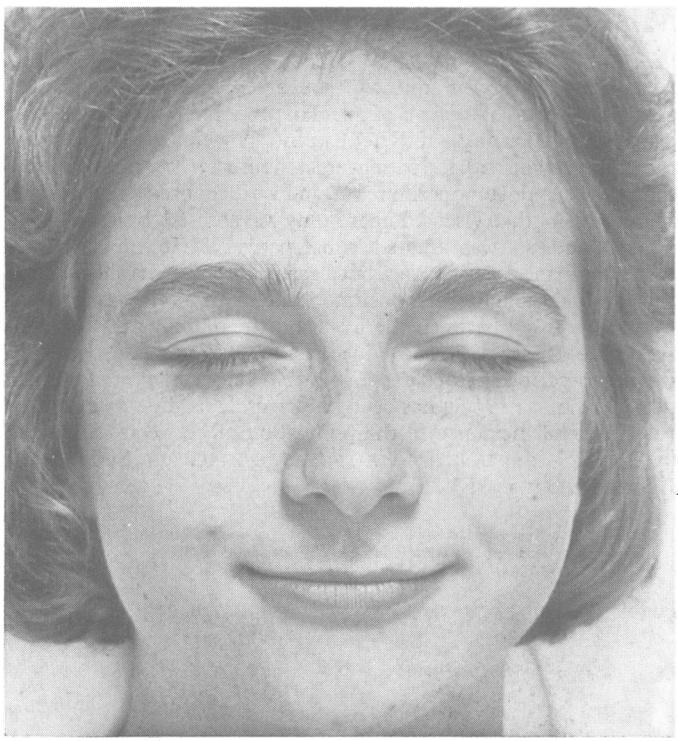

The eyes closed sign

In one third of patients admitted to hospital with acute abdominal pain no cause of the pain has been established by the time of discharge. These patients are said to have non-specific abdominal pain. The diagnosis is usually made by excluding other causes of abdominal pain by investigations of varying complexity. Diagnosis by exclusion is time consuming, inefficient, and expensive. We have observed a physical sign that is present on admission in many patients eventually diagnosed as suffering from non-specific abdominal pain. We have called this "the eyes closed sign," and it is elicited during palpation of the abdomen when the patient keeps her eyes closed during the whole examination (see figure). (Men too may show this sign, but we are grateful to the medical student who so ably mimicked it.) Typically the eyelids are held exquisitely closed and the face wears an embalmed beatific smile.

We offer two explanations for this sign. The patient with serious intra-abdominal disease concentrates all her attention on the face and hand of the examining surgeon to detect immediately the signals that pain is about to be inflicted. Patients with non-specific abdominal pain have no need to detect these visual signals. A psychological explanation might be that those who doubt their own symptoms do not allow the examining doctor to look into their eyes and perhaps discover their secret. Whatever the explanation we have found the sign useful in suggesting the diagnosis of non-specific abdominal pain at the first examination.—JACK COLLIN, D W R GRAY, Nuffield Department of Surgery, John Radcliffe Hospital, Oxford OX3 9DU.

Fairground fever—a cautionary tale

A previously well 18 year old man was admitted with colicky abdominal pain and generalised muscle ache that he had developed after drinking milk from a coconut. He had been at a local fair and to celebrate winning a coconut he had made a hole in the coconut and immediately drank several mouthfuls of the milk. Within half an hour he was ill. On examination he was febrile and had appreciable diffuse erythema of his trunk, arms, and face. There was no urticaria or angioedema. He had no known allergies and had eaten coconut several times before. The rash and abdominal pain settled in two hours, and he was apyrexial the next day. Repeated blood, urine, and sputum cultures were negative. A piece of the coconut was retrieved, and the flesh inside was black. The coconut was sent for microbiological examination and was found to be heavily invaded by various moulds, mainly penicillium and fusarium. No toxins were identified.

Although no toxin was identified, we suggest that ingestion of fungal toxin was the likely mechanism for our patient's sudden illness. He commented that the coconut had been hard to dislodge from its stand. Repeated hits may lead to small cracks in the outer shell of the nut, allowing organisms to enter the cavity. In subsequent months we had two other black coconuts reported to us. We suggest that if a coconut is won at a coconut shy—and particularly if it is difficult to dislodge—the nut be completely opened before drinking any milk. One should be coconut shy shy.—S S FURNISS, A S MCINTYRE, Medical Unit, The London Hospital, London E1. Correspondence to: Dr S S Furniss, Regional Cardiothoracic Centre, Freeman Hospital, Newcastle upon Tyne NE7 7DN.