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Medical Research Council Blood Pressure Unit, Western Infirmary, Glasgow G11 6NT

P. L. PADFIELD, M.B., M.R.C.P., Clinical Scientist

Prolapsing Thrombosed Haemorrhoids: Outcome of Conservative Management

Prolapsed thrombosed haemorrhoids are a common and painful surgical emergency. Though emergency haemorrhoidectomy was discussed as early as 1914[1] the usual treatment in the United Kingdom is non-operative. The natural history of thrombosed haemorrhoids managed conservatively, however, is not known and there are no reports on whether patients continue to have symptoms. We report here the incidence of continuing symptoms after recovery from an acute episode and the incidence of subsequent elective haemorrhoidectomy.

Methods and Results

The records of all patients attending St. Mark's Hospital from 1962 to 1967 with prolapsed thrombosed haemorrhoids were studied. Basic information was extracted and several patients examined.

Altogether 117 patients presented in this period; all were managed conservatively. Four patients had died, 21 could not be traced, and further information was available about 92. At the time of their original presentation 47 (40·2%) patients had had their symptoms for more than three years and 10 (8·5%) for more than 10 years. More patients (69) complained of prolapse than complained of rectal bleeding (62); 47 complained of both. Six patients had had a previous episode of thrombosis. Nineteen patients denied having previous symptoms. Despite these symptoms only 10 (8·5%) patients had had previous treatment; seven had had their haemorrhoids injected while three had had a haemorrhoidectomy performed elsewhere. After treatment at St. Mark's 80 (68·4%) of the 117 patients continued to complain of symptoms. Only 12 (13·0%) of the 92 patients traced had had no further trouble and five of these had had no symptoms before the acute episode. More patients (58) continued to complain of prolapse than complained of rectal bleeding (51); 39 had both. Ten patients had a further episode of thrombosis. Only 27 (23·1%) patients had no further treatment, 45 (38·5%) had their haemorrhoids injected, and 64 (54·7%) were advised to undergo a haemorrhoidectomy because of continuing symptoms. Of the 24 patients with a previous history of less than three years only eight (33%) were advised to undergo a haemorrhoidectomy. In contrast, 35 (74·5%) of the 47 patients with a history of longer than three years were advised to undergo haemorrhoidectomy ($P<0·05$). Only 13 (35·1%) of the 37 patients who did not complain of prolapse were advised to undergo a haemorrhoidectomy compared with 46 (66·7%) of the 69 patients with prolapse ($P<0·05$). Thirty-three of the 42 patients whose history was longer than three years and included prolapse but only eight (42·1%) of the 19 patients with prolapse but a history of under three years were advised to undergo haemorrhoidectomy ($P<0·05$). None of the five patients with symptoms but no prolapse and a history of under three years were advised to undergo haemorrhoidectomy ($P<0·05$), and only six (31·6%) of the 19 patients who had no previous symptoms were so advised ($P<0·001$).

Discussion

There has been no review of the long-term results of conservative management of acutely prolapsing thrombosed haemorrhoids. Our results have shown that thrombosis is merely an episode in the natural history of the disease and does not influence subsequent symptoms.

Two factors in the patient's history are particularly important when assessing the probability of symptoms after the acute episode: a history of more than three years and one which includes a story of prolapse. Several small series have suggested that the incidence of complications after emergency haemorrhoidectomy is no higher than that after routine haemorrhoidectomy;[2 4] in particular the incidence of ascending portal infection has been exaggerated.[5]

The incidence of complications after emergency haemorrhoidectomy needs to be properly assessed in a prospective study. As our results have shown that there is a high incidence of continuing symptoms in patients treated conservatively a previous history of prolapse and a history of longer than three years or both are strong indications for emergency haemorrhoidectomy.

We thank the surgeons of St. Mark's Hospital for allowing us to study patients under their care, and Mr. Broughton and Fison's Pharmaceutical Company for financial assistance. We are particularly grateful to Mrs. Green for her help in tracing the patients.

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St. Mark's Hospital for Diseases of the Rectum, London EC1V 2PS

R. H. GRACE, M.B., F.R.C.S., Senior Registrar (Present appointment: Consultant Surgeon, Royal Hospital, Wolverhampton)

St. Thomas's Hospital, London S.E.1

A. CREED, Medical Student (Present appointment: House Physician, Kingston Hospital, Kingston upon Thames, Surrey)

Infantile Kala-azar in Britain

With increased travel and immigration protozoal infections are being diagnosed more often outside endemic areas.[1] We have seen two British children who developed kala-azar after holidays in Mediterranean countries.

Case Reports

Case 1.—A 15-month-old girl was admitted to hospital with a seven-week history of increasing lethargy, anorexia, and intermittent fever with associated rigors at night. The family had been on holiday in Corfu six months earlier. She was found to have hepatosplenomegaly and slight lymphadenopathy. Since it was feared she might have an underlying malignancy she was transferred to the Hospital for Sick Children. Investigations showed haemoglobin 8·0 g/dl, white blood count (W.B.C.) $2·5 \times 10^9$/l (neutrophils $0·3 \times 10^9$/l), and platelets 50×10^9/l. Tests for salmonella, brucella, and tuberculosis and blood cultures were negative, and serum electrophoresis showed diffusely raised γ-globulin. A hypercellular marrow aspirate showed increased granulopoiesis, and after much searching we found a few reticulum cells containing Leishman-Donovan bodies. Leptomonads were isolated from cultured aspirated marrow, and the Leishmania fluorescent antibody test gave a positive result. After transfusion she was treated with intravenous sodium stibogluconate (Pentostam) 10 mg kg body weight^{-1} day^{-1} for three weeks. She responded dramatically, becoming apyrexial within 24 hours (see fig.). The hepatosplenomegaly receded over the first 10 days of treatment.

Case 2.—This girl was well until the age of 8 months, when she developed a fever and on admission to hospital was found to have hepatosplenomegaly and lymphadenopathy. Investigations showed haemoglobin 7·9 g/dl, W.B.C. 8×10^9/l (neutrophils $2·66 \times 10^9$/l, and platelets 53×10^9/l. Marrow aspiration yielded a normocellular sample showing erythroid hyperplasia and plentiful megakaryocytes. Investigations for bacterial and viral infections were negative; serum γ-globulin was raised; Rose-Waaler and latex tests for rheumatoid factor were positive. Her haemoglobin fell to 6·4 g/dl and she was transfused. She was discharged with a tentative diagnosis of Still's disease. She appeared well for almost six weeks but then intermittent fever recurred, and she was admitted to the Hospital for Sick Children, aged 11 months, for further investigation. She had hepatosplenomegaly, lymphadeno-