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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Correspondents are asked to be brief

Postmenopausal Genital Tuberculosis

SIR,—Towards the end of 1970 a 65-year-old woman presented with abdominal pain she had had for nine weeks, starting in the left loin and radiating into the left iliac fossa and described as a steady ache, relieved by mild analgesics.

She had had a right nephrectomy at 48 years of age for suspected renal tuberculosis. Tubercle bacilli were never isolated but she was treated with streptomycin, P.A.S., and isoniazid for 12 months. She had had two pregnancies, both with normal deliveries. Her periods had been regular and normal, and there had been no postmenopausal bleeding since the menopause at 40 years.

On vaginal examination, a mobile mass was palpable on the left. Radiologically it was a well-defined mass, diameter of 8 cm. Mantoux (1 tuberculin unit) was strongly positive and the E.S.R. was 61 mm/hr.

At operation, a round, red, studded mass attached by adhesions to the small bowel and left Fallopian tube was removed. The mass and both tubes contained caseous material. Histologically the lesion was that of healed tuberculosis. Guinea-pig inoculation and culture were negative. Nevertheless, in view of the findings antituberculous therapy was restarted.

Women with genital tuberculosis presenting postmenopausally may have been fertile in contrast to young premenopausal women, who frequently present with sterility.[1-3] The coincidence of renal tuberculosis with genital tract tuberculosis varies from 5% to 30% according to different authors.[4,5] If genital tuberculosis is present co-incident extrapulmonary infection is most likely to be found in the kidneys and peritoneum.[4] Tuberculosis of the genital tract in postmenopausal women is an uncommon condition which is increasing,[3-6] though this has not as yet been the experience of clinicians in Newcastle (Snaith, personal communication). Diagnosis is often difficult even with the use of laboratory aids.

I would like to thank Mr. Linton Snaith for his help and advice.

—I am, etc.,

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4 Schaeffer, G., *Clinical Obstetrics and Gynecology*, 1970, **13**, 965.
5 Barns, T., *Journal of Obstetrics and Gynaecology of the British Empire*, 1955, **62**, 162.
6 Dellepiane, G., *Revue Française de Gynécologie et d'Obstétrique*, 1965, **60**, 21.

Footballer's Migraine

SIR,—I read with interest the paper by Professor W. B. Matthews on migraine in footballers, precipitated by minor head trauma (6 May, p. 326). While reviewing migraine cases attending the Maudsley Hospital I have come across five cases whose migraine started after head trauma. In all five cases, the head injury was severe enough to result in a temporary loss of consciousness, though subsequent E.E.G.'s showed no focal brain damage. Once initiated, the migraine attacks continued, occurring either spontaneously or being precipitated by stress or in one case related to the menstrual cycle.

Thus, while Professor Matthews's paper highlights a group of migraine patients who are susceptible to precipitation of their attacks by relatively minor head trauma and at no other times, in other cases more severe head trauma might be responsible for initiating attacks of migraine, which then continue to occur in the absence of further trauma.—I am, etc.,

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Recurrent Urinary Infections in a Girl

SIR,—We were interested to read Dr. R. R. Bailey's comments (22 April, p. 232) about our article on this subject in the series "Second Opinion, Please" (12 February, p. 428). We are honoured that he should treat our article as an expert treatise presenting all the latest and best views on problems in this field. It was, in fact, a somewhat truncated factual record of an actual child who presented in 1970, when bladder punctures were infrequently done, and was designed to present a few of the problems as seen from family practice and general hospital level. We agree that bladder puncture can be of use under some circumstances, and indeed use it when indicated in hospital practice, but not that it should become a routine procedure in a general practitioner's surgery. We would certainly not like our own children to have this done, which is our yardstick for dealing with other people's children.

With respect to Dr. Bailey's second point, we would still doubt the wisdom of doing both an intravenous pyelogram and a micturating cystogram in all first urinary tract infections in childhood. Some selection of cases is possible, and provided a careful follow-up is done we doubt whether any real harm would come by delaying a micturating cystogram till there is evidence of failure to cure the initial attack, or of relapse. Dr. Bailey's policy is one of