found in many cases of pseudotumour whatever the cause and consequently is of little help,^{1,2} but adequate temporal artery biopsy may help in diagnosis and should also be performed. Though the condition may remit spontaneously, in temporal arteritis delay in diagnosis may allow further irreversible arteritic complications to occur. Corticosteroids in adequate dosage produce dramatic symptomatic benefit and objective improvement follows within a week, so that it may be clinically prudent to treat elderly patients with a trial of corticosteroids rather than resort to prolonged investigation or transfer to a specialized centre for further procedures.

I tentatively suggest that many of the idiopathic granulomatous pseudotumours of the orbit in elderly patients responding to corticosteroids are in reality caused either by temporal arteritis or Wegener's granulomatosis, possibly in the "limited" form described by Carrington and Liebow.³ After a successful trial of corticosteroids the patient should receive prolonged follow-up to prevent recurrence of the parent disease when corticosteroids are reduced or discontinued.—I am, etc.,

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- 1 Jackson, H., *British Journal of Ophthalmology*, 1958, 42, 212.
- 2 Coop, M. E., *British Journal of Ophthalmology*, 1961, 45, 513.
- 3 Carrington, C. B., and Liebow, A. A., *American Journal of Medicine*, 1966, 41, 497.

Hypothermia, Thrombosis, and Acute Pancreatitis

SIR,—The report by Drs. E. P. Savides and B. I. Hoffbrand (30 March, p. 614) of a fatal case of hypothermia, in which acute pancreatitis was found in association with thrombosis in the upper superior pancreaticoduodenal vein and its intrapancreatic branches, merits comment.

First, though visceral thrombosis and infarction seem to be complications of hypothermia rather than of pancreatitis it is unlikely that the acute pancreatitis so commonly found in patients with accidental hypothermia can be explained on this basis. Pancreatic venous thrombosis in association with acute pancreatitis has not been mentioned in any of the major series of cases of accidental hypothermia so far published.^{1,2} It remains conceivable, however, that even in the absence of such thrombosis ischaemia may still contribute to the pancreatitis.³

Second, the presenting clinical features of generalized and rebound tenderness of the abdomen are not characteristic of the acute pancreatitis in those with accidental hypothermia.^{1,2} In the last few years I have extensively studied more than 100 patients with accidental hypothermia and I have found the signs of an acute abdomen only in those patients in whom one of two associated conditions was present: (1) perforation of an acute gastric or duodenal ulcer with secondary peritonitis; (2) mesenteric vascular occlusion with gangrene of part of the small bowel.

None of my patients in whom pancreatitis was confirmed at necropsy had shown signs of an acute abdomen. It follows therefore that in the case described by Drs. Savides and Hoffbrand an alternative explanation for

their findings is that the hypothermia may simply have been an epiphenomenon in a patient originally suffering from acute pancreatitis, with the venous thrombosis being a later complication of the hypothermia. Like others,⁴ I have found that in the elderly patient with accidental hypothermia the hypothermia is usually a secondary phenomenon in someone suffering from a primary serious underlying illness, the latter often dominating the clinical picture and determining the main need for any therapy. None the less, now that Drs. Savides and Hoffbrand have drawn attention to their finding it will be interesting to see how often it is found by others.—I am, etc.

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- 1 Duguid, H., Simpson, R. G., and Stowers, J. M., *Lancet*, 1961, 2, 1213.
- 2 Mant, A. K., *British Journal of Hospital Medicine*, 1969, 2, 1095.
- 3 Maclean, D., Murison, J., and Griffiths, P. D., *British Medical Journal*, 1973, 4, 757.
- 4 Weyman, A. E., Greenbaum, D. M., and Grace, W. J., *American Journal of Medicine*, 1974, 56, 13.

SIR,—We were interested to read the account by Drs. E. P. Savides and B. I. Hoffbrand of a case of acute pancreatitis associated with hypothermia (30 March, p. 614). It appeared from their review of the literature that acute pancreatitis, as well as other common complications of hypothermia, may have been precipitated by circulatory stasis. The incidence of thrombosis in various vessels has been found to be very high at necropsies following hypothermic deaths.

A possible explanation of this finding may be the increase in blood viscosity with a fall in temperature. The accompanying figure shows the change in viscosity of the

same sample of whole blood at different temperatures ranging from 25°C to 40°C. The viscosities were determined at a number of shear rates, from 2.62 sec⁻¹ to 230 sec⁻¹. The result illustrates the significant effect of temperature on viscosity.

A patient with a rectal temperature of 30.5°C such as the one described by Drs. Savides and Hoffbrand would have had a blood viscosity at most shear rates 25–40% higher than that at normal body tempera-

ture. This would have resulted in a decrease in blood flow sufficient to increase significantly the chances of thrombosis.—We are, etc.,

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Adverse Reactions to Intra-amniotic Urea and Prostaglandin

SIR,—The adverse reaction at the time of an intra-amniotic injection of urea and prostaglandins reported by Mr. A. H. Ross and Mr. W. L. Whitehouse (30 March, p. 642) is not a feature that we have noticed in 200 patients treated by this method, using a fixed dose of 80 g of urea and variable doses of prostaglandins E₂ and F_{2α}.

The symptoms described strongly suggest that a relatively large dose of prostaglandin had rapidly reached the systemic circulation. Such an occurrence is possible if the needle or cannula used becomes misplaced outside the gestation sac, and because of this we advise that a cannula with side drainage holes be used and that care be taken to ensure that there is free flow-back of liquor into the syringe throughout the injection procedure. If not, we refrain from injecting the agents. We also prefer to wait until after 16 weeks because the method is technically easier, there being less likelihood of the amniotic sac being drained following aspiration of the advised 100 ml of liquor and of resultant trauma to the placenta, even with the routine use of ultrasound localization. We feel that the aspiration of some liquor is required since the urea solution administered (80 g of urea added to 80 ml of Hartmann's solution makes approximately 140 ml) may rarely lead to over-distension of the sac with loss of the abortifacient agents and subsequent uterine activity. Our main concern about possible complications occurring with this technique is that of excessive uterine activity resulting in cervical injuries as recently described (4 May, p. 271), and has led to the evaluation of using low doses of prostaglandin—for example, 2.5 mg of prostaglandin E₂.—We are, etc.,

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Ideal Consultation

SIR,—In the course of his generous review of *Six Minutes for the Patient* (6 April, p. 65), Dr. Andrew Smith makes a statement which, unqualified, might appear to perpetuate the mind-body dichotomy, which I am sure was not his intention. He writes, "the patient with tonsillitis needs penicillin, not insight." Without wanting to split semantic hairs might I suggest that it is the tonsillitis which needs penicillin, and that the patient-as-a-person may stand in need of something more? The trouble is that we simply do not know how to assess this need accurately, our present methods being relatively primitive. As Dr. Smith says, the