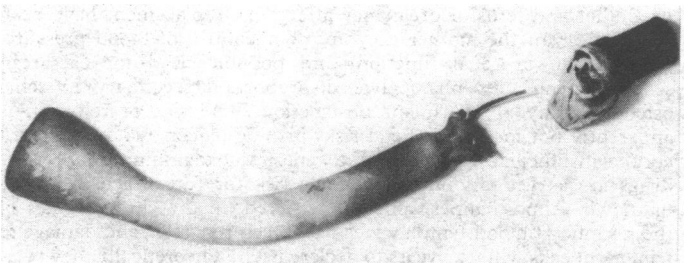
found at the pylorus but its distal end was in the ileum about 20 cm from the ileocaecal valve. The two portions were still attached by the nylon coil that reinforces the latex of the Celestin tube (figure). The small bowel between the two portions of the tube was gathered and shortened over the nylon, and there were seven full-thickness ulcers on the mesenteric border of the 30 cm of ileum immediately proximal to the distal end of the tube. The ulcerated bowel was resected and an end-to-end anastamosis performed. At endoscopy and laparotomy there was no macroscopic evidence of residual tumour. The patient remained well for a further six months but then rapidly developed severe dysphagia due to recurrent malignancy. He died 20 months after the onset of his initial symptoms.



Two sections of Celestin tube removed at laparotomy.

## Comment

Structural deterioration of Celestin tubes has been reported but only after they had been in position for more than two years.[4] In our case the tube had been in place for about six months, and probably the early deterioration was due to damage during insertion. It has subsequently been shown that the pressure exerted on the inner wall of the tube by the introducer can split the latex wall of the tube and release the inner nylon coil (L R Celestin, personal communication). Another possibility is that the tube was damaged by the high dose of irradiation the patient received. Nevertheless, this is unlikely and has never been reported after operative insertion of a Celestin tube. In view of this case care must be taken to prevent undue force on the inner wall of the Celestin tube, and perhaps other methods of inserting the tube should be considered.

We thank Dr J A Bullimore, consultant radiotherapist, for permission to publish this case.

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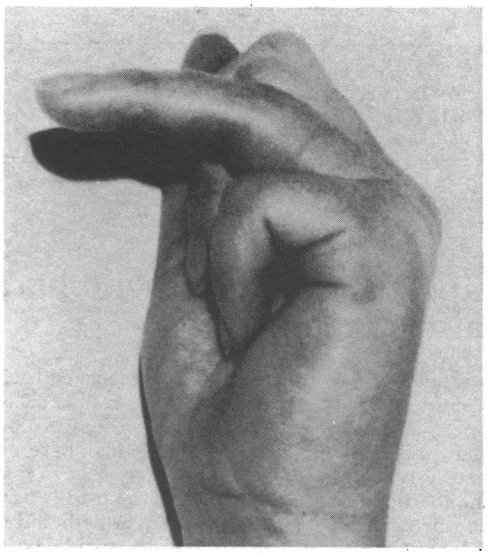
# Tenolysis in juvenile diabetic cheiroarthropathy

Hand changes are not uncommon in diabetes mellitus. They are principally due to small-muscle wasting caused by peripheral neuropathy or a mononeuropathy, usually a carpal tunnel syndrome or ulnar nerve palsy.[1] Although Charcot arthropathy in the UK is now most often caused by diabetes (diabetic osteoarthropathy) it is extremely uncommon in the hand.[2] There is, however, little recognition of juvenile diabetic cheiroarthropathy, a painful arthropathy of unknown cause which affects the interphalangeal joints. It is associated with palmar flexion and is apparently specific to young longstanding insulin-dependent diabetics whose diabetes had its onset before puberty.[3] This cheiroarthropathy is usually regarded as chronic and we report here the benefit of tenolysis in this condition.

## Case report

A 28-year-old woman who had had diabetes for 20 years and was controlled on twice daily soluble and isophane insulins presented with an 18-month history of stiffness and pain in the right and left ring fingers. This affected the metacarpophalangeal and proximal interphalangeal joints and was associated with dermal oedema and a sclerodermatous-like appearance. Her fingers were swollen and tender and could flex to within only 4 cm of the palm (see figure). There was no thickening or shortening of the palmar aponeurosis to suggest Dupuytren's contracture. No other joints were affected. There were no features of Raynaud's phenomenon or systemic sclerosis. Erythrocyte sedimentation rate was 7 mm in first hour (Westergen), she was negative for antinuclear factor, and the Rose-Waaler test was normal, as were radiographs of both hands. Background retinopathy was present, as was proteinuria (1·8 g/24 h) with a creatinine clearance of 77 ml/min. There were no neuropathic features in the arms or legs. Because the hand deformities were affecting her work as a music teacher, exploration of the tendon of the right ring finger was performed, which showed some fibrous thickening of flexor sheath at its palmar end. Tenolysis was carried out until the tendon could be moved freely. Histological examination of the fibrous tissue showed only a mild non-specific oedematous change. During the next nine months the pain and swelling in the joints of the right ring finger gradually disappeared. Tenolysis of the left ring finger was then performed with a similar good result. Two years later the right long finger gradually became affected and could flex to only 3 cm from the palmar surface. Tenolysis was performed six months later, and a similar operation on the left long finger was then carried out, producing free movement of the tendon. As before, the pain and swelling in the affected metacarpophalangeal and proximal interphalangeal joints gradually settled over six months. At the time of writing, the right fifth ring finger had become affected and a fifth tenolysis was to be performed.



Left hand showing diabetic cheiroarthropathy with swelling of metaphalangeal and proximal interphalangeal joints of ring finger with flexion limited to within 4 cm of the palm.

## Comment

Diabetic cheiroarthropathy causes pain, stiffness, and periarticular swelling of the metacarpophalangeal and proximal interphalangeal joints, especially of the long, ring, and fifth fingers, associated with a painful palmar flexion deformity.[3] It is an uncommon condition but the evidence suggests that it is probably associated with diabetes mellitus. The differential diagnosis is from Dupuytren's contracture, again more common in diabetics,[4] which is painless and has puckering of the skin, often with a thickened nodule; at operation the palmar fascia in Dupuytren's contracture is hard and gritty whereas the palmar fascia in cheiroarthropathy is more supple.[5] Also, diabetic cheiroarthropathy must not be confused with a simple trigger finger, where there may be some swelling proximal to the fibrous constriction but

no distal swelling or pain in the metacarpophalangeal or interphalangeal joints and where it is usually easy to flex the finger fully but difficult to straighten it again.

The natural history of diabetic cheiroarthropathy is not clear but the joint contractures may not improve.[3 5] There have been no reports of the benefit of tenolysis, and our case shows that allowing full movements of the finger joint may prevent secondary joint contracture and that the pain and swelling settle over six to nine months.

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# Eclampsia in a patient who had had a renal transplant

Pregnancy is uncommon in patients on maintenance haemodialysis, but occurs more often in those who receive successful renal transplants. The European Dialysis and Transplantation Association's figures for 1978 show that up to 31 December 1977 there have been 79 live births to such recipients.[1] There have also been 73 surgical or spontaneous abortions reported. The former are usually performed for hypertension or deteriorating renal function, or both, but the reasons for the latter are not clear. We here report the rapid development of eclampsia and abortion in a patient who had had a renal transplant.

## Case report

A 14-year-old girl presented in 1973 with hypertension and the nephrotic syndrome due to mesangiocapillary glomerulonephritis. Her renal function deteriorated slowly and haemodialysis was started in May 1977. In August 1977 she received a cadaveric renal transplant (with no HLA antigens in common) which functioned well after three rejection episodes. Her hypertension recurred after transplantation and she had occasional asymptomatic urinary tract infections. In March 1979, after five months months' amenorrhoea, a pregnancy test was positive. Her pregnancy progressed well without deterioration in renal function or blood pressure. In June 1979, at about 30 weeks gestation, she complained of headaches, nausea, and vomiting. Her general practitioner, finding her unconscious and greatly hypertensive, injected diazepam intramuscularly and sent her to hospital. On admission her blood pressure was 170/130 mm Hg, she was oedematous, having fits, and responding only to painful stimuli. Fundoscopy showed normal appearances and there were no focal neurological signs. The fetal heart was not heard. The eclampsia was controlled with infusions of diazepam and hydrallazine. A macerated fetus was delivered several hours later after intravenous infusion of prostaglandin $E_2$ and the fits ceased. She made a complete clinical recovery. Her renal function was unimpaired throughout her admission apart from a transient increase in proteinuria to 1 g/24 h. She has remained well and has been advised against further pregnancies. Necropsy of the fetus showed a macerated girl weighing 2193 g but no other abnormality.

## Comment

Renal transplantation aims at rehabilitating the patient fully, including restoration of fertility in both men and women. The risks to mother and fetus of pregnancy after renal replacement have been reviewed.[2 3] In the mother they are poor control of blood pressure, deterioration in renal function, and possible need for caesarean section owing to cephalopelvic disproportion secondary to renal osteodystrophy or transplant obstruction. The risk of rejection is apparently not increased. Fetal risks include leucopenia and adrenocortical insufficiency. Fears of teratogenesis due to immunosuppressive drugs are as yet unfounded[4] but the risk for future generations is unknown. Abnormalities, albeit short lived, in the chromosomes of the peripheral blood lymphocytes have been reported, and damage to fetal germ cells will take years to declare itself. Theoretically, however, the fetus should be protected from the effects of azothiaprine since it lacks the enzyme inosinate pyrophosphorylase required to convert azothiaprine to thioinosinic acid, the metabolite active on dividing cells.[5] A pregnant woman who has had a renal transplant needs close observation and monitoring before and after delivery. In our patient the risk of developing pre-eclampsia was high, since she was young, primiparous, and hypertensive; but she developed rapid and fulminating eclampsia at a relatively early stage of pregnancy. One week before admission she was well, normotensive, and without oedema or appreciable proteinuria. Though surgical and spontaneous abortions are not uncommon in this group of patients, we have been unable to find a report of a case of eclampsia in a recipient of a renal transplant.

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## Vancouver style

All manuscripts submitted to the *BMJ* from now on should conform to the uniform requirements for manuscripts submitted to biomedical journals (known as the Vancouver style).

The *BMJ*, together with many other international biomedical journals, has agreed to accept articles prepared in accordance with the Vancouver style and will be introducing the system from January 1980. The style (described in full in *BMJ*, 24 February, p 532) is intended to standardise requirements for authors and covers text format, presentation of methods and results, use of SI units, and the form of tables and illustrations. All the participating journals have also agreed to introduce a standard form of references.

In future references to papers submitted to the *BMJ* should include: the names of all authors if there are fewer than seven or, if there are more, the first three followed by *et al;* the title of journal articles or book chapters; the titles of journals abbreviated according to the style of *Index Medicus;* and the first and final page numbers of the article or chapter.

Examples of common forms of references are:

[1] International Steering Committee of Medical Editors. Uniform requirements for manuscripts submitted to biomedical journals. *Br Med J* 1979; **1**, 532-5.
[2] Soter NA, Wasserman SI, Austen KF. Cold urticaria: release into the circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl Med* 1976; **294:** 687-90.
[3] Weinstein L, Swartz MN. Pathogenic properties of invading microorganisms. In: Sodeman WA Jr, Sodeman WA, eds. *Pathologic physiology: mechanisms of disease.* Philadelphia: W B Saunders, 1974: 457-72.

Up to the beginning of October some 100 journals had agreed to accept articles in the Vancouver style, and a full list will be printed early in 1980.