three patients with ulcers and sutures. In only one patient did the ulcer heal, but it recurred three months later without a visible suture. Sutures were removed from 18 patients without ulcers. In 17 symptoms improved initially, but in 13 symptoms had recurred within three months. Six of these patients were later selected for bile-diversion surgery. One year after this operation five of these patients were cured of their dyspepsia or vomiting, although four still had sutures visible at endoscopy.

Peak acid output (mmol/hour) in 24 patients matched in three groups; those with ulcers with sutures, ulcers alone, and sutures alone

Operation	PAO after pentagastrin (6 µg/kg)		
	Suture and ulcer	Ulcer alone	Suture alone
Vagotomy and pyloroplasty	14.7	36.1	5.1
Vagotomy and pyloroplasty	18.0	28.6	2.1
Vagotomy and pyloroplasty	22.2	20.7	2.6
Vagotomy and pyloroplasty	26.3	23.0	5.2
Vagotomy and pyloroplasty	20.5	31.2	6.0
Bilroth II partial gastrectomy	17.2	16.1	3.0
Bilroth II partial gastrectomy	24.1	27.0	0
Bilroth I partial gastrectomy	15.0	26.3	0
Average	19.7	25.5	3.1

In a prospective study of vagotomy and antrectomy all willing patients underwent endoscopy six to twelve months after the operation. Black silk was used for the seromuscular layer and catgut for the mucosal layer in all patients. Thirty-two patients volunteered for review endoscopy. Eleven had dyspepsia and in them sutures without ulceration were seen in six (55%). Twenty-one patients had no symptoms, and sutures were seen in 13 (65%).

Discussion

Sutures situated in an ulcer were found uncommonly in this as in other series.^{1,2} Of 71 patients with ulcers at or near the stoma, only eight had visible sutures. Patients with ulcers associated with sutures had dyspepsia and a high PAO, but those with sutures without ulcers had a low PAO and often no symptoms. Thus sutures with and without ulcers are of different significance.

If a recurrent ulcer and suture were found the suture was situated in the ulcer, and so the suture appeared to determine the site of ulceration. Nevertheless, we found that ulceration occurred only with a high acid output. Our results differ from those of Small *et al.*,¹ who found that the mean maximal acid output in six patients with sutures after Bilroth II partial gastrectomy was 11.9 mmol/h (range 0.3 to 36.2). Nevertheless, they did not always see an ulcer on endoscopy, and some patients with sutures without ulcers may have been included. Removal of the stitch endoscopically may heal the ulcer, but there is a high recurrence rate. Of 13 reported cases, only five remained free of dyspepsia after apparently successful stitch removal.^{1,3,4} As PAO is raised, treatment should be directed towards lowering acid output by surgery or cimetidine and not removal of the sutures. A larger matched sample is needed to determine whether ulcers occur with a lower acid output when sutures are present than when they are not.

Kasugai *et al.*⁵ reported symptomatic improvement after endoscopic stitch removal in 16 patients, but the length of follow-up was not given. We found that dyspepsia was relieved only transiently after removal of a stitch alone. The initial improvement was probably a "placebo effect." Sutures were found as frequently in patients without symptoms as with those with dyspepsia. Sutures without ulcers do not cause symptoms, and their removal is pointless.

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United Birmingham Hospitals, Queen Elizabeth Hospital, Birmingham B15 2TH

A M HOARE, MB, MRCP, senior medical registrar

J ALEXANDER-WILLIAMS, MD, CHM, consultant surgeon, external scientific staff, medical research council

Oleogranuloma of the rectum produced by Lasonil ointment

Oleogranuloma (lipid granuloma, oleoma, paraffinoma) of the rectum is a recognised, uncommon sequel of injection treatment for haemorrhoids. Presenting as a rectal tumour it may be mistaken for carcinoma of the rectum. We report a case of a lesion produced by a self-administered "pile" treatment which we consider has not been described.

Case report

A 57-year-old man presented with a history of discomfort which had become worse for three weeks and was associated with a sensation of a lump at the anus. He had had one episode of fresh bleeding per rectum but his bowel habit had been unchanged and he was otherwise well. Digital examination showed a firm plaque in the anterior rectal wall, five cm from the anal margin. The lesion occupied half of the rectal circumference and was mobile on the prostate. Sigmoidoscopy showed a normal mucosa to 20 cm and biopsies were taken from the plaque. A barium enema was also performed, which showed no abnormality in the colon. The histology report of the rectal biopsies described the lesion as a lipid granuloma (oleogranuloma) affecting the submucosa and parts of the mucosa. There was no evidence of malignancy and the overlying mucosa was normal (see figure).

Oleogranuloma of the rectum (H and E) × 125.

On further questioning the patient stated that he had not had injections for haemorrhoids. Nevertheless, he had used Lasonil ointment, a self-administered preparation with a nozzle attachment. On occasions he had experienced pain when administering the preparation. With the nature of the rectal lesion elucidated and the patient reassured, an expectant policy of management was pursued.

Discussion

Oleogranulomata have been reported as complications of injection treatment of haemorrhoids using 5% phenol in almond oil. They are uncommon (Goligher¹ reported that he had not seen a case) and may present several years after the injections have been performed. The lesions are induced by submucosal reaction to the vegetable oil in which the sclerosant is suspended. The patient may present with the sensation of a mass or the lesion may be an incidental finding. On palpation it is a submucous tumour, just above the dentate line, and on occasions may be annular or ulcerating.²

The histological appearance is that of a histiocytic and giant-cell reaction surrounding circular spaces, which represent the oil dissolved out in the processing of the slide. The process may affect both submucosa and mucosa and a macrocyst variety has been reported.³ The

submucosal tumour may be mistaken for a rectal carcinoma⁴ and unless diagnosed correctly the patient may be subjected to radical surgery.⁵ The granulomata have not been reported to undergo malignant change and may be left alone or treated by submucosal excision.

We have not discovered any reports of the production of rectal oleogranulomata by self-administered medications, although similar lesions may be found in the colon in patients who have used paraffin as a laxative over a long period. Lasonil is an ointment containing heparinoid and hyaluronidase in a suspension of paraffin and wool alcohol and is introduced into the anus through an attached nozzle. We presume that the patient injected the material submucosally on an occasion or occasions when he found administration painful and the position of the lesion in the anterior rectal wall would support this view. The submucosal reaction was probably produced in response to the paraffin, and the presence of hyaluronidase in the preparation may have contributed to spread in the rectal tissue.

We thank Mr W Morris-Jones for allowing us to report on this patient and Dr A Kennedy for advice and the illustration.

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The Royal Infirmary, Sheffield S6 3DA
M G GREANEY, MB, FRCS, research assistant
P R JACKSON, BA, MB, house surgeon

Nickel coin dermatitis

Here I report an unusual distribution of dermatitis confined to the palmar aspect of the fingers in five patients. Probably this type of eruption is not uncommon, but the distribution was so well defined that a record of it should be of value. It is not generally recognised either by physicians or by patients that dermatitis may result on hands in a susceptible person from sensitisation to nickel in money.

In these cases it was concluded that handling white metal coins containing 25 per cent nickel was responsible for the dermatitis.

Patients, methods, and results

The main clinical findings of these five patients are shown in the accompanying table. Morphologically, the lesions varied according to the intensity

of dermatitis. In some cases there were thick keratotic scales and redness on the affected finger, but the others manifested with redness, swelling, vesicles, and fissures. Mild to moderate itch was predominant.

These patients were subjected to the European battery of patch tests,¹ and tests with 5p or 10p coins. Scrapings for mycological examination were obtained from patients with unilateral scaling or redness on the palms. All the patients showed a positive reaction to 2.5% nickel sulphate in soft yellow paraffin after 48 and 96 hours. A positive patch test to rubber in patient 4, probably acquired secondarily to wearing rubber gloves, and a positive patch-test reaction to cobalt in patient 5 seemed to be concomitant sensitivities. The rest of the patch tests including 5% aqueous solution of copper sulphate were negative. The mycology reports were negative for fungus.

Discussion

These five cases are clinically comparable, since in all the palms of the hands and palmar aspects of the fingers were particularly affected. Except the one man who was a tailor, all the other patients whether housewives, clerkesses, or secretaries were concerned in counting money. Nevertheless, the tailor was used to holding his bus fare in his hand for a considerable period. The eruption in all the patients improved when they were advised not to hold money.

Since Rothman² reported an obstinate case of eczema of hands, underarms, shoulders, and neck in a cashier, nickel dermatitis of the hands from the usual handling of nickel coins has been added to the list of suspected causes. Nevertheless, it has been argued that this cause is rare because exposure is transient while the thick palmar horny layer is resistant to developing dermatitis.³

Today white metal coins in most countries contain a fairly high proportion of nickel, and since 1947 British "silver" coins have been made of cupro-nickel, which contains 25 per cent nickel and 75 per cent copper.⁴ Pedersen *et al*⁵ investigated the release of nickel from Swedish coins, estimating the nickel content by atomic absorption spectrophotometer. They found that coins released nickel more than did sheets plated with 100 per cent nickel. Thus it was present in varying amounts (5-122 µg/person) on the hands of persons who had been in contact with coins in their profession, or who had counted coins for five minutes. They concluded that "silver" coins were a possible source of allergen in everyday life.

If the doctor is faced with the pattern of dermatitis described above, the possibility of nickel dermatitis due to coins should be considered. Early recognition could minimise suffering due to the prolonged exposure to coins.

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Contact Dermatitis Investigation Unit, Belvidere Hospital, Glasgow G31 4PG

S L HUSAIN, MB, MRCP, consultant dermatologist

Clinical details of nickel-coin sensitive patients

Number of patients	Sex	Age	Duration of dermatitis	Occupation and duration	Distribution of present eruption	Initial onset	Patch test results	History of dermatitis
1	F	16	6/12	Clerkess/Cashier 9/12	Both palms	Palmar aspect of two, three, four fingers of left palm	Nickel 2.5% 5p coin	Nil
2	M	18	5/12	Tailor, 1 yr	Right palm with scales vesicles and redness in two, three, and four fingers	Left palm	Nickel 2.5% 10p coin	Nil
3	F	57	6/12	Housewife and part-time cashier 6/12	Eczema left palm	Ear (earrings), thigh (suspender clasps)	Nickel 2.5% 5p coin	Yes, 15 yr ago. Allergy to nickel at suspender area and ears
4	F	56	1 yr	Secretary/Cashier 14 yr	Both palms, two, three, and four fingers of both hands. Scattered excoriated lesions on wrists and back of hands	Suspender area, back (beneath brassiere hook)	Nickel 2.5%, rubber and 5p coin	Yes, 10 yr ago at suspender area
5	F	52	4/12	Housewife and voluntary worker in hospital canteen	Right palm and then left palm	Ear (earrings)	Nickel 2.5%, cobalt and 5p coin	Yes, 20 yr

1 index finger; 2 middle finger; 3 ring finger; little finger