The bleeding limit

To the editor: There are many objectionable statements in Robert McCaldon's article "Don't bleed on my carpet" (*Can Med Assoc J* 115: 679, 1976). One of the most striking is "those whom seem hell-bent on... [suicide] should not be impeded in the fulfilment of their destiny". The naïve assumption that people are the way they are because they want to be that way is distinctly unprofessional. The good physician should encourage, not discourage, further study into the causes and remedies of conditions that lead to self-destructive behaviour.

In manic-depressive illness the suicide rate used to approach 20%. The disease was so devastating that arguments for allowing patients to destroy themselves might have had marginal acceptance as recently as 1950. The introduction of lithium therapy has laid such arguments to rest. Many conditions that appear hopeless today may not be so within months or years. The good physician should make reasonable efforts to keep people alive in the hope that truly helpful remedies for their problems will appear.

No sensible editor would permit me sufficient space to enlarge on my other objections to "Don't bleed on my carpet". In general, the bombastic, cynical and nihilistic style smacks of rhetoric and polemic and is distinctly lacking in thoughtful consideration of the serious problem of the limits of clinical medicine.

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Circumcision

To the editor: Some time ago Dr. L.J. Genesove quoted my wartime studies (Circumcision and venereal disease. *Can Med Assoc J* 56: 54, 1947) in defence of circumcision. The reason for my original inquiry was that discussions on circumcision were seldom supported by factual observations.

The situation has not changed much in the last 30 years. Nursery committees still make pronouncements on the subject without examination of the available data.

I would like to see data collected on the frequency of penile pathology — warts, balanitis, chancroid and venereal lesions — in the circumcised v. the uncircumcised. The role of the uncircumcised male as a vector for trichomoniasis, candidiasis or nonspecific urethritis should also be studied. Such studies should be correlated with the social status and sexual habits of the subjects for validity.

Complications are common when circumcision is done without good judgement or surgical skill, so there should be more documentation of the incidence of such complications and the incidence and ill effects of meatal ulcer in circumcised children.

Phimosis still occurs in children with conscientious parents (Fig. 1). I am

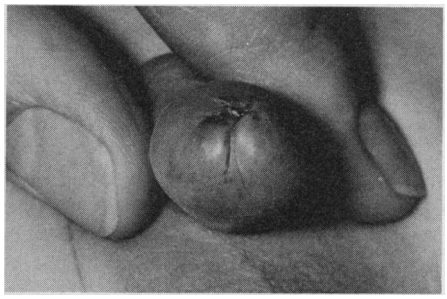

FIG. 1—Phimosis in young child.

also told by my colleagues in geriatrics that similar complications occur in the aged, cause much suffering and may require surgery.

This letter is written as a plea for more light and less heat in discussions regarding circumcision.

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Thrombotic thrombocytopenic purpura

To the editor: Gundlach and Tarnasky recently commented on the treatment of thrombocytopenic purpura (TTP) (*Can Med Assoc J* 115: 1194, 1976). It is now apparent that with three forms of therapy a number of patients have recovered from TTP. These forms of therapy were the use of steroids and splenectomy, the administration of platelet suppressant drugs and, more recently emphasized, the use of exchange transfusions[1] or plasmapheresis (I. Cooper: personal communication, 1977). Although it is now generally accepted that disseminated intravascular platelet aggregation occurs in TTP, its mechanism is uncertain. Favourable results with exchange transfusion support the possibility that the trigger for the platelet aggregation in TTP is an intravascular stimulus,[2] perhaps a circulating immune complex.

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Hypertension secondary to bilateral hydronephrosis

To the editor: Hypertension resulting from hydronephrosis is rare.[1] The following is a case of hypertension secondary to bilateral hydronephrosis of a relatively limited duration.

A 58-year-old man presented in July 1972 with features suggestive of prostatic hypertrophy of approximately 5 years' duration. At that time the blood pressure had been recorded as 142/84 mm Hg, the blood urea nitrogen (BUN) value was 8.2 mg/dl and intravenous pyelography showed findings consistent with prostatic hypertrophy, but indicated normal function of the kidneys.

In January 1975 he complained of lower abdominal discomfort, troublesome frequency of micturition, thirst and frequent headaches. His bladder was palpable but not tender and a large benign prostate was detected. The blood pressure was 200/120 mm Hg in both arms and the BUN concentration was 52.0 mg/dl. Intravenous pyelography on Jan. 9, 1975 showed gross bilateral hydronephrosis secondary to chronic retention of urine (Fig. 1).

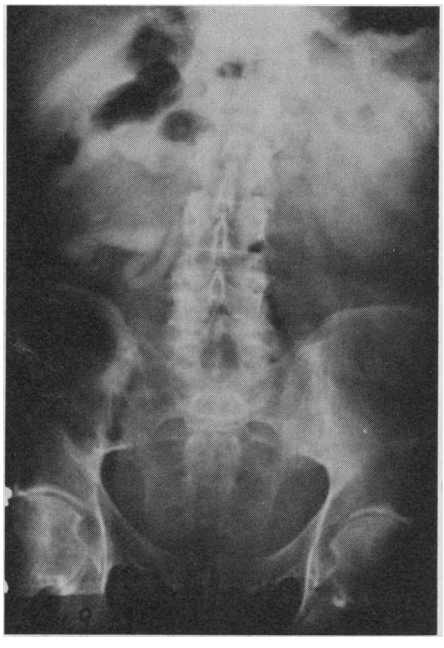

FIG. 1—Gross bilateral hydronephrosis secondary to chronic retention of urine.

Retropubic prostatectomy was performed on Jan. 17, 1975, when 49 g of prostatic tissue was removed. Postoperatively his blood pressure decreased: it was 110/80 mm Hg 24 hours after operation, 140/80 mm Hg on Jan. 22, 1975 and 140/90 mm Hg on Feb. 11, 1975. The BUN value was 12.5 mg/dl on Feb. 11, 1975. Intravenous pyelography on Feb. 19, 1975 showed resolution of hydronephrosis (Fig. 2).