The admitted incidence of alcoholism in the males was 27 cases (75%) and in the females 15 cases (48%). The actual incidence of alcoholism is almost certainly higher than this as many alcoholic patients, particularly women, are very anxious to conceal the truth.

In Boston, Massachusetts, the proportion of alcoholic cirrhosis was given by Garceau and Chlamer1 as 83% (87% of males and 68% of females) and it has been considered that the aetiologic factors of cirrhosis in the U.S.A. differ from those in Britain. But my experience in Liverpool is closer to that reported from Boston than from London and Birmingham. It would be interesting to hear the observations of physicians in other regions of this country.—I am, etc.,

J. FORSHAW

Seflon General Hospital, Liverpool


3 Garceau, and Chlamer, T. C. N., English Journal of Medicine, 1963, 246, 469.

Medical and Social Problems

Sir,—In “Second Opinion, Please” (28 October, p. 224) an experienced general practitioner requests the admission of a patient to hospital. The consultant geriatrician (“Bobby”), who apparently knows the general practitioner (“Graham”) very well, declines to do so without a report from the hospital social worker.

This appears to represent an astounding lack of trust in the judgement of a colleague, which I certainly hope does not spread to other fields of medicine. Surely a “second opinion” could have been more reasonably provided by the offer of a domiciliary consultation. The social worker’s visit was entirely unproductive in judging the necessity for admission. —I am, etc.,

R. E. W. OLIVER

London W.13

** Dr. Oliver sent a copy of his letter to the authors of the “Second Opinion, Please” he comments on, so it is possible to print their reply below.—Ed., B.M.F.

Sir,—Dr. Oliver has a valuable point, but he misses the one that we were trying to make.

Where a request for admission to the geriatric unit is made on medical grounds—that is, for the investigation and treatment of the patient herself—then immediate admission is offered as with all other hospital departments. Where, however, admission is requested primarily on social grounds—that is, for the relief of other people rather than for the treatment of the patient herself—then there is always a social problem which requires expert assessment. Long experience has convinced us that in this situation a social worker can help more than a doctor. Moreover, on the south coast, and Costa Geriatrica, there has been a high proportion of people and of families and nursing homes. These can often be used to save a hospital bed and the social worker is often the best judge of this.

And I would agree with Dr. Oliver that when an admission to the geriatric unit is requested on medical grounds preliminary screening by a social worker is not necessary.—We are, etc.,

G. M. HUNTER

Bexhill-on-Sea

Sussex

Unusual Bullet Embolus

Sir,—Bullet embolization is rare. Hebein and Christensen2 recorded 30 cases from the literature, and Fattah and others2 reported a bullet embolus of the profunda femoris artery in a man who survived for 10 days after sustaining a penetrating gunshot wound of the heart. Embolization of the bullet occurs when the missile gains access to the blood stream by penetrating the heart wall near the aortic root. Of the 29 reported cases of penetrating injuries of the aorta or the heart analyzed by Garzon and Giedman3 nine survived the original cardiovascular injuries. A common site of lodgement of the bullet is the femoral artery, but it may be carried to the popliteal or even posterior tibial artery. One of us (A.F.) has seen two cases with bullets lodged at the bifurcation of the abdominal aorta.

Occasionally, bullets embolize in the arteries of the upper extremities.4 In the following case the bullet lodged in an unusual site.

A 57-year-old man was found dead in a street beside his cab. He had a gunshot wound on the upper lateral aspect of the right shoulder. At necropsy the bullet was found to have passed to the left, slightly downwards and backwards. It had perforated the upper lobe of the right lung and entered the heart through the anterolateral wall of the right ventricle. From the ventricular cavity the bullet was propelled into the pulmonary trunk and carried as an embolus into the pulmonary artery to the lower lobe of the left lung, from where it was retrieved. The bullet measured 5 mm in diameter and 11 mm in length. The cause of death was haemopericardium and haemothorax.

The presence of a bullet with the help of radiographs so that it can be removed. If in a case of gunshot wound with no exit hole the bullet is not seen in the radiographs in the general direction of fire adduced, a film of the extremities should be obtained. In non-fatal cases bullet emboli to the extremities may cause severe ischaemic changes leading to gangrene. Repair of the primary penetrating injury of the heart or the aorta should be carefully considered to prevent possible delayed haemorrhage. In fatal cases retrieval of the bullet may help in the identification of the gun used.—We are, etc.,

ABDULLAH FATTEH

DEWNEY H. PATE

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1 Hebein, H. C., and Christensen, R. K., Rocky Mountain Medical Journal, 1966, 63, No. 5, 56.


Infections in Hospital

Sir,—In your leading article on this important subject (21 October, p. 127) you rightly comment that it is not possible to