SHORT REPORTS

Obstructed labour due to a vesical calculus

A 25-year-old woman was admitted to a district hospital in obstructed labour. She had previously had four spontaneous vaginal deliveries. Her only complaint before the onset of this labour was of frequency of micturition during the last four weeks of pregnancy. A diagnosis of locked twins was made as apparently two heads were impacted in the pelvis. But a single, healthy baby (weight 3400 g) was delivered at lower segment caesarean section, and the second "head" was found to be a large vesical calculus.

Two days later the patient became incontinent of urine. She was referred to the Kilimanjaro Christian Medical Centre four weeks later for removal of the stone and repair of a suspected fistula. Vaginal examination revealed a large, hard mass lying within the bladder partially occluding the vaginal cavity and obscuring the cervix. Urine was pouring down the vagina but the fistula could not be seen. The only other abnormality was a left-sided foot drop. Corrective physiotherapy was started. Radiological examination confirmed an intravesical calculus and calcifications were seen in the left renal area. Haemoglobin was 8.9 g/dl and blood urea 2.5 mmol/l (15 mg/100 ml). Urine culture produced a heavy growth of *Proteus vulgaris*. Chest x-ray examination was normal. An intravenous pyelogram showed a right hydronephrosis and hydroureter. There was no excretion on the left side (figure).

Intravenous pyelogram showing vesical calculus, right hydronephrosis, and non-functioning left kidney with calcifications.

At suprapubic cystotomy a phosphatic calculus 8 cm × 6.5 cm × 6 cm was removed, weighing 130 g. The bladder was inflamed and ulcerated. A 1-cm fistula between the bladder and cervix was noted but no attempt was made to close it. The incision in the bladder was closed and continuous catheter drainage per urethram instituted. The patient was continent after removal of the catheter 16 days later and repeat pyelography showed normal function in the right kidney but still no function in the left. Cystoscopy four weeks later showed a healthy bladder mucosa but a stricture was found 4 cm up the left ureter. Exploration of the left loin found a shrunken, calcified kidney and ureteronephrectomy was performed. Histological examination confirmed renal tuberculosis. Antituberculous therapy was started and the patient recovered uneventfully. When discharged three weeks later she was well and walking normally.

Comment

Vesical calculi are uncommon in women and rare in pregnancy. Cope¹ reviewed 30 cases, of which only five had been reported in the

present century. Management varies according to the size and situation of the calculus and whether the patient is in labour. Small calculi can be removed by lithotripsy per urethram. Suprapubic cystotomy is the safest approach to a large calculus but it should be deferred until late in pregnancy to avoid precipitating premature labour.^{1,2} If the patient is first seen in labour it may be possible to displace the calculus above the presenting part and allow spontaneous vaginal delivery,³ but if this is difficult caesarean section should be performed and the calculus removed at the same time. Bride⁴ describes a case in which suprapubic cystotomy was performed three weeks later. Such delay is, however, unnecessary. Vaginal cystotomy is contraindicated in the presence of infection or bruising of the vaginal wall as a permanent fistula may result.

Multiple lesions should always be excluded, especially in the tropics. A non-functioning kidney is probably best removed. Continuous catheter drainage (for up to four weeks) of a fresh bladder fistula will diminish fibrosis and scarring and may result in complete healing, as in this case. Definitive repair should be delayed at least eight weeks from the causative injury or in the presence of active inflammation.

I thank Mr Ian Hulme-Moir and Dr E Kasarero for their advice and surgical assistance.

¹ Cope, E, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1961, **68**, 476.

² Williams, B, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1954, **61**, 499.

³ Smellie, W, *Treatise on the Theory and Practice of Midwifery*, p 154. London, D Wilson, 1752.

⁴ Bride, J W, *Journal of Obstetrics and Gynaecology of the British Empire*, 1936, **43**, 105.

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Faulty T tube simulating retained common bile-duct stone

In postoperative T tube cholangiography the main diagnostic problem is to distinguish between retained stones and air bubbles, while occasionally oedema of the duct mucosa may cause difficulty. We report a case in which an irregularity on the surface of a T tube led to the false diagnosis of a retained stone.

Case report

A 22-year-old woman underwent cholecystectomy after episodes of biliary colic. She was found to have a dilated common bile duct, and several small filling defects were seen on the operative cholangiogram. The duct was explored via a supraduodenal choledochotomy, and three small stones were removed. A Maingot latex T tube was inserted after the exploration. During the insertion it was noted that the tube was rather sticky but no irregularities were seen on its surface. Postoperative progress was uneventful but T-tube cholangiography showed a translucency strongly suggestive of a small, non-opaque stone. The examination was repeated and the appearances were unchanged. Owing to the relatively small size of the translucency, the composition of the other stones (mainly cholesterol), and the patient's age and disinclination to undergo further surgery, she was transferred to the care of Professor R H Dowling at Guy's Hospital for prospective cholic acid infusion for dissolution of the stone. After further explanation of the procedure the patient was unwilling to remain in hospital, but agreed to return for attempted percutaneous extraction.¹ She returned for this procedure six weeks after the original operation.

On removal of the T tube before attempted catheterisation of the track, a small blister-like excrescence was found on the cross limb of the T tube in the same position as the radiographic filling defect (see fig). A cholangio-

Photograph of T tube after removal. Some contraction of "blister" on cross limb has already occurred.

gram through the T tube track was normal. The patient was discharged and has remained well.

Comment

This was clearly an unusual occurrence that could probably be prevented by carefully inspecting T tubes and using them only when perfect. In this case the T tube, which had undergone autoclaving an unknown number of times, had almost certainly been distorted by handling with forceps during its insertion. Had we suspected that an abnormality of the T tube was causing the filling defect we could have confirmed this by pulling down on the T tube stem and showing that the filling defect moved with the tube. We report this case so that others may be made aware of this possibility and of how to confirm it.

We thank Professor R H Dowling and Mr J McIntyre for permission to report on this patient, who was admitted under their care.

¹ Burhenne, H J, *Radiology*, 1974, **113**, 567.

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Epidemic of Tietze's syndrome

The syndrome of painful swelling of one or more of the upper costal cartilages was described first in 1921 by Tietze.¹ Since then more cases have been recorded² and similar swellings of the sternoclavicular joints have been included in the syndrome.³ The condition is relatively uncommon, runs a self-limiting course, and is of unknown aetiology. During mid-1976, six typical cases of Tietze's syndrome presented to the outpatient clinic of Nchanga North Hospital in Chingola, Zambia.

Case reports

Details of the six cases are shown in the accompanying table. Two of the patients had other illnesses at the time—a tuberculous spinal abscess in case 1, and secondary syphilis in case 5. Various anti-inflammatory analgesics were prescribed to all patients, but these were not of great benefit. All cases ran a benign course and slowly resolved.

Details of six patients with Tietze's syndrome

Case No	Age	Sex	Onset	Site	Duration (months)
1	38	M	3 4/76	Right 4th costal cartilage	6
2	25	M	13 4/76	Left sternoclavicular joint	2
3	30	M	3 5/76	Right 2nd costal cartilage	2
4	23	M	8 5/76	Left 2nd costal cartilage	1
5	38	M	15 5/76	Right 2nd costal cartilage	2
6	28	F	17 5/76	Right 4th costal cartilage	3

Discussion

All these six cases were typical of Tietze's syndrome²—that is, young adults were predominantly affected; the swellings were of the upper thoracic articulations; the disease was self-limiting; and it was largely unaffected by treatment. The aetiology of Tietze's syndrome is unknown, but trauma has been suggested, and various other conditions have been noted in association with it, including respiratory infections⁴ and syphilis⁵ (as in case 5 in this report). The association with spinal tuberculosis noted here in case 1 does not seem to have been recorded.

The patients in this series were all Black Zambians living in the town of Chingola and working for Nchanga Consolidated Copper Mines Limited, though none had any close social or work contact with one another. Moreover, the date of onset of all six illnesses was within a six-week period between April and May 1976. No other cases of Tietze's syndrome have been seen in recent years in Chingola, and at the time of writing (February 1977) no further cases have appeared. This clustering in time and space of such an uncommon condition suggests that environmental factors such as viral infection or exogenous toxins may be of importance in the aetiology of Tietze's syndrome.

¹ Tietze, A, *Berliner klinische Wochenschrift*, 1921, **58**, 829.

² Levey, G S, and Calabro, J J, *Arthritis and Rheumatism*, 1962, **5**, 261.

³ Calabro, J J, and Marchesano, J M, *Journal of Pediatrics*, 1966, **68**, 985.

⁴ Motulsky, A G, and Rohn, R J, *Journal of the American Medical Association*, 1953, **152**, 504.

⁵ Vachtenheim, J, *Deutsche Gesundheitswesen*, 1966, **21**, 1387.

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Acute gastric dilatation in anorexia nervosa

Acute gastric dilatation, a rare complication of anorexia nervosa,¹⁻⁵ is probably caused by a rare combination of factors. The psychiatric diagnosis and difficult behaviour may direct attention from the physical nature of the complication. Delay in starting treatment may jeopardise the survival of an emaciated patient. On the other hand, anorexia nervosa should be considered in patients presenting with acute gastric dilatation.

Case report

A 17-year-old girl was admitted to the psychiatric unit with a six-month history of anorexia, loss of weight from 58 kg to 35 kg, feelings of despair, inability to cope, and vague suicidal thoughts after her grandmother's death. Grief reaction and secondary anorexia nervosa was diagnosed. She responded well to monoamine oxidase inhibitors, chlorpromazine, and social rewards for weight gain. She ate a 12.5 MJ (3000 Kcal) diet with additional biscuits and sweets. After eating most of a fruit cake weighing 1 kg in addition to her normal diet she complained of mid-abdominal, non-colic pain of sudden onset associated with a swollen abdomen and nausea.

On examination her pulse rate was 112/min and BP 120/70 mm Hg. Her abdomen was tightly distended and a tender mass was felt in the upper abdomen. A plain x-ray examination confirmed a diagnosis of acute gastric dilatation. She was transferred to the medical unit where she was treated by "drip and suck." She settled quickly and within three days was back on a 12.5 MJ diet. Urea and electrolytes remained within normal limits throughout. Her subsequent progress was uneventful.

Comment

Acute gastric dilatation when treated promptly has few serious consequences. Delay in treatment may lead to stomach rupture, which has an 80% mortality rate.² In anorexia nervosa diagnosis of dilatation may so easily be delayed because manipulation, self-induced vomiting, and complaints of abdominal discomforts after eating are so common in these patients.