also multiplistic — that is, the factors causing the psychosocial maladjustment and the organic factors contributing to the relapse had to be elucidated. Was there partial bowel obstruction? Was there ileal disease resulting in bile salt malabsorption? Were there fistulas? What was the patient's nutritional state? Did she need parenteral hyperalimentation? Was there sufficient disease activity to necessitate treatment with salicylazosulfapyridine or steroids, or both? What would be the optimal time for surgical correction of possible strictures or fistulas? It would have been equally wrong to have treated only the organic aspects of this disease as to have treated the patient only with supportive or deep psychotherapy. As Drs. Taylor and Davies state, "Clearly, management required close attention to these psychosocial factors as well as the biologic aspects of her illness."

I also agree with the statement by Drs. Taylor and Davies that the physician who treats organic disease should also consider the psychologic factors and, in most instances, should be able to deal with these without help from a psychiatrist. There are, however, situations in which severe psychiatric illness has to be identified and expertly treated, in which case a consultation with a psychiatrist may become necessary.

It is amusing that Drs. Taylor and Davies accuse us of a "mind–body dichotomy". Is it not true that it is some schools of psychiatry that perpetrate this separating of mind from the functions of the endocrine and central nervous systems?

As with our inability to establish an etiologic diagnosis for diarrhea, this dichotomy of mind and body "may reflect only the fact that all questions have not yet been answered and that further research is needed" to reveal the biochemical, neurologic and cell biologic abnormalities that lead to maladjustment of the psyche to social factors. After all, most people can deal in one way or another with their environment. Not every patient acquires Crohn's disease when she discovers that her sister is her mother; there must be some basic "organic" abnormality in the reaction pattern of the central nervous system of an individual to produce a somatic response to psychologic and social stress.

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Primary meningococcal peritonitis

To the editor: It is not unknown for meningococcal disease to present as an "acute abdomen".[1] Although meningococcal peritonitis is rare, a fatal case was described as long ago as 1917.[2] A second case, with some of the features of an appendiceal abscess, was reported in 1938.[3] In each of these cases the peritonitis was associated with meningococcal infection at another site. In the case reported below the symptoms were entirely abdominal and the findings were typical of those of primary peritonitis.

A 4-year-old girl had had fever and increasing generalized abdominal pain for 1 day. The pain was maximal in the umbilical area and aggravated by movement, so much so that she was unable to stand or walk. She had vomited twice.

She looked ill and had a temperature of 39.3°C, tachycardia and a furred tongue. A full, rigid abdomen was noted, with rebound tenderness in the right lower quadrant. The peripheral leukocyte count was 27.8 x 10^9/L with 82% neutrophils and 9% band forms. Blood drawn upon admission yielded no organisms on culture.

Appendicitis was suspected and an operation performed. The peritoneal cavity contained a small amount of free, yellowish exudate that also coated the bowel. The appendix appeared grossly normal; it was removed. The clinical impression was later confirmed histopathologically although serosal changes indicative of peritonitis were reported.

A swab of the peritoneal exudate yielded a pure growth of group C sulfonamide-resistant *Neisseria meningitidis.* Ampicillin, 400 mg/kg•d, administered intravenously *q6h,* was commenced and continued without interruption for 7 days. At the end of this time the patient, whose postoperative course had been uneventful, was discharged.

Two ward roommates, the patient's parents and two siblings received a 2-day course of rifampin, the standard chemoprophylactic regimen for close contacts of patients with meningococcal disease. Only one sibling was subsequently discovered to be harbouring *N. meningitidis* in her throat. Our patient's throat was free of the organism at the time of discharge.

The source of the *N. meningitidis* was not established in this case although it is tempting to incriminate the sibling who carried the meningococcus in her throat.

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