Letters to the Editor

Ginseng – is there a use in clinical medicine?

Sir,

I read with interest the review article on ginseng by Chong and Oberholzer.1 Since the title of their paper was 'Ginseng – is there a use in clinical medicine?', it seems that its effect on the cardiocirculatory system should have been included too.

Ginseng has been used for ages in China for treatment of heart failure among many other circulatory disorders.2 The Chinese Academy of Traditional Chinese Medicine, Beijing, China,3 using the cardiac nuclear probe and technetium-99m reported the therapeutic effects of ginseng in 24 geriatric patients with congestive heart failure (coronary heart disease, 14; rheumatic heart disease, 5; hypertensive cardiovascular disease, 3; dilated cardiomyopathy, 1; syphilitic heart disease, 1). Thirty minutes after intravenous injection of Ginseng Co, which contains 2 g of the crude ginseng, the ejection fraction increased from 0.35 ± 0.02 to 0.42 ± 0.02 ($P < 0.001$). The Ginseng Co also increased the diastolic fast filling rate from 1.15 ± 0.11 to 1.50 ± 0.13 end-diastolic volumes/second ($P < 0.001$).

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References

Free retroperitoneal gas – a radiological sign of penetrating abdominal injury

Sir,

I read with great interest the article on spontaneous pneumoretroperitoneum in a renal transplant recipient.1 I would like to report a case who demonstrated pneumoretroperitoneum in a condition not mentioned in the article, namely retroperitoneal trauma in the acute phase of injury. Such a sign may alert clinicians to retroperitoneal and lumbosacral plexus injuries in the severely injured trauma patient.2

Accordingly, I describe a previously undescribed radiological sign of a penetrating perineal injury communicating with the retroperitoneum.

An 18 year old man sustained multiple injuries following a motorcycle accident. In particular, he had a deep posterior perineal tear. Pelvic X-ray (Figure 1) showed free air on the left side of the psoas. Examination under anaesthesia confirmed a communication of the open injury to the coccygeal region and retroperitoneum.

References

Spontaneous subcapsular splenic haematoma formation in infectious mononucleosis

Sir,

Although rupture of the spleen is a rare but well documented complication of infectious mononucleosis, spontaneous subcapsular splenic haematoma formation without rupture is a very unusual occurrence in this condition. It has been suggested that this complication can be managed conservatively.1,2 We describe the presentation and clinical progress of a case in whom conservative management was successful. A 17 year old male presented acutely with left upper quadrant abdominal pain. He gave a one week history of sore throat, anorexia and general malaise. There was no history of trauma in the preceding 6 weeks. On examination he was apyrexial, pale and slightly jaundiced. His cervical lymph nodes were enlarged and the blood pressure was 110/
60 mmHg. There was marked upper abdominal tenderness with guarding. The spleen could not be palpated although there was dullness to percussion in the left hypochondrium. He had no shoulder tip pain and the bowel sounds were present and normal.

Initial investigation revealed a haemoglobin of 12.1 g/dl, elevated white cell count at 14.3 x 10^9/l (62% atypical mononuclear cells), platelets 208 x 10^9/l, positive Paul Bunnell test (1/640 titre), positive Epstein Barr virus IgM test, and abnormal liver function tests. Chest and abdominal X-rays were normal.

Two days after admission he remained clinically stable although his haemoglobin had fallen to 9.6 g/dl with 42% reticulocytes, negative Coombs’ and anti-i antibodies and a normal serum haptoglobin level. An abdominal ultrasound showed hepatosplenomegaly with a small transonic shadow anterior to the spleen. A computed tomographic scan revealed a minimally enlarged spleen displaced downwards by a low density, non-enhancing, intracapsular collection (Figure 1). A diagnosis of spontaneous subcapsular splenic haematoma complicating infectious mononucleosis was made. He was managed conservatively under combined medical and surgical supervision.

Although tenderness of the spleen tip is commonly found in infectious mononucleosis, guarding in the left flank should alert the clinician to the possibility of haematoma formation. Repeated attempts to palpate an impalpable spleen under these circumstances should be avoided since the consequences could be disastrous.

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References


Bowel perforation in a patient receiving prednisolone for myasthenia gravis

Sir,

Patients on steroid therapy are at increased risk of gastrointestinal perforation.1 The associated morbidity and mortality may be prevented if the diagnosis is made early. Lateral decubitus films of the abdomen to identify intraperitoneal air should be considered for any patient taking steroids who complains of abdominal pain.

A 61 year old woman who had myasthenia gravis diagnosed 12 years previously was admitted with breathlessness. Drugs on admission were azathioprine 150 mg, neostigmine 30 mg five times daily and prednisolone 2 mg twice daily. The breathlessness improved after an edrophonium chloride (Tensilon) test. Neostigmine was increased to 45 mg five times daily and prednisolone to 20 mg twice daily. The patient developed severe abdominal cramps so the neostigmine was reduced to its original dose after 2 days. Three days later the patient developed abdominal pain. She was tender in the left iliac fossa. Abdominal X-rays showed air under both diaphragms. Laparotomy revealed a perforated sigmoid colon. The perforation was localized and thought to originate

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**Figure 1** Computed tomographic scan showing splenic haematoma.

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He remained clinically stable and repeated ultrasound examinations over the next 6 weeks showed a minimal change in the size of the haematoma. The haemoglobin rose to 11.3 g/dl and the patient was allowed home with the advice to avoid all strenuous activities. Subsequent follow-up over a 6-month period showed a progressive rise and fall in the serum unconjugated bilirubin levels (consistent with the resolution of a haematoma), a return of liver function tests to normal, and haemoglobin rising to 14.9 g/dl. Serial ultrasound examinations showed progressive resolution of the haematoma.

It has been suggested that subcapsular splenic haematoma formation precedes rupture in infectious mononucleosis. In a review of 107 cases of ruptured spleens reported in infectious mononucleosis, only 18 were found to be truly spontaneous.3 A case similar to ours but necessitating splenectomy has been described.4 Conservative management has not been adequately assessed because of its infrequent occurrence. Sakulsky et al.,5 Hoagland & Henson6 and McLean et al.7 recommend immediate surgical exploration and splenectomy but two previous reports8,9 describe successful non-surgical management. As our case illustrates, this line of approach seems justifiable in selected cases under combined medical and surgical supervision.
Spontaneous subcapsular splenic haematoma formation in infectious mononucleosis.

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