Adverse reactions to herbal treatment

The correspondence on this subject (July 1999 *JRSM*, p. 386) brings to mind a young asthmatic patient who was always reluctant to use an inhaler because she considered 'these drugs' potentially toxic. One day she came to see me brimming with joy because she had found a herbal treatment that completely solved the problem. On enquiry this proved to be ephedrine, and she was taking it in a dose sufficient to cause sympathetic side-effects. Attempts to persuade her that the inhaled medications were a refined form of the same thing, but in lower dose and less toxic, were entirely fruitless.

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Autoimmune enteropathy with goblet cell antibodies

In their interesting case report (June 1999 *JRSM*, pp. 311–312), Dr Rogahn and colleagues make no comment on the patient's chromosome status or tissue-type. In view of the known relationships of certain tissue types with particular autoimmune disorders it would be helpful to know these data since such a cluster of disorders is rare in one patient.

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Author's reply

The patient's chromosomes were normal but unfortunately we have no information about tissue type. I agree that this would have been of interest although it would probably not have helped in management of the patient.

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Contralateral extradural haematoma after ventriculoperitoneal shunt insertion

As Dr Power and colleagues point out (July 1999 *JRSM*, pp. 306–361), endoscopic ventriculostomy is the current treatment of choice for aqueduct stenosis, at whatever age the presentation. All neurosurgeons will do their utmost to avoid inserting a ventriculoperitoneal shunt. In their Figure 2, the right-sided collection of cerebrospinal fluid (CSF) suggests that too much CSF may have been let out at the time of shunt insertion. In shunt surgery, minimal loss of CSF is without doubt the key to avoidance of both acute and long-term problems.

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A Harley Street address

May I offer some additional comments on the delightful article by Sir Gordon Wolstenholme and Mr Raymond Hurt (August 1999 *JRSM*, pp. 425–428).

Lord Edward Harley married Henrietta Cavendish-Holles in 1713. She was the daughter and heiress of John Holles, 1st Duke of Newcastle, who had purchased Wimpole Hall, a great country house, about 8 miles west of Cambridge, in 1710, and died within a year. Edward Harley thus not acquired only a very well connected wife (there were close family ties even then between the Cavendish and Devonshire families) but also became owner of Wimpole Hall.

When he and his wife developed the Marylebone area, he named after himself Harley Street and gave names derived from his family or locality, Henrietta, Holles, Devonshire and Wimpole to the surrounding streets.

By 1740 financial straits compelled Harley to sell Wimpole Hall. He died a year later. Wimpole Hall remains the grandest country mansion in Cambridgeshire. Its many owners have included the Earls of Hardwicke (name of a neighbouring village) and, finally, the daughter of Rudyard Kipling. It now belongs to the National Trust.

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Management of penile fracture

In their article last year, Morris *et al.*[1] described four cases of fractured penis, all repaired via a subcoronal incision. One patient had a major complication—he developed an abscess which required re-exploration. Other workers using this technique report an early postoperative complication rate of 14%, including wound infection and subcoronal skin necrosis[2].

We believe that the use of the distal circumferential incision, with degloving, is an unnecessarily traumatic approach to the site of the lesion, which is usually more proximal[3]. The site of the tear can be found by gentle palpation of a rounded, tender lump—the 'rolling sign'[4]. Once the exact site has been located, simple repair can be performed under local anaesthesia, via a small longitudinal incision directly over the fracture site, with same-day discharge of the patient[5]. The complication rate of this minimally invasive procedure is negligible.

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The handshake

'Cancer' 'Spread'
Too young to be saying this
Too young to be telling *me* about *my* body
My life

'Only months'
Too young to know about years

'Smoking?'
He is well-dressed
Tie, jacket, shoes, pen
This is not the cloak of Beelzebub

He is well-spoken
'Afraid' 'Understand' 'Sorry'
Authentic and liberal sympathy
Why should it be lavished on me? I feel fine

The warmth of his handshake has faded
Cold
Icy

He speaks of organs, of treatment, of chances
My organs
Me

Is he referring to death?
My death

My spirit leaves me for just a moment
Drained
Holes
Loss
Empty

He has finished speaking
'Questions?'
There never were

Silence
Ether
Creak of chair
Muted nurse

We shake hands again
No contact
No metabolism
No time

I thank him

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Jacques Louis Reverdin

This month in history

1869 was a momentous year in the history of plastic surgery. A young Swiss surgeon from Geneva, Jacques Louis Reverdin (1842–1928), then working in Necker Hospital, Paris, embarked on a most unusual experiment in wound healing. On 16 October 1869, a 35-year-old man suffered an elbow injury during a fall from a ladder. Reverdin noted that 'the skin was cut near the bend of the elbow and torn away in its entire thickness as far as the middle forearm'. The skin flap underwent complete necrosis. By 14 November, a small border of epidermis was evident surrounding the granulation tissue. On 24 November, Reverdin removed two small slivers of epidermis from the right arm of the patient with a lancet, and placed them in the middle of the wound. On 27 November, the epidermal slivers were still in place. Reverdin now repeated the procedure with a slightly larger sliver, placing it on the wound at a distance from the first two. By 1 December, the first two slivers had united and formed a pale white plaque, and by 7 December, the three implants had united. With this innovative experiment, Reverdin succeeded in grafting small pieces of skin in open wounds—an important milestone in plastic surgery, which made possible the healing of large open defects.

Venita Jay