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 anti-diabetic 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 Yin¹ (who reported one case) and Ledger and Wilson² (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-

cerning the patient's objective condition.¹ Minor degrees of wasting can be revealed by measuring and comparing the girth of the affected limb with the opposite limb.²

The standard method of marking a line at a convenient distance from the anterior superior iliac spine and from the tibial tuberosity and of comparing the girth with the opposite side can be replaced by the following simpler method.

An x-ray envelope or another large rectangular paper or cardboard is moved along the margin of the couch or table to the desired (and recorded) level (Fig.) and the

Fig. 1

Fig. 2

Fig. 3

circumference of the limbs measured and compared. In patients with shortening of a limb the x-ray envelope is moved higher according to the amount of shortening in the corresponding segment of the limb—for example, in shortening of the lower limb by $\frac{1}{4}$ in (19 mm) after a pertrochanteric fracture of the femur the x-ray envelope is moved $\frac{1}{4}$ in higher before the girth is measured on the injured limb.

This method has the following advantages. The human element and inaccuracy are reduced in a simple manner. It also avoids marking the skin of the patient by using an x-ray envelope, which is usually at hand. It is a useful and speedy clinical procedure.—I am, etc.,

A. BECK

Accident Unit,
St. David's Hospital,
Cardiff

¹ Clain, A., ed. *Hamilton Bailey's Demonstration of Physical Signs in Clinical Surgery*, p. 57, Bristol, John Wright, 1967.

² Dix, D. Knight, and Todd, A. H., *Medical Evidence in Personal Injury Cases*, p. 66, Lewis, London, 1961.

Foreign Body in the Appendix

SIR,—The incidence of acute appendicitis in Africans is much lower than in Europeans. The different diet and a possible reduction of lymphoid tissue may contribute to this low incidence. Mobile foreign bodies such as round worms can enter the appendix and produce severe obstructive appendicitis. We report here such a case.

A twelve-month-old African female was admitted to hospital with a history of swallowing a dress-making pin three days previously. There were no symptoms of abdominal pain, and no vomiting or melena.

On examination the child had a slight temperature, 99°F (37.2°C), but exhibited no signs of abdominal tenderness or obstruction. A plain x-ray of the abdomen (Fig. 1) showed the pin, similar in shape

to a small hat-pin, in the right side of the abdomen and in retrospect obviously outside the large bowel.

Conservative management was adopted and a further x-ray two days later suggested movement of the pin towards the hepatic flexure. The child continued to remain well and it was hoped that the pin would be passed per rectum. Two days later, however, another x-ray showed the pin in its original position. The decision was made to perform a laparotomy the next morning. A further x-ray (Fig. 2) immediately preceding operation showed the pin in an inverted position compared to the previous films.

At operation the pin was located in the appendix, and the definitive procedure consisted of appendicectomy. The opened appendix revealed the pin measuring 4 cm in length (Fig. 3).

In our case a large foreign body entered the lumen of the appendix but produced no obstruction or constitutional symptoms. On macroscopic examination of the removed appendix no evidence of inflammatory reaction could be noticed at the site of impaction.

It is essential to take radiographs of young children who have a definite or even suspicious history of inhalation or ingestion of foreign bodies. In the case of ingestion it is necessary to take serial x-rays of the progress of the foreign body through the intestinal tract, so that at any indication of hold up operative intervention may be undertaken.

We would like to thank Dr. D. Jenkinson for technical photographic assistance and Miss L. Etchells for secretarial help.

—We are, etc.,

T. G. GEDDES
B. FERNANDEZ
B. L. DUFFY

Nchanga North Hospital,
Chingola, Zambia

Squelching Caecum in Acute Appendicitis

SIR,—The diagnosis of acute appendicitis remains an ever present clinical problem. In 1964 Sir John Bruce drew attention to the "squelching" or "gurgling" caecum as a useful negative sign, and he felt that if the sign was present the diagnosis of acute appendicitis should be reviewed.¹

We have tested the validity of this in 50

patients with suspected acute appendicitis. A caecal squelch was not present in 23, and of these 18 had proven acute appendicitis. A caecal squelch was present in 27, and of these 14 had proven acute appendicitis.

It would appear from our results that a squelching caecum is not a very reliable sign for making either a positive or a negative diagnosis for acute appendicitis. Squelching depends on the stage of the inflammatory process at the time that the patient is examined. If early, and there is no guarding or rigidity of the overlying muscles, a squelch will be obtained. Later, however, when there is guarding or rigidity, it will be impossible to elicit the sign.—We are, etc.,

S. N. JOFFE
J. H. LOUW

Department of Surgery,
University of Cape Town,
South Africa

¹ Bruce, J., *Practitioner*, 1964, 192, 731.

Large Doses of Fluphenazine Enanthate

SIR,—It is suggested that the patients with chronic schizophrenia who do not respond to the usual doses of fluphenazine enanthate (25-100 mg every four weeks) should be treated with much larger doses of the drug at shorter intervals. Kline *et al.*¹ reported a patient who was asymptomatic only when the dose of the drug was raised to 125 mg (5 ml) daily and relapsed on the reduction of the daily dose. They suggested such large doses of injectable fluphenazine enanthate as a possible method of treating patients suffering from chronic schizophrenia in whom progressive rehabilitation is hampered by the presence of active psychotic symptoms. Dr. D. M. Lewis and colleagues (20 March, 1971, p. 671) have similarly reported encouraging results with large weekly doses of up to 250 mg.

Over the past eight months at Bexley Hospital we have treated six patients suffering from paranoid schizophrenia with relatively large doses of fluphenazine enanthate. In each case the dose was gradually increased from 25 mg every four weeks up to 75 mg every week. Our experience is not in keeping with that of Dr. Lewis and colleagues or the American investigators. In our patients there was neither a reduction of unwanted symptoms nor did the drug in