

Correspondence

Letters to the Editor should not exceed 500 words.

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Influenza and Respiratory Failure

SIR,—In his article on influenza and respiratory failure (10 January, p. 97) Dr. J. C. Stoddart mentions the need for artificial ventilation of patients with respiratory failure following influenza and respiratory tract infection. In the intensive therapy unit of the Royal Sussex County Hospital during the current influenza epidemic commencing in early December it has proved necessary to ventilate artificially six patients who were suffering from respiratory tract infection associated with influenza.

The ages of these patients ranged from 30 to 65. Four of them had no previous history of chest disease, and of the two others one suffered from chronic bronchitis and the other was an old poliomyelitis victim with weak respiratory musculature. The indications for intermittent positive pressure ventilation were in all cases progressive hypoxaemia combined with exhaustion. In only two cases was there associated respiratory acidosis as evidenced by an increased PCO_2 , one of these being the chronic bronchitic patient. The length of time the six patients were ventilated via an oral cuffed Portex endotracheal tube varied from 37 to 94 hours. Four of the patients had tracheostomies following their periods of endotracheal intubation, and were then ventilated for periods of up to 10 days. Two of them are being weaned off their ventilators at present. All of the patients were given either phenoperidine or Omnopon, as necessary, during the time they were being ventilated via the oral endotracheal tubes to facilitate adequate artificial ventilation and provide freedom from distress. Two of the six patients died

with fulminating pneumonias.

If the prognosis of these patients is to be improved by the speed with which such treatment is instituted, as Dr. Stoddart suggests, it would seem that hypoxaemia and exhaustion are the two essential features to recognize, and it may be unwise to wait for respiratory acidosis to occur in previously healthy patients.—I am, etc.,

G. GERSON.

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Brighton, Sussex.

SIR,—We would like to record the experience of a small hospital (72 beds) in the use of positive pressure ventilator therapy during the current flu epidemic.

Our criterion for intubation and ventilation was imminent death in patients who were admitted during or after an attack of flu. These patients were all cyanosed, confused, and unable to cough up the secretion with which, clinically, their chests were filled. Six such patients were treated, of whom two died. Three have been successfully extubated and are recovering, and one is gradually being weaned off his respirator. The prognosis at this time seems quite good.

Owing to the arrangements of hospitals and laboratory facilities within this group we have no easy access to rapid blood-gas analysis, nor do we have a Haldane/Aimer CO_2 analyser, but nevertheless we feel that our experience should encourage similarly placed hospitals in the use of this treatment.—We are, etc.,

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Reading, Berks.

Rectal Cancer from Axle Grease?

SIR,—Your leading article entitled "Cancer from Mineral Oil" (22 November, p. 443) prompts us to relate the history of a

patient in whom mineral oil may be related to a carcinoma of the rectum. We propose to report the details of the case later.

The patient, a 36-year-old coloured male, presented with a six-year history of intermittent rectal bleeding. On rectal examination an irregular lesion, which appeared to encircle the rectum, was felt at the tip of the finger. This was confirmed at proctoscopy, and, because the macroscopic appearances of the lesion were somewhat unusual, several biopsies were taken. Sigmoidoscopy with a children's instrument and barium enema examination revealed no other lesion. In two biopsies the changes were those of chronic inflammation, but in the third the appearances were those of a well-differentiated infiltrating adenocarcinoma.

Abdomino-perineal excision was performed. There were no visible secondary deposits in the liver or peritoneum. In the opened specimen the lesion consisted of a series of irregular ridges lying side by side but tending to fan out more proximally. Histological examination revealed a superficial infiltrating well-differentiated adenocarcinoma arising in an area of organized granulation tissue, which disturbed the normal architecture of the rectum.

Because the lesion was so unusual and because the patient was serving his second term of imprisonment, it was thought that further inquiry might reveal some connexion between his long stay in gaol and the carcinoma. It is known that prisoners often hide a variety of articles in their rectum. The patient related that he had had a prolapsed rectum as a child. As a young man he had on occasions passed blood with his motions. He was first sentenced in August 1955. At that time prisoners were apparently not allowed to have tobacco with them. Because he usually worked in gangs breaking stones, the opportunity often arose to obtain tobacco from passers-by. This was carefully wrapped in paper—usually torn-up cement bags—and then inserted into the rectum, the passage of the wrapped tobacco being facilitated by grease obtained from wheel-barrow axles. In the quiet of the evening the rectum was emptied and the unharmed tobacco recovered. He was unable to estimate how many times a week he hid tobacco in this way.