

Letters to the Editor

Notes: a suitable case for audit

Sir,

The problems highlighted by Twigg *et al.*¹ constitute a crisis in the clerical standard of the case notes which is so profound as to negate most of the potential benefits of medical audit. The deficiencies in the clinical input would be largely corrected by a universal adoption of the problem-oriented approach to note keeping, in place of the present system of cryptic shorthand which totally fails to reflect the logic and complexity of clinical decision making. The chaotic state of filing of laboratory reports could be alleviated by investment in cumulative laboratory report sheets, colour coded according to the type of report. The problem of bulk arises mainly from the 'nursing process' input, principally because of the proliferation of A4 size proformas and charts designed to cater for various eventualities, including those of the most trivial kind. At the risk of 'political incorrectness', I would add the comment that the sheer volume of note keeping now expected of the nursing staff poses a threat not only to the sheer bulk of the case notes, but also to the time available for 'hands on' nursing care. The final problem is that of provision of adequate numbers of clerical staff. The reason why this remains insoluble is that it is rooted in the failure to perceive that the care of the case notes is an extension of patient care, and that clerical standards are a reflection of clinical standards of care. This aspect of clinical management has been largely ignored because we do not address these problems on an ongoing basis. Surely the best preventive measure would be for consultants to do discharge summaries on randomly selected cases routinely, so as to acquire first-hand experience of the defects of the system?

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Myositis related to mycoplasma infection

Sir,

The most recent of a small number of case reports proposed a link between *Mycoplasma pneumoniae* infection and myositis was published in the Journal in 1990.¹ We present a supportive case.

A 21 year old male was admitted 5 days after the onset of fevers, dizziness, abdominal cramps and headache. Additional symptoms included nausea, vomiting, diarrhoea, dyspnoea and a severe dry cough. Workup at another hospital included stool and blood cultures,

hepatitis serology, abdominal ultrasound, sigmoidoscopy and lumbar puncture, all of which were negative. During this workup, serum lactic dehydrogenase (LDH) and aspartate transaminase (AST) rose from normal levels to 1,599 IU/l and 370 IU/l, respectively. On admission, the patient denied arthralgias, myalgias, sore throat and risk factors for human immunodeficiency virus.

He was ill-appearing, tachypnoeic with a temperature of 103°F. Blood pressure was 110/80 mmHg. The neck was supple with tenderness and the extremities were non-tender.

Laboratory data showed mild hypoxia with respiratory alkalosis and modest leucocytosis. Serum LDH was 1,417 IU/l, AST 615 IU/l and creatine kinase >16,000 IU/l. Urine tested positive for myoglobin. Chest X-ray showed a diffuse interstitial pattern.

Many potential aetiologies were considered and investigated including *Legionella*, toxoplasmosis, cytomegalovirus, adenovirus, enterovirus and influenza. The only positive findings were for IgG and IgM mycoplasma titres.

The patient was treated with copious intravenous fluids, alkalinization and intravenous erythromycin, and recovered fully. The patient was lost to follow-up and convalescent titres could not be obtained.

We found three English language references reporting a relationship between *M. pneumoniae* infection and myositis.^{1–3} The nature of this association is not known. Antibodies to smooth muscle in patients with *M. pneumoniae* have been reported; however, this may be the result of tissue damage rather than the cause.² Direct tissue invasion has been hypothesized but not demonstrated.¹

Spillane and Chessner provide an alternative view of this phenomenon.⁴ The patient from Bennett's case report¹ was readmitted with evidence of myositis, this time in apparent association with hepatitis A. The authors surmised that the patient had a tendency to develop myositis as a non-specific response to acute infections.

Although of limited significance due to lack of follow-up data, we felt it important to add our case to the small number of reported associations between *M. pneumoniae* and acute myositis. Whether a specific complication or non-specific response, increasing awareness of this relationship may result in the recognition of more cases and greater insight into its pathophysiology.

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Tumouricidal effect of indomethacin in the oesophagus

Sir,

In a recent correspondence, we proposed that non-steroidal anti-inflammatory drugs (NSAIDs) possess tumouricidal properties in the colon.¹ We extend our hypothesis into another organ of the gastrointestinal tract, namely the oesophagus.

The NSAID indomethacin inhibits the growth and promotes regression of oesophageal tumours induced by oesophagotropic carcinogens in rodents.^{2–4} This beneficial effect may be related to the ability of indomethacin to inhibit prostaglandin (PG) formation,⁵ since oesophageal tumours produce excessive amounts of PGE₂.^{6,7} This PGE₂ may play a role in pathophysiological processes including tumour-related angiogenesis⁸ and depression cellular immunity.⁹ Tumour-derived PGE₂ may therefore further tumour growth and metastatic potential in the oesophagus.⁶ By contrast, NSAID inhibition of PGE₂ synthesis could be tumouricidal by reducing blood flow to the tumour coupled with enhanced immunorejection.⁹ Thus, indomethacin and other NSAIDs may possess tumouricidal properties in the oesophagus. Regular NSAID use may therefore reduce the risk of both colon¹⁰ and oesophageal cancer, the latter hypothesis requiring epidemiological confirmation. Of clinical interest would be the effect of NSAIDs on established oesophageal cancers.

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Squamous cell carcinoma of the scrotum in an aluminium worker

Sir,

In the late 1960s the approximate incidence of squamous cell carcinoma of the scrotum was calculated to be 0.2–0.3 cases per 100,000 men over the age of 35 years. Nevertheless, a decade later only 10 cases/year were detected in the USA.² The recent experience of the American Referral Cancer Centers can be summarized as one patient every 2–3 years.^{3,4}

Many factors such as race, social class, personal hygiene, and specially environmental factors must be taken into account if one tries to explain the epidemiological data of this neoplasm.⁵

A 54 year old male presented with two lesions, one on each side of the scrotum. The left one, located anterolaterally, was a 2.5 cm in diameter ulcer with seropurulent discharge. It was noticed 4 months earlier. The other, a 1 cm nodule, was placed medially in the right hemiscrotum and had developed during the last 3 weeks. Malignancy was suspected and complete excision with 1 cm margin performed. At surgery, multiple metallic shavings were discovered within the lesion. This finding was in consonance with his job as an aluminium worker. In fact, he gave a history of metallic dust all over his clothes and body every day. He denied any sort of contact with industrial oil for such product is not necessary to make aluminium windows. Previous exposure to paraffin, PUVA radiation, or any other chemical carcinogen was carefully ruled out. Histopathology revealed a well-differentiated squamous cell carcinoma not otherwise specified. After the histopathological diagnosis, a second excision was performed on both sides and no residual tumour was evident. Using Z-plasties the scrotal wall defect was easily closed. No inguinal lymph nodes were palpated and a computerized tomography scan revealed the absence of pelvic disease. Bilateral sentinel node biopsy performed a month after diagnosis did not reveal micrometastases. More than 3 years later the patient remains free of disease.

Scrotal carcinoma was the first occupational cancer