Unusual Cause of Urinary Obstruction

SIR,—Lately we have seen a case of vulvar fusion due to lichen sclerosus et atrophicus which was of such severity that it caused frequency, incontinence, and finally urinary obstruction.

In 1959, a widow, then aged 69, presented at the casualty department with a complaint of widespread ulceration of the tongue and buccal mucosa, together with intense vulvo-vaginitis and ulceration of the perivulvar and perianal skin. A diagnosis of lichen sclerosus was made. Over the next few months she was treated with topical hydrocortisone applications. By January 1960 it was noted that the vulva was becoming atrophic and that there was less inflammation. Her other symptoms were considerably improved. By March 1961 she was still improving and continuing with her treatment. She failed to attend for further follow-up. In March 1968 she attended at the geriatric outpatient clinic here, complaining of frequency of micturition and occasional incontinence of urine. She had been treated for urinary infection with a course of sulphonamide prior to her referral.

On examination the vulva was found to be completely fused, and there was adhesion between the labia majora. A pinhole-sized opening for the escape of urine was found, with extreme difficulty, at the posterior commissure. The surrounding skin showed considerable depigmentation (Fig.). A midstream specimen of urine was sterile on bacteriological examination. Intravenous pyelogram was performed and the after-micturition films showed a considerable amount of residual urine in the bladder. The upper urinary tract was normal.

Operation for division of the adhesions was carried out by one of us (J.F.S.) on 8 July 1968. At operation there was found to be a sump of infected urine behind the adhesions of the labia majora. On culture, this specimen of urine produced a moderate growth of *Escherichia coli*. Postoperative healing was satisfactory. The elimination of the obstruction has led to control of the back-

pressure changes and infection in the urinary system.

Lichen sclerosus et atrophicus of the vulva is a rare cause of frequency of micturition and of incontinence of urine.

We should like to thank Dr. D. I. McCallum, consultant dermatologist at the Nottingham General Hospital, for advice on this report and Dr. S. J. G. Semple, St. Thomas's Hospital, for permission to publish this report.

—We are, etc.,

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Anticoagulant Therapy after Myocardial Infarction

SIR,—We were very interested in the M.R.C. trial which showed no significant reduction in mortality in the group of patients treated with high dosage anticoagulants (8 February, p. 335).

We were a little surprised that more comment was not made on the difference in mortality between men and women which to our unsophisticated eyes made rather alarming reading. Excluding the question of treatment there was an overall mortality in women of 24% compared to 15% in men. Such a difference has been noted before¹⁻³ but not in all series.⁴⁻⁶ When the figures are broken down there appear to be other differences, though from the figures supplied it is impossible to tell whether these could be accounted for by age. The greater mortality in women is most marked in those cases selected as mild, in both high and low dosage groups. We would be most interested to know from the M.R.C. statisticians how significant these differences are, which superficially appear so striking.

Some years ago we analysed the cases of myocardial infarction which had occurred in our practice between 1955 and 1965 (77 men, 53 women). The relevant finding to this communication was the difference in mortality between the group of patients treated at home and those treated in hospital. There was very little difference in the mortality between the men treated at home or in hospital (39% and 35% respectively), but a striking difference in the case of women, which could not be accounted for by age. Nineteen per cent. treated at home died, but of those treated in hospital 50% died. It might have been argued that the cases treated at home were less severe, but the M.R.C. trial seems to indicate that mild cases in women had a relatively high mortality in hospital. If all these figures mean what they seem and can be confirmed by others, then there would appear to be a need for general practitioners to be very cautious about admitting women to hospital with acute myocardial infarction.

The importance of considering men and women separately when assessing the response to treatment was stressed many years ago by Peel.¹ One could speculate that because of their evolutionary development women are less well able to tolerate stressful situations away from their home environment. We would be interested to learn

whether others can support or repudiate this evidence.—We are, etc.,

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Hypercalciuria in Sarcoidosis

SIR,—Dr. G. O. Thomas (12 April, p. 96) affirmed that hypercalciuria is more common than hypercalcaemia in sarcoidosis; both abnormalities can be acute or chronic. The case that he reported had pulmonary involvement and chronic hypercalciuria, partially resistant to cortisone. Renal function was preserved, and, possibly because of this, there was no hypercalcaemia. The output (and also probably the input) of calcium was accelerated, and renal stones formed. Phosphate loading then altered the balance, and it was hoped that no more calculi would form. Increased sensitivity to vitamin D is an extra factor, not needed to explain the metabolic fault in this case. Instead, perhaps, the clue lies in inappropriate hormone secretion. Any infiltration of endocrine glands can affect homeostasis. For example, "sub-acute thyroiditis" is described concurrent with sarcoidosis.¹ We are shortly reporting a further case.

The short duration and mildness of the inflammation in this condition accounts for its apparent rarity. The anatomical situation of the parathyroid glands suggests that they can be likewise involved, and three cases have been reported.²⁻⁴ Raised calcium levels in "acute" cases are transient, but the metabolic disorder in chronic examples can persist, perhaps because of "tertiary" changes. It is interesting that Dr. Thomas has managed thus to break a vicious circle. Balance studies may shed light on the calcium-phosphate enigma in early sarcoidosis. Calcitonin may enter the arena soon.—I am, etc.,

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Oestriol Excretion in Pregnancy

SIR,—We were most interested to see the report by Dr. Alan M. Driscoll concerning urinary oestriol excretion in a pregnant patient given large doses of prednisone (1 March, p. 556). He states that the low maternal oestriol excretion may be due to de-