) Male, aged 52. Intestinal obstruction, carcinoma colon. Transverse colostomy, July 3. Paramedian incision reopened twelfth day and partial colectomy performed. Only traces of catgut found.

All wounds were uninfected, and Cases 2, 3, and 4 have healed without further incident. Case 1 developed a heavily infected wound (*Proteus*).—I am, etc.,

Lincoln. G. A. BAGOT WALTERS.

REFERENCE

[1] Luck, R. J., and Eastcott, H. H. G., *Brit. med. J.*, 1961, **1**, 1200.

Cooling of Operating Theatres

SIR,—I have read the account in *The Times* of July 11 of a patient who died of heatstroke after an operation in a theatre where the temperature was 86° F. (30° C.). I happen to work in the second oldest hospital in England, in which there has been installed a new ventilating system. This is temporarily sealed up with polythene whilst other rebuilding is going on. For this reason there is no proper ventilation, and the heat and humidity can rise to really unpleasant heights. To control this I use a very simple procedure. I have a large block of ice in a tin bath on to which is played the draught of an electric fan. This is a very simple and cheap expedient, and I find it far superior to a £12,000 installation in another theatre where I also work.

British hospital authorities install air-conditioning but appear frightened of the cost, so they frequently cut out the cooling to save expense. As we seldom have very hot summers in England it certainly seems more reasonable to use an inexpensive, easily procured method such as I have described.—I am, etc.,

Bristol. KENNETH H. PRIDIE.

Spontaneous Biliary Peritonitis

SIR,—The case of spontaneous biliary peritonitis recorded by Mr. E. F. Shanahan (July 15, p. 154) prompts me to report a very similar case I encountered recently. This was also a young woman, aged 25, who had complained of abdominal pain during 24 hours prior to admission.

At laparotomy about 1 litre of brownish-green, turbid biliary fluid was evacuated: the pancreas was swollen and some local spots of fat necrosis were seen. There was much oedema around the pancreas and the gall-bladder was noted to be tense and a little thickened. It contained no stones and there was no evidence of any perforation. I did not see any indication to open or remove the gall-bladder and simply closed up. Penicillin and streptomycin were given subsequently, but at no time did the temperature rise above 99° F. (37.2° C.) and her recovery was perfectly straightforward.

While acute pancreatitis is common enough, biliary peritonitis is unusual. These two cases show a clear association between the two conditions, and one must ask why biliary peritonitis is not more common. I would suggest that distension of the biliary system together with the continuing entry of pancreatic ferments into the bile duct is necessary to allow the permeation of bile into the peritoneal cavity. Peritoneal irritation might further account for some of the free fluid, which, in my case at least, was not normal clear bile.—I am, etc.,

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H. T. FLEMING.

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