Letters to the Editor

Bacterial endocarditis

Sir,
With reference to the article by GK Davis *et al.* I am surprised by authors' suggestion to examine the lower gastrointestinal tract in patients with bacterial endocarditis due to oropharyngeal commensal organisms. It is well known that a majority of cases of infective endocarditis (60–80%) are caused by *Viridans* streptococci, which are oropharyngeal commensals; there is no evidence in the literature that there is an increased risk of colon carcinoma in patients having endocarditis by these organisms.² The publication of one or two cases linking these conditions, which could be coincidental, does not justify investigations for colon carcinoma in the overwhelming majority of the cases of bacterial endocarditis caused by *Viridans* streptococci and other oropharyngeal organisms.

ASHOK VAGHJIMAL
Division of Allergy and Immunology,
Albert Einstein College of Medicine,
New York, NY10451, USA

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- 1 Davis GK, Brack MJ, Hendrickse MT, *et al.* Bacteremia and intestinal obstruction in a 74-year old man. *Postgrad Med J* 1997;73:377–8.
- 2 Johnson CC, Tunkel AR. *Viridans* streptococci and groups C and G streptococci. In: Mandell GL, Bennett JE, Dolin R, eds. *Principles and practice of infectious diseases*. 4th edn. New York: Churchill Livingstone, 1995; pp 1845–61.

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

Sir,
Thank you for your interest in our self-assessment case. We aimed to highlight the

fact that, while the association between bacterial endocarditis and colonic adenocarcinoma is well recognised for endocarditis due to gut commensal organisms, this case adds to previous reports of colonic adenocarcinoma occurring in association with bacterial endocarditis due to oropharyngeal commensal organisms. This diagnosis should therefore also be considered in patients with colonic symptoms and bacterial endocarditis due to non-gut commensals. Investigation of the lower gastrointestinal tract should be performed if clinically indicated.

GERSHAN K DAVIS
Blackpool Victoria Hospital NHS Trust,
Blackpool, Lancs FY3 8NR, UK

Perforated diverticulitis following extra-abdominal surgery

Sir,
We read with interest the report of Gaya and colleagues who highlight the complication of diverticular perforation after extra-abdominal surgery.¹ Currently being treated at our unit is a 66-year-old woman who developed faecal peritonitis as a result of diverticular perforation, two weeks after surgery for total knee replacement. Recovery from the knee operation was complicated by severe lobar pneumonia.

This obese lady with rheumatoid arthritis underwent uncomplicated joint replacement, her case notes highlighted her long history of diverticular disease and constipation. Her rheumatoid disease prior to this was managed with indomethacin SR 75 mg bid, methotrexate 2.5 mg od and oromorph and MST anal-

gesia. She had never taken steroids and non-steroidal anti-inflammatory drugs (NSAIDs) had not been prescribed after knee replacement.

Two days after discharge from the orthopaedic ward the patient was re-admitted under the care of a general physician with severe lobar pneumonia. During recovery from this, some three weeks after initial knee replacement, she developed pleuritic chest pain and peritonitis. Erect chest X-ray confirmed air under both hemi-diaphragms. At laparotomy gross faecal contamination of the peritoneum was found, resulting from a small mid-sigmoid perforation. Hartmann's procedure was performed, with betadine wash-out and Wallace drain insertion. The patient is making a slow and steady recovery, after a period in our intensive care unit.

This case highlights the message of Gaya *et al.*, that sigmoid diverticular disease may perforate after extra-abdominal surgery. In our case previous NSAID treatment may have contributed to the perforation. Additionally, the pneumonia may have contributed to mucosal ischaemia, as a result of impaired gas transfer.

DAVID WALKER
C D JOHNSON

University Department of Surgery, F-Level,
Southampton General Hospital, Southampton SO9
4WX, UK

Accepted 25 November 1997

Correspondence to Dr Johnson

- 1 Gaya AM, Chisholm EM, Scott HJ, Donaldson DR. Perforated diverticulitis following extra-abdominal surgery. *Postgrad Med J* 1997;73:739–40.

Books received

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Landmarks in gene regulation, DS Latchman, ed. pp xii + 302, illustrated. Portland Press, London, 1997. £20, paperback.

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