Letters to the Editor

Spinal tuberculosis

Sir,

With reference to the article by Scullion and Al-Kutoubi, on spinal tuberculosis,¹ 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. Ganguli² made an extensive study in an Indian population and did not find posterior arch involvement to be common. Hodgson *et al*³ from Hong Kong reported that "tuberculosis infection rarely involves the transverse process, the pedicle, the lamina and the spinous process but it may do so in an isolated case". Bell *et al*⁴ reported a few cases of posterior arch involvement in some Nigerians and did not consider that 'the description of this form of tuberculosis in West Indians 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,⁵ only one patient had tuberculosis confined to a single vertebra. The rest had involvement of two or more vertebrae and of the intervening disc spaces.

Allen *et al*⁶ described a greater incidence of sclerosis in the vertebrae of coloured patients compared to that in white patients, while a study by Jacobs⁷ carried out in UK has described more atypical and multiple sites of tuberculosis involvement in coloured immigrants from Pakistan and India. More recently, Tuli,⁸ 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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7 Jacobs P. Osteoarticular tuberculosis in coloured immigrants – a radiological study. *Clin Radiol* 1964; 15: 59–69.

8 Tuli SM. *Tuberculosis of the skeletal system*. Delhi: Jaypee Brothers Medical Publishers, 1991.

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 our article, however, 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 considerable overlap between racial groups and, given the protean manifestations of this disease, an attempt to divide patients into racial groups based on radiological features would be extremely unwise. 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 illustrates the commoner 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'.

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Coital emergencies

Sir,

Banerjee¹ 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.^{2–4} 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.^{2,4} Late sequelae such as dyspareunia, scarring and cicatrization 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.⁴ 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.

Secondly, Banerjee states that a period of six to 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.⁵ Following interview of a national sample of 858 patients with MI who were sexually active in the year before the MI, they found that 79 (9%) reported sexual activity in the 24 hours preceding the MI and 27 (3%) reported sexual activity 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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1 Scullion D, Al-Kutoubi A. Weight loss. *Postgrad Med J* 1996; 72: 373–5.

2 Ganguli PK. In: Middlemiss H, ed. *Tropical radiology*. London: W Heinmann, 1961.

3 Hodgson AR, Wough W, Yau A. *X-Ray appearance of tuberculosis of spine*. Springfield, Ill: Thomas, 1969.

4 Bell D, Cockshott WP. Tuberculosis of the vertebral pedicles. *Radiology* 1971; 99: 43–8.

5 Fifth report on the Medical Research Council Working party on tuberculosis of the spine (1976). A five year assessment of controlled trials of inpatient and outpatient treatment and of plaster of paris jackets for tuberculosis of the spine in children on standard chemotherapy. *J Bone Joint Surg* 1976; 58B: 399–411.

6 Allen EH, Cosgrove DD, Millard FJC. The radiological changes in infections of the spine and their diagnostic value. *Clin Radiol* 1978; 29: 31–40.

1 Banerjee A. Coital emergencies. *Postgrad Med J* 1996; 72: 654–6.

2 Makinde OO, Gbolade BA. Traumatic injuries of the lower female genital tract: a review of 32 cases. *Trop J Obstet Gynaecol* 1990; 8: 31–3.

3 Adeleye JA. Vaginal injury during coitus in Ibadan. A review of 50 cases. *Niger Med J* 1971; 1: 234–7.

4 Sau AK, Dhar KK, Dhali GI. Non-obstetric lower genital tract trauma. *Aust NZ J Obstet Gynaecol* 1993; 33: 433–5.

5 Muller JE, Mittleman MA, Maclure M, Sherwood JB, Tofler GH. Triggering myocardial infarction by sexual activity. Low absolute risk and prevention by regular physical exertion. *JAMA* 1996; 275: 1405–9.