Central Hospital, Wick, in early 1971. He was taken there by the police who had found him lying unconscious in the street on a cold winter's evening. In his pocket there was a card stating that he was a diabetic taking 16 units of soluble insulin twice daily, on his wrist there was a diabetic identification bracelet, and in a holdall an insulin syringe and soluble insulin. Hypoglycaemic coma was diagnosed. A Dextrostix reading was 65 mg/100 ml; he was given intravenous dextrose and recovered consciousness although remaining dazed.

On subsequent days he was given no insulin by the nursing staff, his urine glucose tests were almost all negative, and his blood sugar values remained low. He had several episodes of hypoglycaemia relieved by oral glucose, the lowest laboratory blood glucose value obtained being 40 mg/100 ml. Only after the insulin syringe and insulin had been removed from his possession did the hypoglycaemic attacks cease, although it must be observed that we had no direct proof of insulin self-administration. No oral antidiabetic drugs were found in his possession.

He said he was a seaman who had travelled from London to Wick for a holiday—a suspicious act when done in winter. After being given confusing information we eventually learned that the name on the diabetic bracelet and card was not his, and he explained that he had been sailing under an assumed name after his failure to conceal diabetes had been detected while he sailed under his own name. A postal strike was in force at the time he was in the Central Hospital and it was difficult to check precisely on other aspects of his history. For a time the possibility of organic hyperinsulinism with secondary brain changes and personality disturbance was considered, but later discarded. Later I learned from his family doctor that this patient was known as a psychopath but not a diabetic, and that the family doctor had never given him insulin. Apparently he had had several emergency admissions to other hospitals because of diabetes and hypoglycaemia, and one hospital did dismiss him as a psychopath after proper investigation of carbohydrate tolerance. On one admission to Doncaster Royal Infirmary he had an epileptic attack and had been taking tolbutamide tablets.

Munchausen syndrome was diagnosed, and despite confrontation with evidence of falsehood he remained courteous and evasive. He left the north quite amicably deprived of his insulin and insulin syringe. Nothing has been heard of him since.—I am, etc.,

P. D. ROBERTSON

Caithness Central Hospital,
Wick, Caithness

Bone Disease after Gastrectomy

SIR,—I was consulted one weekend by a 50-year-old graduate school teacher, who had come to spend her half term in the country. She was complaining of severe pains in her ribs and in one foot. These pains had been diagnosed as fibrositis, and she had been receiving vigorous physiotherapy for the previous three months. Unfortunately the pains were getting worse, and they were aggravated both by physiotherapy and by travelling to the hospital by crowded trains. She did not really want to trouble me, but she had run out of her pain-killing tablets. She gave a past history of chronic duodenal ulceration, which had been cured by a partial gastrectomy operation performed at the teaching hospital four years earlier.

On examination I found tender swellings overlying some of her ribs and metatarsal bones. I therefore had her *x*-rayed at the cottage hospital and found five pathological fractures together with partial decalcification of the skeleton, especially the vertebrae, which were in danger of collapse.

With this experience in mind, I welcome your recent leading article on "Bone Disease after Gastrectomy" (19 February, p. 461). Osteomalacia may be a crippling and deforming condition, particularly when the vertebral column is severely affected. But, like other diseases of insidious onset, it may be easily missed unless a high level of diagnostic suspicion is maintained.—I am, etc.,

W. M. JORDAN

Bungay, Suffolk

Removal of Extruded I.U.D.

SIR,—We read with interest Dr. R. S. Ledward and others' (19 February, p. 508) report of the removal through a laparoscope of an intrauterine contraceptive device extruded into the abdominal cavity.

We have recently seen two such cases of extrusion of an intrauterine device through the uterine muscle into the pouch of Douglas. In each case the device was fairly simply removed by colpotomy.

In the first patient, a 34-year-old woman who had two children, the string of the intrauterine device was noted to be absent on cervical inspection. There had been no symptoms of perforation, but abdominal *x*-ray and hysterosalpingogram confirmed the position of the coil (Saf-T-coil) as being in the pouch of Douglas. At examination under anaesthesia the coil was felt to be free in the pouch of Douglas, behind a mobile, anteverted uterus. The pouch of Douglas was opened through the posterior fornix and the coil was easily retrieved by two fingers, passed through the incision. The peritoneum and vaginal wall were repaired with catgut.

In the second patient, a 25-year-old woman who had had four pregnancies, there was some doubt as to the exact position of the coil, but at examination under anaesthesia it was felt partially extruded through the posterior uterine wall, mainly embedded in the peritoneum on the posterior aspect of the uterus, with the end protruding through the peritoneum into the pouch of Douglas. Colpotomy was again performed, and with two fingers the device was grasped, manipulated downwards, digitally freed from the peritoneum, and removed. Both patients had a painfree, uneventful postoperative course and were discharged within 48 hours.

Colpotomy as a method of removing an extruded intrauterine device was mentioned by Ratnam and Yin[1] (who reported one case) and Ledger and Wilson[2] (who reported five cases), but no actual description of the method is given. In view of the painfree and uncomplicated postoperative course and the short stay necessitated in hospital, we recommend this method in cases in which the coil can be felt in the pouch of Douglas as a good alternative to the more major procedures of laparotomy and laparoscopy.—We are, etc.,

U. E. MOUNTROSE
W. L. WHITEHOUSE

Westminster Hospital,
London S.W.1

1 Ratnam, S. S., and Yin, J. C. K., *British Medical Journal*, 1968, 1, 612.
2 Ledger, W. J., and Wilson, J. R., *Obstetrics and Gynaecology*, 1966, 28, 806.

Recurrent Urinary Infections

SIR,—May I add to the recent question and answer (12 February, p. 428) and correspondence a third voice upon the matter of pyelograms?

Dear Hugh and Andy,

I am sure that every radiologist would agree that if every excretion pyelogram were to be performed by a high dose (infusion) technique with routine tomography then there would be a small proportion of cases where significant additional information was obtained.

Alas, Hugh, I fear that writing as you do from that curious atmosphere of St. Peter's Hospital which is at one and the same time both rich and rarefied, it is possible that the simple economics of the matter may have escaped you.

My colleague and I have just been checking the list of *x*-ray equipment being ordered for the new district general hospital at Sidcup, which is approaching completion after nearly a quarter of a century on (or in?) the stocks. We have graciously been permitted to choose the make of the equipment to be supplied, but we have had little voice as to the actual items, and the regional board has refused absolutely to provide any piece of specialized tomographic equipment. The most that they would authorize was a "tomographic attachment." I think, Hugh, that you are old enough to remember these rather useless gadgets of a quarter of a century ago that took so long to set up and gave such poor results that they spent most of their lives hanging on the *x*-ray room wall.

Even were the board to supply a proper tomograph this would not really end the matter. If every excretion pyelogram performed at a busy fair-sized district general hospital were to be done using this technique then the additional cost per annum would be of the order of £8,000, and would roughly equate with the salaries of one additional consultant radiologist and one registrar. I have little doubt in my own mind as to whether the radiologists or the pyelography would make the greatest overall contribution to the services provided by the hospital. After all, on the odd occasions when an ordinary pyelogram gave inconclusive results, one could always pop the patient over to St. Peter's.

—I am, etc.,

H. GLYN JONES

Shoreham, Kent

Simple Method of Measuring Disuse Atrophy

SIR,—The measurement of muscular wasting forms an important part of a record of the patient's clinical condition. The amount of wasting is a statement of absolute fact con-

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