**Letters to the Editor**

**Spinal tuberculosis**

Sir,

With reference to the article by Scullion and Al-Kutoubi, on spinal tuberculosis, our experience with a large number of cases has been different with respect to the ‘distinguishing features’ in non-Caucasians. Furthermore, our experience is supported by other authors. Gasinda et al.6,7 have examined in detail an Indian population and did not find posterior arch involvement to be common. Hodgson et al.8 from Hong Kong reported that ‘tuberculosis infection rarely involves the transverse process.’ According to him, the lamina and the spinous process but it may do so in an isolated case. Bell et al.9 reported a few cases of posterior arch involvement in some Nigerians and did not consider that ‘the description of this feature in the publications of West Indian and Nigerians provides a ground for suggesting a racial role in its etiology.’

In a five-year study of 350 patients conducted by the Medical Research Council in Korea, only one patient had tuberculosis confined to a single vertebra. The rest had involvement of two or more vertebral and of the intervening disc spaces. Allen et al.10 described a greater incidence of sclerosis in the vertebrae of coloured patients compared to that in white patients, while a study by Jacobs11 carried out in UK has described more atypical and multiple sites of tuberculosis in Pakistan and India. More recently, Tuli,12 who has studied tuberculosis of spine for over 20 years in India reported that 98% of lesions were the typical paradiscal type. According to him, the active lesion is characterised by osteoporosis and osteolysis, whereas osteosclerosis indicates healing of the lesion. Moreover no standard textbook on radiology or orthopaedics describes differences in the presentation of tuberculosis of spine based on race or colour of the skin.

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This letter was shown to the authors, who responded as follows:

Sir,

We thank Drs Bahn and Mittal for their interest in our case report and feel sure that their experience of patients with bony tuberculosis is indeed extensive. The phrase ‘distinguishing features’ does not actually appear in the text, and box 1 serves merely to illustrate the various manifestations of spinal tuberculosis that may occur in Caucasians and non-Caucasians.

There is of course an overlap between racial groups and, given the protein manifestations of this disease, an attempt to divide patients into racial groups based on radiological features would be extremely unfair. Moreover, excluding tuberculosis infection merely on the presence or absence of particular radiological features may be detrimental to patient care.

We agree that involvement of a single vertebral body is uncommon. Our discussion does not suggest otherwise. In addition we concur that vertebral sclerosis is more commonly seen in coloured patients. This is referred to in box 1. Posterior arch involvement is indeed uncommon, especially when it occurs in isolation, but when seen it is more likely to be in non-Caucasians, hence its position in box 1. This perhaps could have been made clearer in the text.

Our case is an atypical, the uncommon radiological features of spinal tuberculosis and in practice the correct diagnosis was straightforward. In the discussion less common features are presented that, when present, may mislead those whose experience is less extensive. It is precisely these less common features that one would not necessarily find referred to in ‘standard texts’.1

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**Coital emergencies**

Sir,

Baneree1 provided an excellent review of coital emergencies but I wish to comment on certain aspects.

Firstly, the review article failed to mention injuries of the lower female genital tract resulting from coital activity. Vaginal injury following sexual intercourse is one of the most common presentations of post-coital emergencies.2-4 The majority of coital injuries result from vigorous voluntary sexual activity while a smaller proportion result from violent involuntary sexual activity. The age range spans the pre-pubertal to the post-menopausal. The commonest site of injury is the posterior vaginal fornix.3-4 Speculation as to why this region should suffer the most trauma abounds, including unusual sexual practices or inadequate preparation of the woman with the resultant increased intra-abdominal pressure on her part tending to make the cul-de-sac tense and lessening the elasticity of the vaginal vault, especially the posterior fornix during deep penetration. Most of the injuries are not serious but severe injuries in this region may lead to acute complications such as shock from severe haemorrhage requiring blood transfusion, resuscitation and surgery.1

We were sex workers from ages 15 to 19 years. We were made conscious of the effects of scarring and cicatization of the vagina and cervix, intractable genital infection as well as psychological upset and emotional instability may also occur. Misdiagnosis occurs either because a detailed history is not taken or the patient does not volunteer a history of antecedent sexual activity.1 It is therefore imperative that a detailed history be taken and examination performed on women presenting in the accident and emergency department with vaginal bleeding in order to make an accurate diagnosis.

Babarunde1 has postulated that a period of sex lasting for eight weeks abstinence from sexual intercourse is usually advised following myocardial infarction (MI). There does not appear to be any evidence for this advice. While a decrease in sexual activity following MI is often due to fear of the unknown risk of precipitating another MI, Muller et al’s recent study in Boston shows that there are grounds for reassurance on this issue.2 Following interview of a national sample of 858 patients who were sex workers for at least a year before the MI, they found that 70% (95% CI) of reported sexual activity in the 24 hours preceding the MI and 27% (3%) in the two hours preceding the MI. They concluded that while there is an increased risk of MI in the two hours following sexual activity, the risk is about the same for patients with and without previous cardiac diseases. Thus, sexual activity has a low probability of precipitating MI. However, the question remains as to how soon after an MI can full sexual activity be resumed.

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