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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General Hospital,
Nottingham.

M. DAMANSKI.
M. E. BARKER.

J. F. SHEEHAN.

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.,

AUBREY COLLING.

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ANGUS BIRD.

CHARLES I. AITCHISON.

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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-

pression of the foetal adrenal by the cortisone analogue. Such a conclusion appears to be based upon previous work which delineates the foeto-placental unit.¹⁻³ It must be realized that the major portion of such work has been carried out during the second trimester of pregnancy.

A normal baby has also been delivered at term by a woman who had previously undergone bilateral adrenalectomy. The urinary excretion level of oestriol during the last trimester was low, and in addition the testosterone level was only 10% of that found in normal pregnancy.⁴ The latter report and subsequent studies of a further two pregnancies in a patient who had undergone bilateral adrenalectomy reveal that the maternal adrenal plays an important role in steroid biosynthesis during pregnancy. It might be justifiable to propose the existence of a materno-placental unit in addition to the already well-established concept of a foeto-placental unit.⁵ In view of the latter concept and the work of Brown and associates,⁶ the administration of cortisone analogues could result in the depression of the maternal adrenal glands and thereby affect the precursors for oestriol which would be reflected in the low maternal urinary excretion pattern of this oestrogen metabolite.

Other studies^{7,8} also tend to support the possibility of a materno-placental unit as the major factor in steroid agenesis during the third trimester of pregnancy.—We are, etc.,

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Closed Method of Chest Aspiration

SIR,—The usual method of aspirating the pleural cavity with a needle, syringe, and three-way tap has several practical objections. When large quantities of fluid have to be removed it is time-consuming and prolongs discomfort for the patient. Air often enters the pleural cavity and this is usually undesirable. It is difficult to maintain asepsis, and sticky fluid can affect movement of the syringe plunger. Furthermore, while withdrawing the plunger changes in position of the needle often occur with the risk of damage to the underlying lung.

Because of these objections a method has been devised to provide continuous, controlled suction in a closed system. The apparatus is readily available and easily assembled (see Fig.). Infiltration of the chest wall with local

anaesthetic is carried out in the usual way. A large-bore cannula (size 2 Braunula with Luer fitting) is inserted through the anaesthetized area and any fluid required for examination may be aspirated at this stage. Plastic tubing connects the Braunula to a sterile, evacuated Redivac bottle. Convenient tubing to use is the Baxter drip extension set (BR-348), which has Luer fittings. The screw clip is applied to the tubing and closed. When the apparatus is assembled the vacuum preserving clip on the Redivac bottle is opened and the screw clip gradually opened until fluid flows. The operator remains with the patient, regulating the rate of aspiration with the screw clip. When the vacuum is exhausted the screw clip is closed and a fresh bottle attached. Two or three prepared Redivac bottles, each of which will remove 400 to 500 ml., are required. After aspiration the screw clip is closed, the Braunula removed without disconnecting the tubing, and a dressing applied.

This method has been used with satisfactory results and is preferred by patients who have previously been aspirated with a needle and syringe. Up to a litre of fluid can be removed in 10 or 15 minutes. Faster rates than this are not desirable, as patients tend to become breathless. With large effusions it is probably not desirable to remove much more than one to one and a half litres of fluid at a time. Pus, blood, and pleural effusions are easily removed and air does not enter the pleural cavity. The relatively blunt point of the Braunula is unlikely to damage the expanding lung.

I should like to thank Mr. R. Burr, theatre technician, for his help.

—I am, etc.,

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Newcastle upon Tyne.

Outpatient Operations

SIR,—May I reply to one point in Mr. R. S. Laurie's letter (19 April, p. 186). He states that not to operate may be condemning these patients to two years on a waiting-list, unable to work and with their symptoms unrelieved. This comment might carry weight, even if one honestly believes it is not the best method, if it were true. However, of those unable to work the majority can be fitted as

a temporary measure with a perfectly adequate truss.

I cannot imagine any hospital with an efficient admission procedure which would not arrange priority admission to the very small remaining cases unable to work as a result of their hernia.—I am, etc.,

Oldchurch Hospital,
Romford, Essex.

DOUGLAS PARK.

Immigrant Doctors

SIR,—I have worked and stayed in Britain, have many good friends among British doctors, and am a great admirer of the British people. I grieve for Britain, therefore, to read the recent spate of sweeping and derogatory statements about the skill of doctors who come from overseas. I concede that the quality of some immigrant doctors is questionable, but so is the quality of some British doctors practising within and outside Britain.

The Junior Hospital Doctors' Association of your country claims that the admission of foreign doctors into Britain (I take it that the word "foreign" nowadays includes Commonwealth doctors) without any language test or real inquiry into their ability is a "scandal." That association seems to forget the immense trouble British doctors practising in non-English-speaking countries have given to their long-suffering and uncomplaining colleagues and nurses who waste so much valuable time translating for them.

I am confident that wiser and more sober opinions among the medical profession in Britain shall prevail; and that the graduates of Commonwealth medical schools which are recognized by the General Medical Council shall continue to be allowed to practise in Britain without such unwarranted restrictions.

I must make it clear that I am writing now in my personal capacity, but hope and trust that, should such tests for Commonwealth doctors be instituted, my fellow doctors in Singapore and other Commonwealth countries would demand corresponding language and clinical tests for all British doctors wishing to practise in those countries. In Singapore such tests should, of course, include those for proficiency in at least several Chinese dialects and the Malay language.—I am, etc.,

W. O. PHOON.

Singapore.

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Pay Rise

SIR,—Regarding the recent pay rise it might be worth drawing your attention to the fact that at least one hospital in the Leeds area requires doctors to apply for their additional money. This hospital has not notified past members of its staff that the money is due, and medical staff in other areas may find that unless they make specific application to their group treasurer they will not be paid the money they are entitled to.

The explanation offered by the group treasurer for this practice is that doctors, leading of necessity a peripatetic existence, are extremely difficult to trace.—I am, etc.,

Leeds, Yorks.

JOHN E. DEB. NORMAN.