Letters to the Editor

Preference is given to letters commenting on contributions published recently in the JRSM. *They should not exceed 300 words and should be typed in double-spacing.*

Calculus in a congenital recto-urethral fistula: a late presentation

Sir, An increasing number of children with major congenital anomalies who were treated as neonates are surviving to adulthood and practitioners in a variety of specialties will encounter them. Some will present with difficult surgical problems. The case of calculus in a congenital recto-urethral fistula reported by Rowe *et al.* is an example (July 1988 *JRSM*, p 422).

Innes Williams and Grant have described the problems of recto-urethral fistula in high anomalies of the rectum[1]. Although such a late presentation is rare, complications relating to the fistula, including that described, are well recognized in paediatric practice, albeit little written about. A large urethral diverticulum with calculus formation and even recurrence of the fistula results from division of the fistula short of the urethra at the time of pull-through. It is extremely unlikely that the fistula was missed during the course of an abdomino-anal operation in the case described because the fistula represents an extension of the rectum itself in high anomalies, and is thick walled[2]. Flush division of the fistula in the neonate is hazardous and it may not always be divided close to the urethra or even formally closed. The rarer types of urethral fistula which tend to be missed are fistulae without atresia or those lying below the pelvic floor in association with a low anomaly[1].

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References

1 Williams DI, and Grant J. Urological complications of imperforate anus. *Br J Urol* 1969;41:660-5
2 Durham Smith E. The bath water needs changing, but don't throw out the baby: an overview of anorectal anomalies.*J Pediatr Surg* 1987;22:335-48

Death, dissection and the destitute

Sir, Your reviewer of Ruth Richardson's recently published book (July 1988 *JRSM*, p 433), is entitled to his view that the author's account is 'a polemic, insisting on class war as the explanation for evil', but your readers are surely entitled to a more balanced view of its great merit and interest. It is certainly the case that Miss Richardson approaches the whole question of the attitude to corpses, body-snatching and dissection from a distinctly sociological position. But it is also the case that the late 18th and early 19th centuries were an insensitive period, and it is easy to overlook the fact that the advances in surgery and anatomical knowledge made at that time, by distinguished men like Astley Cooper and his contemporaries, were achieved at the cost of great suffering and misery, largely falling on the indigent. Perhaps, inevitably and understandably, the majority of the surgeons and anatomists of the day were, at least to our view, insensitive and even cynical in their attitude to this aspect of their work, but it is surely right that both sides of the story, the advances in knowledge and in surgical technique and the price in terms of human suffering at which they were obtained, should be recorded.

Miss Richardson certainly focuses on the horrors and suffering attendant on the study of anatomy in the period covered in her study, and she clearly shows indignation that the main burden consequently fell on the poor. At the same time her book is an outstanding work of scholarship, meticulously documented, which many will find absorbing reading.

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Magnetic resonance muscle studies

Sir, Yonge's comprehensive review (June 1988 *JRSM*, pp 322-6) of the role of magnetic resonance imaging (MRI) in the study of muscle pathophysiology draws attention to an important observation concerning muscle metabolism in patients complaining of the so-called postviral fatigue syndrome (PVS) or myalgic encephalomyelitis (ME), namely, that it readily becomes acidic early in effort. The original observers of this phenomenon[1] postulated that the abnormal acidosis early in effort could be caused either by reduced intracellular buffering capacity or by impaired extrusion of acid from the cell. They plumped for the latter because they found a relatively normal pH was recovered later in the experiment.

There is a striking similarity between the symptoms of so-called ME[2] and those recognized and treated conventionally as 'effort syndrome' or chronic habitual hyperventilation[3] where the clinical syndromes, particularly the fatigue and incapacity for effort, depend upon the reduction of buffer base reserves[4]. Lum has pointed out that hyperventilators continue to overbreathe after exercise and this readily accounts for the subsequent return of pH to normal. Capnography enables hyperventilation to be investigated non-invasively in clinical practice today. We tested 15 patients purporting to be suffering from ME and the results were unambiguously positive in all.

None of the reviews published to date have excluded hyperventilation in the investigation of ME or PVS patients: this is surely a necessity if tenuous disease categories are not to be created. Professor Mowbray rightly pointed out in his editorial[5] that, 'by the rather loose labelling of virus infections, we may prevent ourselves from taking a step back and looking more widely at the causes of a disease.'

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References

1 Arnold DC, Bore PJ, Radda GK, Styles P, Taylor DJ. Excessive intracellular acidosis of skeletal muscle on exercise in a patient with a post-viral exhaustion/fatigue syndrome. *Lancet* 1984; i: 1367-9
2 Ramsay AM. Epidemic neuromyasthenia 1955-1978. *Postgrad Med J* 1978;54:718-21