

clinical purposes, the pH remains unaffected, even when blood and heparin are added in equal amounts. This finding may also relate to pH determinations of empyema fluid. These observations should be helpful in interpreting arterial blood gas determinations, especially in situations where only small aliquots of blood are available for analysis or carelessness occurs in obtaining a sample.

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Diagonal Earlobe Creases

TO THE EDITOR: The excellent work reported by Jorde, William and Hunt¹ found a lack of association between diagonal earlobe creases and other cardiovascular risk factors (blood pressure, smoking, weight, height, skin-fold thickness, cholesterol, high-density lipoprotein, intracellular sodium, sodium-lithium countertransport and renin).

I would like to take this opportunity to comment on my own incidental observations made while conducting studies on weight gain secondary to amitriptyline maintenance in a hemodialysis population.² In two distinctive regards, observed earlobe creases were prominent: (1) the age of the patients was relatively young, the incidence of creases absolutely and relatively high and (2) the degree to which creases existed was great. Frequently the earlobes were divided in two with each half of the bilobe appearing spherical. Unfortunately, no simple quantitative method was devised for measuring the full range of changes observed; so a contemplated study was not carried out. This area remains open for other investigators.

The question of physiologic factors (for example, tissue fluid tides) and external mechanical factors (such as compression by a pillow while sleeping) comes to mind. Obviously anephric patients accumulate water, salt and waste products between dialyses. These are stored in the first, second and even third fluid spaces. With potassium levels high some measure of intracellular as well as extracellular edema could be expected.

A linear observation of my own earlobes made over a 12-year period showed them to be uncreased at first, then later creased. The depths of my own diagonal creases were generally not stable, and the surrounding earlobe tissue composition likewise seemed to vary. When the substance of the lobes was engorged, the lines were deep and suggested cleavage. When dietary

restriction and physical activity, on the other extreme, had led to "dehydration," the skin of the earlobes appeared loose, the diagonal lines little more prominent than many other lines that appeared locally; a deflated rubber balloon was suggested.

An additional observation made was that of easy bruisability; manipulation of earlobes, even though not severe, occasionally led to bruises. This was a variable finding sometimes suggested by the presence of pre-existing discoloration. In my own case, bruisability came and went. The causes were not studied.

The suggestion to be found in all of these observations is that genetic, hormonal, dietary and mechanical factors all can play a role in the development of diagonal earlobe creases. The question is, do these same factors simultaneously influence the development of coronary artery disease?

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Flexible Sigmoidoscopy— A Provocative Test?

TO THE EDITOR: We are all aware of the "chandelier sign" wherein a patient with pelvic inflammatory disease leaps toward the ceiling during manipulation of the cervix on pelvic examination. We have observed a less dramatic but still impressive response during flexible sigmoidoscopy of patients sent to us with unexplained abdominal discomfort or with a tentative diagnosis of irritable bowel syndrome. Upon manipulation of the instrument or air insufflation, these patients also writhe and contort with pain. When specifically asked if this is the identical discomfort that brought them to us, or whether it is an entirely different sensation, 29 of 41 patients (70.73%) said it was identical.

We suggest that when this phenomenon is observed in the presence of a negative workup, this sign be taken as evidence for irritable bowel syndrome. We feel that flexible sigmoidoscopy should be considered not only a useful tool to exclude other diseases of the distal colon but also a provocative test in this setting because irritable bowel syndrome is primarily a diagnosis of exclusion. Additionally, a positive response is reassuring to both patient and physician.

On the other hand, lack of this sign could be produced by a spastic component proximal to the splenic flexure. Colonic spasm is frequently seen in sigmoidoscopy and appears to have no correlation with production of pain.

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