

enough to keep him awake at night. He had some frequency of micturition but no dysuria, and his pain was aggravated by coughing and deep breathing.

On examination his temperature was 101.8° F. (38.8° C.), pulse 96, respiration 20. The W.B.C. count was 11,200 (90% neutrophils). The E.S.R. was 22 mm. in the first hour. The urine was acid in reaction and contained neither protein nor pus cells and yielded no significant bacterial growth on culture. A nose swab grew *Staph. pyogenes*. An x-ray of chest and left ribs showed no abnormality. A blood culture also grew *Staph. pyogenes*. The only abnormal physical signs were tenderness in the left loin, renal angle, and over the left lower ribs, posteriorly with obvious swelling in the same regions.

The temperature remained around 104° F. (40° C.) for 24 hours, returning to normal by the fourth day. The differential diagnosis was considered to be perinephric abscess, ruptured spleen, or osteomyelitis of the ribs.

Treatment with oral tetracycline 250 mg. six-hourly was started on admission. On the fourth day a needle was introduced into the ill-defined swelling and a few beads of blood-stained pus were withdrawn from near the 10th rib. A presumptive diagnosis of osteomyelitis of the rib was made, and the patient's antibiotic was changed to intramuscular soluble penicillin, 1 mega unit b.d. A swab of the pus was sent for culture and yielded a heavy growth of *Staph. pyogenes*, confirming the diagnosis. On the same day the E.S.R. was 11 mm./first hour, and W.B.C. 6,800, a substantial improvement which was in keeping with his clinical progress.

The *Staph. pyogenes* isolated from the nose swab, blood culture, and swab from the rib was sensitive to tetracycline and penicillin. In view of the long-term antibiotic therapy required for osteomyelitis intramuscular penicillin was considered the preferable choice.

This boy had suffered from a boil on the back of his neck for three weeks prior to the onset of his pain, for which he had no treatment. He was very fond of wrestling, and thought he probably received a blow on the left ribs. I assume that local trauma to his rib made it a suitable nidus for the blood-borne *Staph. pyogenes*.

—I am, etc.,

R. J. CUNNINGHAM.

Royal Free Hospital,
London W.C.1.

Maternal Deaths from Aspiration Asphyxia

SIR,—Dr. P. Dransfield (September 28, p. 809) has written an admirable statement on general anaesthetics in obstetrics with which few would disagree. The lateral position, however, is not the only solution to the problem. In his letter to the *Journal* (August 17, p. 446) Dr. A. H. Morley implied that regional analgesia was used as the exception.

May I suggest that we ask ourselves, "Is a general anaesthetic really necessary?" In the Derby City Hospital, which admits all the obstetric emergencies from this area, only 5% of the forceps deliveries are performed under general anaesthesia. I feel sure that the use of pudendal block has great advantages. A very great deal of pre- and post-anaesthetic treatment is avoided with benefit to the mother and often to the child.

Needless to say, the problem of aspiration asphyxia does not arise.—I am, etc.,

ROBERT JAMIESON.

Derby.

Diagnosis of Coarctation

SIR,—Coarctation of the aorta is rare, but its clinical diagnosis can be so simple, and prognosis in the late-diagnosed case is so unfavourable, that it would seem worth while feeling the femoral pulse at routine school medical inspections.

Of four cases known to me, in only one was the diagnosis made as the result of the first routine medical examination at the age of 5 years. The second case was a boy of 18 years who had had three routine medical examinations and who died of cerebral haemorrhage associated with coarctation, the latter being diagnosed in hospital one month before death, with confirmation at necropsy. The third case is a boy who had many medical examinations because of his symptoms, which were those usually associated with high blood-pressure. Fortunately, he developed appendicitis, and the coarctation was discovered while he was in hospital. The fourth case was asymptomatic when spotted at his second routine medical.

The time to diagnose and treat coarctation is, surely, in the first ten years of life. After all, it takes less than ten seconds to feel the femorals.—I am, etc.,

R. A. STRANG.

Wembley, Middlesex.

Acute Appendicitis in Childhood

SIR,—Dr. R. H. Jackson's article (August 3, p. 277) re-emphasizes the diagnostic difficulties and frequent complications of pelvic appendicitis. Even longer delays than he mentions can arise when gastro-enteritis is diagnosed and the child is admitted to an infectious diseases unit.¹ The larger isolation hospitals regularly see children in this predicament, and during a three-year period, largely in the Manchester area, one has encountered a dozen such misdiagnosed cases. Three, transferred from general hospitals, are particularly worthy of recall to illustrate the consequent clinical difficulties—and embarrassments:

(1) Girl, aged 2 years.—Onset with vomiting and central abdominal pain; diarrhoea after 36 hours; transferred from paediatric unit as gastro-enteritis. Examination showed slight guarding over her tender lower abdomen and exquisite rectal tenderness; bowel sounds scanty. After retransfer, ruptured pelvic appendicitis was confirmed at laparotomy.

(2) Boy, aged 11 years.—Sent to paediatric unit by family doctor as acute appendicitis giving 36 hours' history of vomiting, initially with central abdominal colic, later with diarrhoea and lower abdominal pain. The surgical and medical housemen agreed in diagnosing "acute dysentery"; the consultant paediatrician later concurred and transfer for isolation was uneventfully arranged. Next day a high leucocytosis was reported, and this initiated a full reappraisal which revealed lower abdominal guarding and a tender pelvic mass. His appendix abscess subsided after retransfer, and he had an interval appendectomy later.

(3) Boy, aged 3 years.—Sent to casualty department with six days' diarrhoea and fever. Paediatric registrar diagnosed gastro-enteritis and referred him for isolation. Later re-examination of an unexpectedly ill child showed a tender suprapubic mass, more readily palpable rectally. A surgical consultation confirmed the diagnosis of appendix abscess, which settled with conservative treatment. The parents eventually recalled central abdominal colic, awakening him from sleep, as the initial symptom; the diarrhoea had begun on the second day.

This spurious diarrhoea is certainly misleading but hardly uncommon,² for one appendicitis in four is pelvic, and half such cases have diarrhoea—e.g., it occurred in 19 of the 31 reported by Hindmarsh.³ In the differential diagnosis, abdominal pain is the decisive symptom, being unimpressive in bowel infections; vomiting, too, is surprisingly infrequent in gastro-enteritis after infancy, except in food-poisoning, when diarrhoea rapidly becomes the predominant complaint. And any degree of sustained lower abdominal or rectal tenderness, with resistance to palpation, must suggest appendicitis with irritation of the pelvic peritoneum—even before frank rupture with peritonitis and abscess formation.

Classically the lax, rumbling, non-tender abdomen of infective enteritis contrasts strongly with the tense, tender, silent lower abdomen of ruptured pelvic appendicitis. But an earlier arousal of suspicions will come from a vigilant analysis of the history—particularly when diarrhoea has been delayed until the second or later days of an illness which began with vomiting or abdominal pain.—I am, etc.,

J. P. ANDERSON.

Taunton Isolation and
Chest Hospital,
Taunton, Somerset.

REFERENCES

- ¹ Bunton, G. L., *Brit. med. J.*, 1953, 2, 71.
- ² *Ibid.*, 1953, 2, 1148.
- ³ Hindmarsh, F. D., *ibid.*, 1954, 2, 388.

Infant Feeding During Ramadhan

SIR,—In a study of infant-mother interaction among the Ganda¹ it was observed that babies of Muslim mothers showed signs of underfeeding at the breast during the Ramadhan fast. Those mothers were not malnourished and by tropical standards their food intake was not unusually low or unbalanced even during the fast. Was this an infant-mother anxiety syndrome related to a change in meal-time routine? Was it perhaps a result of dehydration?

We wonder whether these findings are common in Muslim countries. We also wonder whether in any Muslim community dispensation is allowed to lactating mothers—particularly with regard to their fluid intake during the fast.—We are, etc.,

MARY D. AINSWORTH.
HEBE F. WELBOURN.

London N.W.3.

REFERENCE

- ¹ Ainsworth, M. D., in *Determinants of Infant Behavior*, 1961, Vol. 2. Edited by B. Foss, Methuen, London.