Unsuspected Bowel Injury

SIR,—In his paper (23 November, p. 485) on seat-belt injuries, Mr. J. B. Hamilton mentioned the deceptive ability of the abdominal wall to withstand, without apparent damage, trauma which has caused serious underlying injury. I have met three examples, two in general practice and one in industry.

Case 1.—A youth was brought to see me early one evening by a friend. During the afternoon the two boys had been trespassing, using a piece of woodland as a bicycle assault-course. The patient had become airborne while riding over a hummock and had fallen on the bicycle face downward, his abdomen across the handlebars. The activity being forbidden, he had not told his parents, but, as abdominal discomfort persisted, his friend had become sufficiently concerned to bring him on foot to see me. His demeanour was perhaps a little anxious, but his colour, pulse, and blood pressure were normal. The skin of the abdomen was unscathed and there was no bruising, undue tenderness, rigidity, or guarding. But for the history of injury and the relatively slight discomfort, there was no indication that there had been a serious abdominal mishap. He was referred for surgical observation, and laparotomy later that evening revealed a tear of the jejunal wall adjacent to the duodeno-jejunal junction.

Case 2.—I was called late one night, during a snowstorm, to a remote cottage where a robust young farm labourer had complained of abdominal pain. The patient was sitting in the living room watching television when I arrived and told me, with some embarrassment, that the pain had disappeared. Apparently he had been kicked in the abdomen by a cow during milking that afternoon. This had not disturbed him unduly, and he completed milking and the rest of the day's tasks. The transitory epigastric pain, for which I had been summoned, had occurred almost immediately after he swallowed a drink of tea on returning home in the evening. I thought it best to examine him, and he preceded me upstairs to the bedroom at the double. As in Case 1, there was no apparent abrasion or bruising of the abdominal wall. There was no abdominal rigidity or tenderness, or evidence of constitutional upset. He was sent to hospital for observation, and laparotomy in the early hours of the morning revealed a ruptured jejunum adjacent to the duodeno-jejunal junction.

Case 3.—A young male factory worker was unwise enough to remain inside sitting on the edge of a large empty crate while it was being raised by a fork-lift truck. The crate overbalanced, and he was tipped out on to his back on the ground. The heavy crate rotating through 180°, followed him, the edge opposite to the side on which he had been sitting landing across his abdomen. He was brought to the factory medical department for a check-up. There were no constitutional signs of injury, nor was there skin damage or bruising of the abdominal wall. There were no localizing signs other than an equivocal impression of guarding, and slight tenderness in the hypogastrium. He was sent to hospital in case he had sustained a ruptured viscus, possibly the bladder. Laparotomy shortly afterwards revealed a tear in the jejunum adjacent to the duodeno-jejunal junction.

Each patient made an uneventful recovery in the care of competent surgeons, but their misadventures illustrate the significance of the history in contrast to physical signs at an early stage after rupture of undistended intestine. Shearing forces acting on bowel close to a point of anchorage over the prominence of the anterior vertebral surface was presumably the cause of their injuries, as when the less mobile third part of the duodenum is involved. It seems important to

stress this possibility to first-aiders, nurses, and doctors.—I am, etc.,

M. L. H. FLINDT.

Department of Occupational Health,
University of Manchester.

Prostatic Hyperplasia

SIR,—In their interesting paper Mr. J. B. Bourke and Dr. J. P. Griffin (23 November, p. 492) have claimed that 50% of patients submitted to operation for benign prostatic hyperplasia were diabetic. What in fact they have shown is that 23 out of 46 patients when tested 7–12 days after prostatectomy exhibited reduced glucose tolerance, sufficiently slight for three to have only fasting glycosuria. Although the authors concede that their findings might be in part attributed to operative stress, they nevertheless state that their results give “further support to the hypothesis that benign prostatic hyperplasia is one manifestation of a relative increase of oestrogens with advancing age.” This conclusion would seem unjustified. The mere reiteration of this hypothesis, and without any steroid levels being presented, does not increase its plausibility.

The use of matched control patients who had had operations other than prostatectomy could have strengthened the argument. But it is completely baffling why glucose tolerance was investigated at just the time when an erroneous result was likely. Testing prior to surgery or during the two years that have elapsed would have been preferable. It would also be interesting to know if the reduced glucose tolerance was associated with the degree of operative stress, which could be assessed by the operative procedure used, by the nature of the anaesthetic, by the need for blood transfusion, and by the occurrence of postoperative complications. The claim that there was an association between a previous history of cardiac infarction, E.C.G. evidence of ischaemia, raised blood pressure, and abnormal glucose tolerance has been made with small figures and without statistical analysis. Although the “age of the patients . . . were recorded,” the omission of these values from the paper nullifies the argument concerning the significance of co-existing vascular disease.

On the evidence present in this paper the association of diabetes mellitus and benign hypertrophy of the prostate is as yet unproved and therefore hypotheses propounded to explain this correlation are pure fantasy.—I am, etc.,

R. W. LACEY.

Department of Clinical Pathology,
Royal Infirmary,
Bristol.

SIR,—I feel that a more mundane explanation of the link between diabetes and prostatectomy (not benign hyperplasia) than that put forward by Mr. J. B. Bourke and Dr. J. P. Griffin (23 November, p. 492) is possible. Namely, that the symptoms occasioned by diabetes—that is, frequency, nocturia, or neurogenic bladder, summated with a benign prostatic hyperplasia—may make a man seek relief in prostatectomy, whereas an identical degree of hyperplasia in a non-diabetic would be symptomless, or at least tolerable, and medical help would not be sought.

Although the article states that the presence of preoperative glycosuria was noted, the incidence cannot be found in the text, nor its relationship to the abnormal postoperative glucose tolerance tests. As in balanitis, would not routine preoperative urinalysis and post-prandial blood sugar be of value, and in some cases avert operation, with the relief of symptoms produced by treating the diabetes? —I am, etc.,

R. M. ROBERTSON.

Penhow, Mon.

Measles Vaccination

SIR,—About a hundred children die every year in the British Isles from measles. Approximately one out of every thousand cases of measles develops encephalitis. Other complications are not usually difficult to treat, and seldom cause lasting damage. There is a good case for trying to eliminate measles by vaccination, provided such vaccination does not simply postpone the disease to adult life, and provided that the vaccination is very safe.

Vaccination against measles has been used on a large scale in the United States of America for five years. So far it seems to have been safe, and the level of immunity appears to be maintained at a high level, but it cannot yet be known whether this immunity will persist into adult life. This doubt should make us reluctant to continue with our large-scale campaign. There is a possibility of a much more serious danger. This danger is subacute sclerosing panencephalitis. Dr. Connolly and his colleagues¹ have reported on three cases of subacute sclerosing panencephalitis, in two of which there was strong evidence to suggest that measles virus had remained latent in the central nervous system for a period between 11 and 13 years before the subacute sclerosing panencephalitis developed. They remark that this observation might have considerable bearing on the use of live attenuated measles virus strains as vaccines.

The strength of the case for measles vaccination is known, but the strength of the case against measles vaccination cannot be known for several years yet. It may turn out to be a very strong one, and much damage may have been done before we know. We should wait.—I am, etc.,

A. W. O. TAYLOR.

Edinburgh.

REFERENCE

- 1 Connolly, J. H., Allen, I. V., Hurwitz, L. J., and Millar, J. H. D., *Quart. J. Med.*, 1968, **37**, 625.

SIR,—A 15-month-old baby was recently admitted with a severe reaction seven days after measles inoculation with live attenuated virus. The baby had two convulsions and a rectal temperature of 40.7° C. Her similarly immunized non-identical twin sister had a rectal temperature of 39.4° C. at the same time, but did not convulse and was treated at home with salicylates. These and several other cases encountered imply that measles inoculation is not without risk, anoxic cerebral damage and vomit inhalation being possible complications of a fit.