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CORRESPONDENCE

Correspondents are asked to be brief

Safety-pin Swallowers

SIR,—We expect that after the letter by Mr. J. A. C. Neely and Mr. A. Rhodes (12 December, p. 681) there will be a flood of reports of similar cases. May we then join in with the following account of a 21-year-old girl admitted to Guy's on 14 December?

She presented with a history of swallowing safety-pins "whilst dressmaking." There were several scars on the abdomen—some old, some of recent origin—for which various explanations (some plausible, some not so plausible) were offered. In addition there were multiple needle puncture sites in the upper and outer quadrants of each buttock—"from iron injections." Plain x-ray films of the abdomen confirmed the presence of two open safety-pins.

Bit by bit the true story emerged. She stated that she had had a partial gastectomy at the Northern General Hospital in Sheffield. On telephoning this hospital it transpired that they had received several inquiries about this girl's previous history from hospitals in Birmingham and London during the past few months. In fact the Sheffield operation was a gastrotomy for removal of pins—and she had later had a further laparotomy for a similar story. For the present two pins she has already had admissions to St. Mary's Hospital, in Paddington, and University College Hospital, each time taking her own discharge.

During her present admission we have watched the progress of the pins with serial x-ray films. One has passed on and now that the other appears to be approaching the rectum, she has now discharged herself.

Obviously these patients present a management problem. It seems that whatever one does they will continue to swallow pins. This being so they present as candidates for repeated enterotomies. If operation can be avoided then that is clearly preferable for both parties. The patient reported by Mr. Neely and Mr. Rhodes passes his pins per rectum without incident, and so it seems does this girl. Is this the general experience of other surgeons, we wonder? We cannot help feeling that the surgeon is obliged to admit these people in case an open pin should perforate the bowel. Can one state that treatment should always be expectant in the first instance and are manoeuvres such as enemas, rectal washouts, suppositories, and laxatives thought to be advisable?—We are, etc.,

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Gold for Rheumatoid Arthritis

SIR,—In recent years there has been a renewed interest in gold therapy, which has been accompanied by reports of adverse reactions, including blood dyscrasias. As the manufacturers of sodium aurothiomalate (Myocrisin), we should like to reiterate the recommendations of precautions to be carried out when it is used. For the treatment of rheumatoid arthritis and some related conditions gold is at least as safe as other therapeutic agents, but it must be used both with care and understanding. The "standard" course, in which the weekly dose rises to, but should not exceed, 50 mg, giving a total of 1 gramme, may cause some reactions. Attempts to predict such reactions through an estimation of gold serum levels, urinary excretion, or changes in erythrocyte sedimentation rate have had no success, and it has been suggested, but not yet proved, that the appearance of an eosinophilia may be an early warning sign. However, a sudden fall in the platelet level indicates that a marrow toxicity is developing. It is believed that the most likely time for a toxic reaction is during the period when 300-500 mg of gold has been given. Occurrence has seldom been reported during the later stages of the initial course and subsequent maintenance therapy.

Ideally, every patient receiving gold should have a full blood count with each weekly injection, and the result should be known before the injection is given. In practice a monthly blood count is all that may be possible, but whatever its frequency the request to the laboratory should always specify a numerical platelet count rather than an estimation. Probably the most important preventive measure is the assessment of the patient's condition before each injection. This should be carried out by the doctor personally and not delegated. The urine should be tested for albumin and evidence sought of malaise, rashes, and above all the occurrence of a sore throat or buccal ulceration. The patient should be instructed, preferably in writing, to report at once should any such effects arise between injections—particularly the sore throat, the onset of which will necessitate a full blood count (including platelets) followed by immediate action if there is any evidence of a thrombocytopenia.

If these precautions are adopted as routine the incidence of severe reactions will be minimized and the undoubted benefits of gold therapy realized.—I am, etc.,

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Abnormality in Mediaeval Femur

SIR,—The specimen described here was found at Carrow Abbey, Norwich, a mediaeval monastic foundation which flourished from A.D. 1146 to 1538. It was part of a chaotic medley of bones churned up by a bulldozer, but although remains of at least 16 persons could be identified in no case could more than about half a dozen bones be allocated to any one body. The fragment to be discussed (which is now in the Castle Museum, Norwich—Acc. No. 214,967) is unaccompanied by anything else that can be attributed to the same individual.

It consists only of part of a right femur proximal to the lesser trochanter (Figs. 1 and 2). Even this is incomplete, part of the greater trochanter having been damaged during excavation. This surviving fragment of what seems to have been a fairly large male thighbone, is grossly pathological. Its axis from the most lateral part of the greater trochanter to the fovea deviates from normal; an osteophytic outgrowth obscures the neck; the head of the bone is eroded and eburnated, has a heavy flange of new bone along its superolateral margin, and is severely distorted by craggy osteophytes around and below the fovea. The fovea itself lies at the base of an osseous tunnel about 13·5 mm deep, from which a smooth sulcus, impressed into the newly formed bone, marks the course of the ligamentum teres over about 40 mm.

It is unfortunate that as no trace of the corresponding innominate was found the