during the 2 h of surgery and the radial pulse became impalpable 30 min after induction.

The abdominal wall was infiltrated with lignocaine and incised in the mid-line. 3 litres of semisolids food was removed from the stomach and exploration revealed gross gaseous distension of small and large bowel, with infarction of the small bowel, and gas bubbles in the mesenteric veins. The ischaemic bowel was decompessed and packed with hot towels without any improvement and the patient died 1 h after surgery had been abandoned.

Necropsy revealed extensive haemorrhage into the submucosal layers of the stomach and small intestine, and the stomach wall was torn. The whole bowel was invaded by *Clostridium perfringens*. There was also melanososis coli, a condition often associated with purpura.

The main cause of death was probably septicaemia, but the massive abdominal distension, diaphragmatic splinting, and high serum potassium may well have contributed to a fatal outcome.

Abdominal distension inhibits return along the inferior vena cava and in acute distension there is not the physiological adjustment that occurs in pregnancy, ascites, or large ovarian tumours. During laparoscopy cardiac output fails when intra-abdominal pressure increases. The risk of inhalation of gastric contents could be a major problem in bulimia nervosa because of the gastric atony. Such patients often vomit effortlessly, and Russell describes a patient who could empty her stomach at will simply by placing one foot on a chair and leaning forward. For this reason the left lateral position should be used for induction of anaesthesia in such cases, together with auffed endotracheal tube to divert stomach contents away from the larynx. Abdominal restriction can reduce total lung capacity by displacing the diaphragm upwards, and this can affect arterial oxygenation in conscious and anaesthetised patients. In this patient the cyanosis did not respond to oxygen.

The preoperative hyperkalaemia precluded the use of suxamethonium (this drug raises the serum potassium and may thus cause cardiac arrest). Intubation under local anaesthesia was not possible and general anaesthesia was used. The patient was then allowed to breathe spontaneously since slight manual pressure on the reservoir bag caused the peripheral pulses to disappear.

There are some comparisons between this case and "pig-bel", in which necrosis and invasion of the gut by *Clostridium perfringens* follow the ceremonial eating of unaccustomed large quantities of partly cooked pork in New Guinea.

Bulimia nervosa is infrequently diagnosed, though this does not mean that it is rare. It needs to be recognised and treated early, if only to avoid the need for general anaesthesia when the gorging results in an abdominal emergency.

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POSSIBLE MECHANISMS OF PRIMARY THALAMIC HAEMORRHAGE IN NEWBORN

The report of primary thalamic haemorrhage in the newborn by Dr Trounce and colleagues (Jan 26, p 190) suggests that the short-term prognosis for affected infants is favourable. This is in sharp contrast to previous reports of two infants who were severely neurologically impaired and subsequently died (Toce S, personal communication, and Donn SM, unpublished). Unlike Trounce's...