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Hemorrhagic colitis associated with *Escherichia coli* O157:H7

A 62-year-old woman had severe abdominal cramps followed by watery diarrhea on July 2, 1984. The next day she was seen at an outpatient clinic in Rosetown, Sask. complaining of "flu-like symptoms". She stated that she "felt warm". No blood was present in the stool. Three days later she had several bowel movements that appeared to be "completely blood" and was admitted to the local hospital. She continued to pass bloody stools for the next 2 days and was treated with fluid replacement. Her temperature remained normal. By the third hospital day there were only traces of blood in the stool. The next day she was discharged from hospital free of symptoms.

Two stool specimens taken July 7 were described in the laboratory as "red fluids". When cultured they grew sorbitol-negative *Escherichia coli* serotype O157 but showed no evidence of *Salmonella*, *Shigella*, *Campylobacter* or *Yersinia*. The isolate was confirmed by the Enteric Bacteriology Division, Laboratory Centre for Disease Control, Ottawa as an *E. coli* strain that in culture produced a cytotoxin against vero cells.

The patient had visited Saskatoon on June 29 and had eaten meatloaf in a restaurant. No other cases were detected in Rosetown or Saskatoon. Meat samples were not available for investigation.

Comments

Cases of hemorrhagic colitis associated with *E. coli* O157:H7 have been reported from at least six provinces across Canada.[1] This serotype of *E. coli* may not be as rare as earlier reports suggested.[2] Findings common to most of the reported cases include crampy abdominal pain; acute watery diarrhea, followed by grossly bloody diarrhea; normal or slightly above-normal temperature; and recent ingestion of hamburger meat.

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Association of Sjögren's syndrome with psoriatic arthritis

In their study "Frequency of HLA antigens in patients with psoriasis or psoriatic arthritis" McKendry and colleagues (*Can Med Assoc J* 1984; 130: 411–415) reported that 16 of the 64 patients with psoriatic arthritis had a positive result of the antinuclear antibody (ANA) test (a titre of 1:20 or greater).

In 80 patients with psoriatic arthritis we found 4 (3 females and 1 male) to have a positive result of the ANA test.[1] The titres were 1:160 in three of the cases and 1:320 in the fourth, and in all four indirect immunofluorescence showed a homogeneous pattern. Two of the patients also had elevated titres of rheumatoid factor (1:1280), demonstrated by latex fixation.

The four patients had associated Sjögren's syndrome; xerophthalmia was shown by Schirmer's test and xerostomia by sialography.

In patients with psoriatic arthritis who have a positive result of the ANA test the possibility of associated Sjögren's syndrome should be investigated.

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Unusual use of ultrasound in a paranoid patient

The headlong and calculated pursuit of the destruction of human life can be called by many names, but "creative" is most certainly not one of them. The tragedy referred to in the letter by Cook and Howe (*Can Med Assoc J* 1984; 131: 539) was not avoided: it was perpetrated on the life of an innocent being.

The use of ultrasonography or any other new technique for such a deviant purpose does not offer an acceptable solution to the problem but succeeds only in compounding it.

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I have read and reread Cook and Howe's letter and find it hard to describe the feelings that it evokes within me. The abortion issue has been debated at length and will probably continue to be. I think that the extent to which any individual believes in or takes part in abortions is a very personal issue and not one that I can pass judgement on.

None the less, the letter from Cook and Howe disturbs me, I think in part because of their feeling that they have made a "creative use of technology" and that they have avoided a "possible tragedy" by taking the life of a human being because of the "risks" to it. What risk could have been higher to that person (the fetus) than death?

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Can vitamins prevent neural tube defects?

Smithells (*Can Med Assoc J* 1984; 131: 273, 274, 276) adds some useful new data and observations in response to my article.[1] We are in agreement that although there were differences in the social class, area of residence and previous reproductive history of the two groups in his trial, these differences do not explain the results.

The interpretation of the results, however, hinges on the specific weakness of nonrandomized trials: no adjustment can be made for factors that might affect the outcome and that are not assessed. Only a randomized trial with adequate numbers of subjects gives a reasonable probability that there will not be major differences between the treatment groups in factors that are not assessed. The substantial differences between Smithells' two groups in the measured factors, such as social class, raise the question of whether there were also differences in other factors that were not measured — for example, other aspects of diet. Such differences may have arisen through the different methods of entering the subjects in the two groups. The voluntary response to the offer of supplements was only one aspect of this process; the control group was composed predominantly of women who, unlike those who received supplements, had not been referred to the study centres before becoming pregnant again.

Smithells objects to my inclusion of natural incredulity among the factors contributing to the assessment of scientific evidence. But in the alternative guises of "biologic plausibility" or "coherence" it has been accepted by many authorities who have attempted to define criteria for accepting a causal interpretation, including Hill[2] and the United States surgeon general.[3] It is an uncertain criterion and can erroneously hold up acceptance of a dramatic new finding that may lead to progress in related areas. I included it because I was reviewing not only Smithells' study but also the reactions of the profession to it, and the incredulity or plausibility factor certainly exists.

The suggestion that the great difference in recurrence rates of neural tube defects in different Dublin hospitals might have been due to differing routines in supplying supplements after discharge is a very interesting one; unfortunately, we have no information on whether the supplements were taken or on the interpregnancy intervals. Kirke[4] does not feel that differing routines are likely to explain the differences in recurrence rates.[5]

The preparation used did not contain vitamin B_{12}, of course; the suggestion was that low vitamin B_{12} levels might be associated with neural tube defects and that folates might act by counteracting some effects of vitamin B_{12} deficiency.[6]

I continue to hope that Smithells' results are valid, because they offer the most dramatic advance in preventive medicine in many decades, but I regard the evidence supporting them as still insufficient. Clarification will come with the results of the current randomized trials.[7]

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