Letters to the Editor

Reversible coma in Wernicke's encephalopathy

Sir,

One of us (H.R.) was fortunate enough to witness the recovery of the gentleman reported in your Journal in July (Gibb *et al.*, *Postgraduate Medical Journal*, 1985 61, 607). This experience proved very valuable when we recently admitted a 36 year old man in coma. He was known to drink approximately half a bottle of whisky a day, and a liver biopsy 12 months previously had shown severe fatty change.

Two days prior to admission, he collapsed in the toilet and was unable to stand. His wife dragged him to another room where he lay on the floor, mumbling incoherently. She assumed he was intoxicated but became increasingly concerned when he progressively lost consciousness and had 2 episodes of generalized rigidity.

On arrival, only his arms responded to deep pain and he had roving conjugate eye movements. There was no meningism, his fundi were normal and his reflexes were symmetrical. The right plantar response was extensor. The blood glucose was 6.5 mmol/l. He was given 250 mg of thiamine intravenously and by the next morning was able to talk although he remained confused. There was horizontal nystagmus on lateral gaze and severe truncal ataxia. The right plantar response remained extensor. Thiamine supplements have been continued over the last 4 weeks. His eye movements are now normal but he remains confused and is barely able to walk due to truncal ataxia.

We agree that this presentation of Wernicke's encephalopathy may well be under recognized and that all patients arriving comatose without an obvious cause should receive immediate parenteral thiamine. The toll of neurologically incapacitated patients salvaged by this treatment will inevitably rise as alcoholism continues to increase. Surely the time has come for compulsory supplementation of alcoholic beverages with thiamine.

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The management of liver trauma

Sir,

Macfarlane (1985), surprisingly, appears to recommend needle paracentesis for the diagnosis of liver trauma. The low accuracy of needle paracentesis and the potential risk of visceral injury have however, led to its decreasing use (Sloop, 1978). Peritoneal lavage

has replaced abdominal paracentesis as the latter is associated with many false positive results (Ismail *et al.*, 1984). False negative results are also common with paracentesis – 79% of the patients with negative paracentesis but positive lavage were found to have significant intraperitoneal visceral injuries (Thal & Shires, 1973). Peritoneal lavage is an important diagnostic test for detection of intra-abdominal bleeding (Meyer & Crass, 1982). It has 95–97% accuracy and false negative results are rare (Ahmad & Polk, 1976). In the absence of clinical evidence of bleeding peritoneal lavage can be used to exclude intraperitoneal injury. It is also a reliable indicator of haemoperitoneum in patients with multiple injuries and those with decreased levels of consciousness (Ahmad & Polk, 1976).

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This letter has been shown to Dr Macfarlane who replies:-

Sir,

I am grateful to Dr Kapoor for his comments on abdominal paracentesis. My choice of words was ambiguous, and I certainly did not mean to propose 'four quadrant tap' as a useful test for the detection of intra-abdominal haemorrhage. As he points out this has been shown to be a worthless investigation, and lavage with a peritoneal dialysis catheter is far superior.

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