Ozaena and Iron Deficiency

SIR,—Dr. Håkon Barkve and Dr. Gisle Djupesland (11 May, p. 336) state that iron deficiency is a common disease in Norway, but ozaena is rare. This applies to Hungary also; although sideropenic dysphagia is still less frequent here than ozaena, we—like Waldenström[1]—are convinced that it is due to iron deficiency.

It is further stated by the authors that none of their nine ozaena patients revealed signs of iron deficiency. Four women had, however, taken iron for long periods. The question arises why these patients received iron if no deficiency was present, further, whether iron deficiency could be expected after prolonged iron treatment. One patient is stated to have had fissures in the corner of the mouth, but the authors fail to point to the probable aetiological factor of the phenomenon. Iron concentration in the serum of another patient was low, and so was the iron content of his marrow. Yet no iron deficiency was diagnosed. The four iron-treated patients had not observed any change in the ozaena during the therapy. It would be interesting to know whether objective changes did occur in these cases. Patients do not always estimate changes in their condition correctly; it happens that they feel improvement although the local manifestations of ozaena remain unchanged, while also the opposite may occur.

A female medical student aged 22 years was recently seen in this clinic. She had been suffering from ozaena since the age of 6, was subjected to nasal surgery at the age of 12, and solicited medical aid because she felt that iron therapy, prescribed by her physician a year before, had improved her disease but very slightly. Rhinolaryngological examination showed the mucosa of the nose, pharynx, and larynx to be practically normal without any sign of crust formation.

We have obtained highly satisfactory results from iron therapy in more than 50% of our ozaena cases. Considering that iron therapy is a substitutive treatment, this is a decisive proof that the disease is caused by iron deficiency. Our findings have been confirmed by others.[2,3] Of course, iron therapy remains unsuccessful if the mucosa is irreversibly atrophied and no longer capable of regeneration. We agree with the authors that their small series of ozaena patients does not justify general conclusions. It would follow from their material that the incidence of atrophic rhinitis is equal among the two sexes (4 males, 5 females), although the usual ratio is known to be 1:5 to 2:5 in favour of women. Nor is their table sufficiently clear as regards age distribution. The disease is more frequent in adolescence, and—in women—at the age of sexual maturity, whereas, according to their table, one of the patients was between 30 and 40, three between 40 and 50, two between 50 and 60, and three were more than 60 years of age. I should be glad if the authors were to report later on observations made in connexion with a larger material.—I am, etc.,

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Unusual Cause of Haematemesis

SIR,—An 80-year-old man was admitted to hospital in November 1967 with a four-day history of melaena and one haematemesis. He gave a history of vague dyspepsia but nothing else of note. On examination he was fat and had epigastric tenderness. A barium meal revealed a sliding hiatus hernia. While in hospital he had haematemeses on two consecutive days and was treated conservatively, but in view of his age and the recurrent bleeding it was decided to perform a laparotomy.

At operation the stomach was full of blood and there were superficial duodenal erosions which were not bleeding. There was no other source of bleeding in the oesophagus, stomach, or first, second, and fourth parts of the duodenum. There were two small nodules in the liver far back. In the middle of the body of the pancreas extending into the root of the mesentery there was a small rubbery area. This was biopsied. The head of the pancreas was normal. It was thought the duodenal erosions had been the cause of the bleeding. I underran them and did a vagotomy and pyloroplasty.

Six days later it was evident that he was still bleeding, and that the pyloroplasty had broken open. The biopsy report read "adenocarcinoma of pancreatic origin." In view of his previous fitness, we reopened him and found a leaking pyloroplasty. Mobilization of the third part of the duodenum revealed a carcinoma in the body of the pancreas invading and partly obstructing it, with a walnut-sized cavity in the pancreas. A gastroenterostomy was done, the pyloroplasty repaired, and the abdomen closed. He did well, but died very suddenly on the fifth day. Consent for necropsy was withheld.

The object of describing this case is to draw attention to this rare cause of haematemesis and melaena which is not discussed in standard works. Carcinoma of the head of pancreas may present with melaena or haematemesis, but "occult" carcinoma of the body of the pancreas has not been described as doing so.[1-3] It illustrates the importance of examining the whole duodenum (if no obvious source of bleeding is found) before embarking on any blind procedure.—I am, etc.,

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G.P. Obstetric Beds

SIR,—Dr. K. L. Oldershaw and Mr. J. M. Brudenell (13 July, p. 112) have carried out an excellent experiment in the organization of an obstetric service in their area which has provided general practitioners with the opportunity of using and maintaining their skills in this branch of medicine. They have shown that this can be done while maintaining the highest standards. It is to be hoped that this will be the forerunner of similar schemes elsewhere. It is clear that the success achieved was dependent on the close co-operation and understanding between the general practitioners and hospital staff involved. It is this feature that is one of the most heartening aspects of the report.

It must be emphasized that new organizational systems must be as effective as, or better than, the existing one. It is therefore important that a record of the results of an existing system should be available for comparison before a new one is introduced. DR. Oldershaw and Mr. Brudenell's report applies to a densely populated area and would have to be modified if it is to be applied to a rural or semi-rural area.

The present system in use in the Isle of Wight is combined antenatal care, with alternate hospital and general-practitioner attendances by the patients, for the antenatal period. A careful selection of normal patients is made for domiciliary delivery, with a hospital confinement rate of 76.6%. The services of clinical assistants are used extensively in the hospital.

The following results were obtained in 1967 in the Isle of Wight:

Total confinements	1,372
Total stillbirth rate	10 per 1,000
Total perinatal mortality rate ...	18.4 per 1,000
Domiciliary confinements ...	322
Total stillbirth rate	6 per 1,000
Total perinatal mortality rate ...	9 per 1,000

These figures show a considerable absolute improvement since the introduction of this system and an improvement relative to national statistics. (Stillbirth rate England and Wales 14.8 per 1,000. Perinatal mortality rate England and Wales 25.4 per 1,000.[1])

The employment of general practitioners living at a distance from the hospital could only be successful if facilities for residence on duty were made available.—I am, etc.,

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REFERENCE

1 *The Registrar General's Quarterly Return, 1967*, 1968. H.M.S.O., London.

SIR,—Dr. K. L. Oldershaw and Mr. J. M. Brudenell must be congratulated on their article relating to the use of general-practitioner obstetric beds in a consultant unit (13 July, p. 112). The co-operative spirit which is conveyed by this article is particularly laudable and illustrates the point that consultants and general practitioners should not be competing for "better" results but co-operating for the "best" result.

One item in this article is, however, very disturbing. The authors claim that the liaison with the general practitioner "extends to all levels." This breadth of liaison does not seem to have overcome the problem of the dominating patient in so far as intrauterine death happened in one pregnancy where the mother had not been, or could not be, persuaded to accept the benefit of consultant influence. It seems to me very tragic that under such excellent conditions it still remains difficult to influence the patient to accept the best in maternity care.

Should the general practitioner adopt a firmer attitude, refusing to accept responsibility for management which he feels is outside his limitation of competence, as he would refuse to perform appendicectomy on the kitchen table? Is there a need for many of us to take an active part in informing and encouraging our patients towards a change of ideas and attitudes?