Hs sei en, the cak as a cause of rectal prolapse in infancy. Kulczynki and Shwachman reported that this symptom was the initial complaint in 16 patients with cystic fibrosis and that 386 patients with cystic fibrosis gave a history of rectal prolapse. The National Cystic Fibrosis Research Foundation's guide to the diagnosis and management of cystic fibrosis states that cystic fibrosis is the commonest cause of prolapse of the rectum in the paediatric age group in the United States. The recent observations you refer to show that rectal prolapse is an unusual event in patients with cystic fibrosis and has also been noted in this clinic.

The diagnosis of cystic fibrosis should always be considered in infants and children with rectal prolapse and a sweat test is advisable if there is no obvious cause. Treatment is with a low-fat, pancreatic enzyme supplement, and measures to improve the pulmonary condition. Surgery is rarely required.—We are, etc.,

W. T. COAKLEY
D. E. HUGHES
Microbiology Department, University College, Cardiff

Problems of Rectal Prolapse

Sin.—Your leading article on this (14 November, p. 381) sadly fails to lead. May I respectfully suggest, firstly, that all the many reports indicate that cystic fibrosis is the commonest cause of rectal prolapse in infancy. Kulczynki and Shwachman reported that this symptom was the initial complaint in 16 patients with cystic fibrosis and that 386 patients with cystic fibrosis gave a history of rectal prolapse. The National Cystic Fibrosis Research Foundation's guide to the diagnosis and management of cystic fibrosis states that cystic fibrosis is the commonest cause of prolapse of the rectum in the paediatric age group in the United States. The recent observations you refer to show that rectal prolapse is an unusual event in patients with cystic fibrosis and has also been noted in this clinic.

The diagnosis of cystic fibrosis should always be considered in infants and children with rectal prolapse and a sweat test is advisable if there is no obvious cause. Treatment is with a low-fat, pancreatic enzyme supplement, and measures to improve the pulmonary condition. Surgery is rarely required.—We are, etc.,

J. S. SLADE
K. M. LAURENCE
Department of Child Health, Welsh National School of Medicine, Penarth, Glam.

Haemoptysis in Cystic Fibrosis

Sin.—Your recent leader "Haemoptysis in Cystic Fibrosis" (19 December, p. 702) is timely, for these children and adults suffering from this disease are living longer and are presenting with previously rarely seen complications. However, this is a rare disease and the experience of any one surgeon dealing with severe haemoptysis in these patients is likely to be limited, and for this reason a brief note on the treatment of such a patient may be of interest.

A boy was known to suffer from fibrocystic disease of the lungs since early life, was referred with severe haemoptysis in February this year. At that time he was expectorating up to 300 ml of bright red blood daily. An intelligent boy, he was sure that this was coming from the base of his right lung, for prior to each episode of haemoptysis he felt the blood bubbling at the back of his right lower chest. He was treated conservatively, and fortunately after two weeks, during which time he received 8 units of blood, this symptom subsided. However, he was readmitted in October 1970 with further severe haemoptysis, and on this occasion he was producing up to 800 ml daily. He was now very anaemic and demoralized, and for this reason surgery was considered but while waiting for a suitable time and when severe haemoptysis of 1,500 ml of bright red blood, it was assumed that the bleeding was originating from a bronchiectatic right lower lobe and that the blood was coming from bronchial arteries rather than pulmonary arteries. Emergency right thoracotomy was undertaken. The lung was boggy and pale but the striking feature was the hyperplastered bronchial artery, coursing along the lower edge of the right main bronchus. This was almost the size of a normal brachial artery, 0.5 cm in diameter, giving off a small ascending and a large descending tortuous artery to the right lower lobe. The bronchial artery was divided between ligatures. Postoperatively the haemoptysis ceased dramatically although there was a further small episode one week postoperatively. He did not have a severe pulmonary infection, which responded to appropriate antibiotics, and was discharged well four weeks after operation. This appears to have been a successful operative procedure, although it is likely that adventitious and equally large bronchial arteries will in due course develop and may produce further haemoptysis.

Contrary to the gloomy attitude of some writers, these patients are not necessarily disabled. This patient leads an otherwise fairly normal life.

I thank Dr. Beryl Corner for asking me to treat this patient.—I am, etc.,

JOHN LLOYD-STALL
KON-TAI KHAW
HARRY SHWACHMAN
Children's Hospital Medical Center, Boston, Massachusetts, U.S.A.

Skin Disease and the Gut

Sin.—Several important points are raised by Dr. E. J. Moynahan's interesting letter (28 November p. 559).

The first concerns the apparent difference in the incidence of rashes in coeliac disease in children and adults. We ourselves have also noticed this unexplained difference and the general feeling that rashes are rare in childhood coeliac disease is based on a recent detailed study of children with coeliac disease.

The second point concerns the incidence of the more specific rash of dermatitis herpetiformis in these patients. From a reply to a recent national questionnaire sent out through the Coeliac Society it is interesting that of the coeliac who had a rash in about 15%, this was in fact dermatitis herpetiformis. We have in our care three such patients with proven gluten-sensitive enteropathy, all male, aged 11, 12 and 26 years, respectively. We were referred to us with a rash which has turned out to be dermatitis herpetiformis and several similar cases have been reported in Britain.3 So far, however, no study of the bowel in juvenile dermatitis herpetiformis has been published.

Important though the association of dermatitis herpetiformis with clinical coeliac disease is, this is not really our message.1-7 In our original paper we reported that two-thirds of patients with dermatitis herpetiformis had on biopsy a jejunal mucosal appearance indistinguishable from that found in patients with coeliac disease or "idiopathic steatorrhoea." This is a separate issue from the occurrence of clinical coeliac disease and indeed most of our patients, including those with the most severe changes on mucosal biopsy, have no symptoms and some of them have no biochemical evidence of malabsorption either. It is therefore irrelevant to say, as Dr. Moynahan and many others have said, that patients with dermatitis herpetiformis have no symptoms or signs and therefore do not have an enteropathy.—I am, etc.,

ELEONORE M. ETTLINGER
Little Common, Near Sudbury, Suffolk

Resuscitation Too Late

Sin.—This week I saw with my own eyes for the first time the relatively recent syndrome of a patient who was resuscitated too late—that is, after prolonged cerebral anoxia. The general practitioners who, like myself, qualified a couple of decades back have never even seen these new man-made syndromes unless they happened to see them on their way to hospital. Nevertheless, unless certain criteria are established and made known, we ourselves may be guilty of resuscitating people too late, with all the anguish that usually results. I feel it is long overdue that the profession was given the chance to create a new platform on which new developments may be debated up and down the country, together with church leaders and others concerned with our present-day ethics. Even the question of euthanasia must constantly, by implication, be reassessed so that we may have the consolation that there exists a widespread and uncontested opinion of that is constantly under review. We can no longer escape these issues and it is cowardly to do so.—I am, etc.,

ELISABETH M. ETTLING
Little Common, Near Sudbury, Suffolk

1 Wally, C., Proceedings of the Royal Society of Medicine, 1959, 52, 602.

2 W. T., Coakley, D. E. Hughes, Microbiology Department, University College, Cardiff.

3 J. S., Slade, W. T., Coakley, D. E. Hughes, Microbiology Department, University College, Cardiff.
our findings are not peculiar to Newcastle for we have now found that incidence of jejunal mucosal abnormalities has been found in large series from London11, 15 and Glasgow16 and several cases have been reported from the Netherlands,17 Canada,18 and the U.S.A.19 The jejunal finding in patients with dermatitis herpetiformis should be investigated for coeliac disease solely on the grounds that they have dermatitis herpetiformis. The evidence is now so unequivocal that the day may not be far off when any of us may be called to answer a charge of negligence if we omit this essential investigation.—We are etc.,

JANET MARKS  
SAM SHUSTER  
Department of Dermatology,  
Royal Victoria Infirmary,  
Newcastle upon Tyne


Cystic Degeneration of the Portal Artery  
SIR,—Your leading article on this subject (19 December, p. 699) is a good review of this uncommon cause of intermittent claudication in young adults. Only one point of practicing importance should perhaps be added. While it is likely that most cases will go unrecognized until arteriography or operation show the typical lesion, which at once distinguishes it from the common obstructions due to arteriosclerosis or Buerger's disease—that is, in the 70% or so of this age group of the population who smoke cigarettes—yet when the cystic lesion (or portal entrapment for that matter) becomes advanced, the problem of a non-smoking 30% non-arteriosclerotic cause should be suspected. Such a case was diagnosed clinically, even before arteriography, in my report some years ago.2 The incidence of non-smoking in male diabetics in my experience remains, as it was then, about 1%.—I am, etc.,

DEWI REES  
Llandilo, Mon.


Dehydration and Oral Contraception  
SIR,—One factor that has not been mentioned in the discussion on oral contraceptives and depression is the high incidence of dehydration in women in their childbed. These no doubt form a sizeable proportion of women attending family planning clinics and the majority of those receiving birth control advice in my own practice. Pitt1 found that 10% of women delivered at a London teaching hospital suffered from postpartum depression. More recently, Miss Sylvia Lutkins and I2 used the Beck Depression Inventory to assess the incidence of dehydration associated with childbirth. At a cutting score of 17, the incidence of moderately severe depression was 10%, in line with the finding of Pitt. We also found that throughout the 12-month period following childbirth the incidence of moderately severe depression was constant at 10%, with about 3% of mothers severely depressed. Incidentally, during the antenatal period 9% of mothers were moderately depressed and 3% severely depressed, while the before and after rate for moderate depression among fathers remains constant at 2%.

The finding that particularly interested me in the paper by Dr. Brenda N. Herzberg and her colleagues (17 October, p. 142) was that "no difference was found between the average depression scores of the oral contraceptive and the control groups." I would have liked to have seen much emphasis given to this finding as given to the fact that 6-7% of those taking oral contraceptives were severely depressed. The latter finding surprises me perhaps less than the former as, from my own use of the Beck Depression Inventory, I expect about 3% of women to have depressive advice from me to be severely depressed at the first interview.—I am, etc.,

H. G. EASTCOTT  
London N.W.1


Spontaneous Rupture of Spleen  
SIR,—I wish to report a case of spontaneous rupture of a normal spleen. Traumatic rupture of the spleen is very common while spontaneous rupture of a pathological spleen, although rare, is well documented especially in tropical diseases such as malaria and kala-azar where the spleen may be markedly enlarged. Spontaneous rupture of a normal spleen, however, is extremely rare. A 55-year-old housewife was admitted to hospital after an emergency with abdominal pain of one week's duration. The latter was a constant dull ache in the left hypochondrium markedly accentuated by deep breathing and by coughing. There was no upper abdominal tenderness. She was certain that she had not sustained any injury. On examination she was very pale but not in pain. The relevant abdominal findings were a pulse of 120 per min; an abdomen which was soft but with slight tenderness in the left upper quadrant; deep pitting varicose veins; and a haemoglobin of 5 g/100 ml; and a reticulocyte count of 7-2%. A barium meal a few days after admission showed a large filling defect in the fundus of the stomach very suggestive of a carcinoma.

The patient was transfused with packed cells and 12 days later a laparotomy was performed. A very large perisplenie haematoma was found pushing the fundus of the stomach medially and forwards but otherwise the stomach was normal. There was about 300 ml of dark altered blood in the peritoneal cavity. The haematoma was evacuated easily by an incision over the left dome of the diaphragm, and abdominal wall, and in its centre was a normal-sized spleen showing no signs of extending into the splenic parenchyma. The spleen and the surrounding haematoma were removed and a liver biopsy was performed although the liver was not enlarged. No other abnormality was found in the peritoneal cavity. Histology showed a normal spleen and liver.

To exclude the diseases with which spontaneous rupture of the spleen has been associated we did repeated blood counts, bone marrow examination, plasma proteins and electrophoretic pattern, and Paul-Bunnell test, and these were all normal. She has now been followed up for over a year and remains well with a normal blood count. During the postoperative period the patient was questioned closely by different people and she was absolutely certain that she had not sustained any injury, however slight, in the preceding few weeks.

This case differs from the other reported cases of spontaneous rupture of the spleen in that our patient did not present with the clinical picture of bleeding into the peritoneal cavity, as is normal, but instead presented as anaemia due to carcinoma of the stomach—a very misleading presentation of an extremely rare condition.—I am, etc.,

A. GRECH  
Redhill, Surrey  
Redhill General Hospital.