

artificial "sphincter" by placing a reversed jejunal loop between stomach and duodenum. There is, however, rarely if ever any need to operate on patients with "dumping."

### Conclusions

The patient who complains of pain, nausea, vomiting, weight loss, diarrhoea, or faintness after partial gastrectomy presents a problem that is rarely easy to evaluate. All symptoms tend to be buried beneath a mound of ineffective antacids.

The essential principle of the approach to the problem is to take a careful history from the patient with no preconceived ideas or with no empty mental pigeonholes labelled "——— syndrome" waiting to receive the problem as soon as the patient admits to the first classical symptom. Then evaluate the symptoms, looking for objective evidence of organic disease. The symptoms of pain and vomiting always require a comprehensive series of investigations, whereas loss of weight, diarrhoea, or faintness are best managed initially by simple empirical methods.

In some patients with recurrent dyspepsia after gastrectomy no definite diagnosis will be made or no permanent cure found. Some of these will be psychologically unstable and others will appear to become so as their symptoms remain undiagnosed and unrelieved. This residual group of unhappy complaining patients taxes the sympathy and resources of anyone who has to deal with many postgastrectomy patients. From several years' experience of reviewing many and reoperating on some of these unfortunate patients, I believe that they frequently need sympathy and continued interest but only rarely benefit from reoperation.

### REFERENCES

- <sup>1</sup> Nyhus, L. M., in *Surgery of Stomach and Duodenum*, ed. H. N. Harkins and L. M. Nyhus, 1962, p. 196. Little, Brown and Company, Boston.
- <sup>2</sup> Warren, K. W., *Mod. Trends Gastroent.*, 1961, 3, 264.

## ANY QUESTIONS?

We publish below a selection of questions and answers of general interest.

### Corticosteroids in Pregnancy

**Q.**—What are the particular hazards in pregnancy and childbirth in primiparae who have been taking corticosteroids continuously for some years for intractable asthma? What may be done to minimize the hazards, and should the baby be given corticosteroids after birth?

**A.**—The dangers of long-term corticosteroid therapy are due mainly to adrenal suppression, but since pregnancy itself stimulates the adrenals to double the normal secretion of cortisol this effect is minimized.<sup>1</sup> There is usually no need to increase the dose of steroid during pregnancy, but the possibility of steroid deficiency arising during any acute illness remains.

Labour is regarded as any major surgical operation would be, and hydrocortisone is given parenterally throughout this period of stress. Postpartum haemorrhage may produce a more dramatic collapse than in the normal patient, and must be treated with intravenous hydrocortisone as well as blood volume replacement.

Though corticosteroids do cross the placenta, they do not usually produce any noticeable effect on the baby. There is no

reason to give steroids to the baby unless signs of deficiency are manifest.

Patients receiving corticosteroids should be confined in hospital.

### REFERENCE

- <sup>1</sup> Cope, C. L., and Black, E., *J. Obstet. Gynaec. Brit. Emp.*, 1959, 66, 404.

### Animal Hosts to Rabies

**Q.**—Do lemurs contract rabies, and are there any other of the rarer infections which they may convey to humans by biting?

**A.**—The host specificity of rabies virus is low and the range of susceptible species includes man, domesticated mammals, and many wild ones, including foxes, wolves, mongoose, skunks, rodents, and certain kinds of bat. Monkeys can be infected experimentally, and the first natural case was recently recorded<sup>1</sup> in a rhesus monkey (*Macaca mulatta*) which had been imported into Britain from India. Lemurs are primitive primates of the suborder *Prosimii*. Though I know of no report of rabies in these animals, the possibility cannot be ruled out in view of the wide host-range of the virus, and it should not be ignored because

of the extreme danger attending the bite of an infected animal.

Monkeys may also, while showing trivial or no mouth lesions, harbour herpes B virus (*Herpesvirus simiae*), which, if transmitted to man, causes a serious and usually fatal condition. B-virus infection has been detected in many Old World monkeys,<sup>2</sup> and, though lemurs have not been examined, the risk of infection should be considered after any bite inflicted by these animals.

Local sepsis or septicaemia resulting from infection by mouth flora are also possible, and it might be remembered that pulmonary tuberculosis, with the production of infective sputum, can occur in captive primates. Extreme caution should be the watchword where primates are being kept. Every effort should be made to avoid contact with the animals or material derived from them, in particular from the mouth, and bites should be regarded most seriously as matters for immediate and thorough surgical attention.

During 1966 only one licence was issued, under the Animals (Restriction of Importation) Act, 1964, for the importation of a lemur—a *Lemur catti* from a French zoo. On the other hand, licences covering more than 20,000 Old World monkeys, required mainly for scientific purposes, were granted.<sup>3</sup>

### REFERENCES

- <sup>1</sup> Boulger, L. R., *Lancet*, 1966, 1, 941.
- <sup>2</sup> Hartley, E. G., *ibid.*, 1966, 1, 87.
- <sup>3</sup> Report of the Advisory Committee for the year ending 31 December 1965, Department of Education and Science, 1967. H.M.S.O., London.

- <sup>3</sup> Smith, R., in *Surgery of the Gallbladder and Bile Ducts*, ed. R. Smith and S. Sherlock, 1964. Butterworth, London.
- <sup>4</sup> Mix, C. L., *Surg. Clin. N. Amer.*, 1922, 2, 617.
- <sup>5</sup> Le Quesne, L. P., Hobsley, M., and Hand, B. H., *Brit. med. J.*, 1960, 1, 141.
- <sup>6</sup> Sullivan, M. B., *Surgery*, 1966, 59, 645.

### BIBLIOGRAPHY

#### Dumping

- Le Quesne, L. P., Hobsley, M., and Hand, B. H., *Brit. med. J.*, 1960, 1, 141.  
Fenger, H. J., *Acta chir. scand.*, 1965, 129, 201.  
Sullivan, M. B., *Surgery*, 1966, 59, 645.

#### Afferent Loop Syndrome

- Wells, C., and Welbourn, R. B., *Brit. med. J.*, 1951, 1, 546.  
Stammers, F. A. R., *Brit. J. Surg.*, 1961, 49, 28.  
Williams, J. A., *Pacific med. Surg.*, 1967, 75, 105.

#### Small Stomach Syndrome

- Wells, C., and Welbourn, R. B., *Brit. med. J.*, 1951, 1, 546.  
Stammers, F. A. R., in *Partial Gastrectomy*, ed. F. A. R. Stammers and J. A. Williams, 1963, p. 65. Butterworth, London.

#### Postgastrectomy Malnutrition

- Johnston, I. D. A., Welbourn, R., and Acheson, K., *Lancet*, 1958, 1, 1242.  
French, J. M., and Crane, C. W., in *Partial Gastrectomy*, ed. F. A. R. Stammers and J. A. Williams, 1963, p. 227. Butterworth, London.

#### Postgastrectomy Anaemia

- Deller, D. J., Richards, W. C. D., and Witts, L. J., *Quart. J. Med.*, 1962, 31, 89.  
Davidson, S., *Anaemia and Operations on the Gastrointestinal Tract*, Royal College of Physicians of Edinburgh, 1960.  
Cox, E. V., Williams, J. A., and Jones, C. T., in *Partial Gastrectomy*, ed. F. A. R. Stammers and J. A. Williams, 1963, p. 148. Butterworth, London.

#### Postgastrectomy Bone Disease

- Deller, D. J., Edwards, R. G., and Addison, M., *Aust. Ann. Med.*, 1963, 12, 295.  
Clark, C. G., *Proc. roy. Soc. Med.*, 1964, 57, 580.  
Williams, J. A., in *Postgraduate Gastroenterology*, ed. J. J. Thompson and I. E. Gillespie, 1966, p. 290. Ballière, Tindall and Cassell, London.