Ozaena and Iron Deficiency

Sirs.—Dr. Håkon Barkve and Dr. Gisle Djupelesd (11 May, p. 336) state that iron deficiency is a common disease in Norway, but ozaena is rare. This applies to Hungary also; although sideropenic dysphagia is still less frequent here than ozaena, we—like Waldenström—are convinced that it is due to iron deficiency.

In this paper the authors state that none of their nine ozaena patients revealed signs of iron deficiency. Four women had, however, taken iron for long periods. The question arises why these patients received iron. Is it possible that this is present, further, whether iron deficiency could be expected after prolonged iron treatment. One patient is stated to have had fissures in the corner of the mouth, but the authors fail to point to the probable etiological factor of the phenomenon. Iron concentration in the serum of another patient was low, and so was the iron content of his marrow. Yet no iron deficiency was diagnosed. The four iron-treated patients had not observed any change in the ozaena during the therapy. It would be interesting to know whether objective changes did occur in these cases. Patients do not always estimate changes in their condition correctly; it happens that they feel improved when the symptoms of the local manifestations of ozaena remain unchanged, while also the opposite may occur.

A female medical student aged 22 years was recently seen in this clinic. She had been suffering from ozaena since the age of 6, was subjected to nasal surgery at the age of 12, and subjected to medical aid because she felt that iron therapy, prescribed by her physician a year before, had improved her disease but very slightly. Radiological examination showed the massosa of the nose, pharynx, and larynx to be practically normal without any sign of crust formation.

We have obtained highly satisfactory results from iron therapy in more than 50% of our ozaena cases. Considering that iron therapy is a substitutive treatment, this is a decisive proof that the disease is caused by iron deficiency. Our findings have been confirmed by others.2 Of course, iron therapy reverses the manifestations of the disease and makes it no longer capable of regeneration. We agree with the authors that their small series of ozaena patients does not justify general conclusions. It would follow from their material that the incidence of atrophic rhinitis is equal among the sexes (4 males, 5 females), although the usual ratio is known to be 1:5 to 2:5 in favour of women. Nor is their table sufficiently clear as regards age distribution. The disease is more frequent in women at the age of sexual maturity, whereas, according to their table, one of the patients was between 30 and 40, three between 40 and 50, two between 50 and 60, and three were more than 60 years of age. I should be glad if the authors were to report later on observations made in connexion with a larger material.—I am, etc.,

I. Bernát.

Robert Károlyi Central Hospital,
Budapest 13, Hungary.

References

2 Hospital Practitioner, 1953, 9, 132.

Unusual Cause of Haematemesis

Sirs.—An 80-year-old man was admitted to hospital in November 1967 with a four-day history of melena and one haematemesis. He gave a history of vomiting of 17 days' duration without anything else of note. On examination he was fat and had epigastric tenderness. A barium meal revealed a sliding hiatus hernia. While in hospital he had haematemeses on two consecutive days and was treated conservatively, but in view of his age and the recurrent bleeding it was decided to perform a laparotomy.

At operation the stomach was full of blood and there were superficial duodenal erosions some of which were covered by blood. There was no other source of bleeding in the oesophagus, stomach, or first, second, and fourth parts of the duodenum. There were two small nodules in the liver far back. In the middle of the body of the pancreas extending into the root of the mesentery there was a small rubery area. This was biopsied and the biopsy report read "adenocarcinoma of the pancreas." In view of his previous fitness, we reopened him and found a leaking pyloroplasty. Mobilization of the third and fourth parts of the duodenum was performed in the body of the pancreas, and the pyloroplasty being in part of the duodenum, it was resected and the body closed. He did well, but died very suddenly on the fifth day. Consent for necropsy was withheld.

The object of describing this case is to draw attention to this rare cause of haematemesis and melena which is not discussed in standard works. Carcinoma of the head of the pancreas may present with melena or haematemesis, but "occult" carcinoma of the body of the pancreas has not been described as doing so.2,4 It illustrates the importance of biopsying the whole duodenum (if it was obvious source of bleeding is found) before embarking on any blind procedure.—I am, etc.,

A. P. R. Aluwhare.
St. Mary's General Hospital,
Milton, Portsmouth.

References


G.P. Obstetric Beds

Sirs.—Dr. K. L. Oldershaw and Mr. J. M. Brudnenn must be congratulated on their article relating to the introduction of an obstetric consultant obstetric beds in a consultant unit (13 July, p. 112). The co-operative spirit which is conveyed by this article is particularly laudable and illustrates the point that consultant and general practitioners should not be competing for "better" results but co-operating for the "best" result.

One item in this article is, however, very disturbing. The authors claim that the liaison with the general practitioner "extends to all levels." This breadth of liaison does not seem to have overcome the problem of the dominating patient in so far as intrauterine death occurred in one pregnancy where the mother had not been, or could not have been, persuaded to accept the benefit of consultant influence. It seems to me very tragic that such excellent conditions it still remains difficult to influence the patient to accept the best in maternity care.

Should the general practitioner adopt a firmer attitude, refusing to accept responsibility for management which he feels is outside his limitation of competence, as he will refuse to renew an appointment on the kitchen table? Is there a need for many of us to take an active part in informing and encouraging our patients towards a change of ideas and attitudes?

It must be emphasized that new organizational systems must be as effective as, or better than, the existing one. It is therefore important that a record of the results of an existing system should be available for comparison before a new one is introduced. Dr. Oldershaw and Mr. Brudnenn's report applies to a densely populated area and would have to be modified if it is to be applied to a rural or semi-rural area.

The present system in use in the Isle of Wight is combined antenatal care, with antenatal hospital and general-practitioner attendances by the patients, for the antenatal period. A careful selection of normal patients is made for the antenatal unit, with a hospital confinement rate of 76.6%. The services of clinical assistants are used extensively in the hospital.

The following results were obtained in 1967 in the Isle of Wight:

<table>
<thead>
<tr>
<th>Total confinements</th>
<th>1,372</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total stillbirth rate</td>
<td>10 per 1,000</td>
</tr>
<tr>
<td>Total perinatal mortality rate</td>
<td>18.4 per 1,000</td>
</tr>
<tr>
<td>Domiciliary confinements</td>
<td>222</td>
</tr>
<tr>
<td>Total perinatal mortality rate</td>
<td>6 per 1,000</td>
</tr>
</tbody>
</table>

These figures show a considerable absolute improvement since the introduction of this system and an improvement relative to national statistics. (Stillbirth rate England and Wales 14.8 per 1,000, perinatal mortality rate England and Wales 25.4 per 1,000.)

The employment of general practitioners living at a distance from the hospital could only be successful if facilities for residence on duty were made available.—I am, etc.,

W. R. Edwards.
Department of Obstetrics and Gynaecology,
St. Mary's Hospital,
Newport, Isle of Wight.

Reference