

at 5-12 h from onset of symptoms, and 38% ($2P=0.01$) at 13-24 h. The numbers of patients available for these subgroup analyses were 3643 and 1222 respectively.

Indications of a beneficial effect of thrombolysis in patients treated 'late' after the onset of symptoms of myocardial infarction were found in studies² carried out in the 1970s. This was the basis for the inclusion of time delay as a primary hypothesis in ISIS-2. By the end of the study 9720 patients had been randomized at 5-24 h after the onset of symptoms in the various treatment groups. Comparison with the total size of other thrombolytic trials such as ASSET (tissue plasminogen activator versus placebo, $n=5011$), AIMS (APSAC versus placebo, $n=1004$) and ECSG (tissue plasminogen activator versus placebo, $n=721$)³⁻⁵ which did not include late treated patients underlines the weight of evidence in favour of the use of streptokinase and aspirin at any time up to 24 h after the onset of symptoms in patients without contraindications.

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References

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Irritable bowel syndrome

I read Whorwell's paper on the 'Diagnosis and management of the irritable bowel syndrome' (October 1989 *JRSM*, p 613) with interest and full agreement. I would add two characteristics which in my opinion are very significant to the criteria for diagnosis which Whorwell describes, they are:

(1) The very definite pattern in which irritable bowel pain resolves once the patient gets into bed at night and sleeps. Very rarely does IBS pain give the sufferer a bad night and usually does not cause him to wake up during the night with recurrence of pain, whereas pain caused by organic disease is often worse at night, preventing sleep.

(2) The important part which intestinal gas plays in the causation of IBS pain. Some authorities claim that the IBS patient does not produce excess gas but the colon especially is very sensitive to collections of gas and spasm occurs where gas

collects resulting in colic. If the patient is able to pass this gas by for example lying down on the left side the spasm and pain usually resolves. I suggest that the IBS colon is very sensitive to gas pressure and that the propensity of some food, especially vegetables to generate gas is more important than classical food sensitivity for the prevention of spasm and pain. I believe that the development of a drug to minimize gas production in the irritable colon would be of considerable benefit in the management of this common and troublesome condition. The relief at night appears to be due to the easier passage of gas in these patients when lying in the horizontal position.

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Bilothorax - an unusual problem

I think that Rowe may have missed the point with his 'unusual case of bilothorax', (November 1989 *JRSM* p 687). His patient had had a gastrectomy 40 years earlier, presented with pancreatitis, but the management was conservative.

The classic textbook of emergency surgery unequivocally states that 'if there is a scar on the abdomen which suggests, or is known to be the result of, previous gastric surgery and the patient has the clinical and biochemical features of acute pancreatitis *he should be explored*' (author's italics)¹. This is because the pancreatitis is really due to efferent loop obstruction. Ultrasound in the case presented did show a distended epigastric loop yet laparotomy was not performed until perforation had occurred.

The significance of pancreatitis after gastrectomy was well known to the older generation of gastric surgeons but the message evidently requires re-emphasis.

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Paget's disease of bone

We were concerned about the conclusions drawn by Gray *et al.* (October 1989 *JRSM*, p 626), in their case report of implant failure following the internal fixation of a femoral fracture in a patient with Paget's disease of bone. They state that 'an interlocking intra-medullary nail was inserted' in the treatment of the fracture, which failed 4 months following internal fixation. The radiograph presented (Figure 1c) shows what would appear to be a Grosse and Kempfe femoral nail, which has been proximally (and one presumes distally) locked. The fracture would appear to have been 'held apart' by the interlocking nail, and this may well have been an important factor in the development of the subsequent non-union. The fracture was shown to be healing satisfactorily (Figure 1d) following removal of the interlocking nail and its replacement with a Kuntscher intramedullary nail. The replacement nail would have allowed for impaction of the fracture, and this would have encouraged the fracture to unite.