Adverse reactions to herbal treatment

The correspondence on this subject (July 1999 *JRSM*, p. 386) brings to mind a young asthmatic patient who was always reluctant to use an inhaler because she considered 'these drugs' potentially toxic. One day she came to see me brimming with joy because she had found a herbal treatment that completely solved the problem. On enquiry this proved to be ephedrine, and she was taking it in a dose sufficient to cause sympathetic side-effects. Attempts to persuade her that the inhaled medications were a refined form of the same thing, but in lower dose and less toxic, were entirely fruitless.

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Autoimmune enteropathy with goblet cell antibodies

In their interesting case report (June 1999 *JRSM*, pp. 311–312), Dr Rogahn and colleagues make no comment on the patient's chromosome status or tissue-type. In view of the known relationships of certain tissue types with particular autoimmune disorders it would be helpful to know these data since such a cluster of disorders is rare in one patient.

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Author's reply

The patient's chromosomes were normal but unfortunately we have no information about tissue type. I agree that this would have been of interest although it would probably not have helped in management of the patient.

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Contralateral extradural haematoma after ventriculoperitoneal shunt insertion

As Dr Power and colleagues point out (July 1999 *JRSM*, pp. 306–361), endoscopic ventriculostomy is the current treatment of choice for aqueduct stenosis, at whatever age the presentation. All neurosurgeons will do their utmost to avoid inserting a ventriculoperitoneal shunt. In their Figure 2, the right-sided collection of cerebrospinal fluid (CSF) suggests that too much CSF may have been let out at the time of shunt insertion. In shunt surgery, minimal loss of CSF is without doubt the key to avoidance of both acute and long-term problems.

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A Harley Street address

May I offer some additional comments on the delightful article by Sir Gordon Wolstenholme and Mr Raymond Hurt (August 1999 *JRSM*, pp. 425–428).

Lord Edward Harley married Henrietta Cavendish-Holles in 1713. She was the daughter and heiress of John Holles, 1st Duke of Newcastle, who had purchased Wimpole Hall, a great country house, about 8 miles west of Cambridge, in 1710, and died within a year. Edward Harley thus not acquired only a very well connected wife (there were close family ties even then between the Cavendish and Devonshire families) but also became owner of Wimpole Hall.

When he and his wife developed the Marylebone area, he named after himself Harley Street and gave names derived from his family or locality, Henrietta, Holles, Devonshire and Wimpole to the surrounding streets.

By 1740 financial straits compelled Harley to sell Wimpole Hall. He died a year later. Wimpole Hall remains the grandest country mansion in Cambridgeshire. Its many owners have included the Earls of Hardwicke (name of a neighbouring village) and, finally, the daughter of Rudyard Kipling. It now belongs to the National Trust.

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Management of penile fracture

In their article last year, Morris *et al.*[1] described four cases of fractured penis, all repaired via a subcoronal incision. One patient had a major complication—he developed an abscess which required re-exploration. Other workers using this technique report an early postoperative complication rate of 14%, including wound infection and subcoronal skin necrosis[2].

We believe that the use of the distal circumferential incision, with degloving, is an unnecessarily traumatic approach to the site of the lesion, which is usually more proximal[3]. The site of the tear can be found by gentle palpation of a rounded, tender lump—the 'rolling sign'[4]. Once the exact site has been located, simple repair can be performed under local anaesthesia, via a small longitudinal incision directly over the fracture site, with same-day discharge of the patient[5]. The complication rate of this minimally invasive procedure is negligible.

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