size (3·2 cm and 2·0 cm, respectively) and increased in size (3 cm) in one lesion. In the 25 women who continued with oral contraceptives, size of FNH changed in only one patient who initially presented with two lesions (3·0 cm and 2·2 cm, respectively). Despite continuation of oral contraceptives, the largest FNH disappeared 2 years after the first diagnosis, whereas the other FNH remained unchanged. Moreover, during this follow-up study, 12 women became pregnant; no increase in lesion size was seen during pregnancy or follow-up of a median of 32 months (11 months to 5 years) after the pregnancy.

Our findings show that low-dose oral contraceptives can be maintained in young women with FNH.

4 Cherqui D, Rahmouni A, Charlotee F, et al. Determinants of potassium concentrations for hospital patients could be maintained in young women with FNH.

### Characteristics of patients

<table>
<thead>
<tr>
<th>Patients</th>
<th>No oral contraceptive intake (n=23)</th>
<th>High-dose oral contraceptive intake (n=6)</th>
<th>Low-dose oral contraceptive intake (n=8)</th>
<th>Highdose and low-dose oral contraceptive intake (n=23)</th>
<th>Progestagen intake (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (range) age (years)</td>
<td>29 (17–52)</td>
<td>38 (26–51)</td>
<td>33 (25–49)</td>
<td>35 (23–52)</td>
<td>33 (20–53)</td>
</tr>
<tr>
<td>Mean (range) duration of intake</td>
<td>24 (12–36)</td>
<td>36 (24–52)</td>
<td>7.2 (6 mo to 21 yrs)</td>
<td>7.4 (9 mo to 28 yrs)</td>
<td>3.2 (3 mo to 6 yrs)</td>
</tr>
<tr>
<td>FNH lesions</td>
<td>Mean (range) number</td>
<td>1·1 (1–4)</td>
<td>1·3 (1–6)</td>
<td>1·4 (1–9)</td>
<td>1·3 (1–6)</td>
</tr>
<tr>
<td>Mean (range) diameter (mm)</td>
<td>63 (10–120)</td>
<td>63 (15–150)</td>
<td>66 (10–180)</td>
<td>66 (10–145)</td>
<td>54 (15–110)</td>
</tr>
</tbody>
</table>

### Discussion

The correlation was strongest for samples obtained by family physicians ($r=–0.33$), but was weaker than that reported by Masters and colleagues. Hospitals further from laboratories had stronger significant correlations with ambient temperature (figure), but the range of correlation coefficients from $–0.09$ to $–0.19$ suggests that ambient temperatures were not major determinants of the potassium concentrations for these samples. The slope of the correlation line for family physician samples equates to a reduction in mean potassium concentrations of 0·02 mmol/L for each degree rise in ambient dry bulb temperature (SE 0·002).

The results lead to certain implications. In cases of borderline hypokalaemia, clinicians should find out whether the sample was delayed between collection and analysis. This possibility should be considered even for samples from inpatients, especially if the laboratory is not on site. A 10°C rise in temperature, which is possible even in temperate climates, could produce up to 0·2 mmol/L decrease in potassium concentration. In patients treated with diuretics, potassium concentrations might decrease to less than the reference range. This finding may also explain partly the higher number of decreased potassium concentrations that are observed during the summer months. Coronary-care...
Follow-up of patients with chronic anal fissure treated with topical glyceryl trinitrate

Jonathan N Lund, John H Scholefield

Topical glyceryl trinitrate (GTN) has been shown to be an effective treatment for chronic anal fissure, healing over two thirds of patients after 8 weeks of treatment.1 It is thought that healing is mediated by increased blood supply to the site of the fissure after surgical or "chemical" sphincterotomy with GTN.2 However, unlike surgical sphincterotomy, treatment with topical GTN has no permanent effect on the internal anal sphincter and return to pretreatment pressures of the sphincter has been shown by 3 months after initial healing.1 Some investigators have expressed concern that return to high sphincter pressures means that the likelihood of relapse is high. No long term follow-up of patients treated with topical GTN has yet been reported.

Patients whose chronic anal fissures had healed in two previously reported trials of topical GTN were identified and contacted by telephone.3,4 Patients were asked from a standardised questionnaire whether they had experienced recurrent symptoms of pain and bleeding on defaecation after an initial diagnosis of anal fissure.3 Of those reporting recurrent symptoms, 11 symptomatic relapses were of short duration (1–3 days), two settled spontaneously, and the other three were treated by a further course of GTN. In all three cases the GTN used was effective treatment for chronic anal fissure, healing over two thirds of patients after 8 weeks of treatment.1 It is thought that healing is mediated by increased blood supply to the site of the fissure after surgical or "chemical" sphincterotomy with GTN.2 However, unlike surgical sphincterotomy, treatment with topical GTN has no permanent effect on the internal anal sphincter and return to pretreatment pressures of the sphincter has been shown by 3 months after initial healing.1 Some investigators have expressed concern that return to high sphincter pressures means that the likelihood of relapse is high. No long term follow-up of patients treated with topical GTN has yet been reported.

Patients whose chronic anal fissures had healed in two previously reported trials of topical GTN were identified and contacted by telephone.3,4 Patients were asked from a standardised questionnaire whether they had experienced further symptoms of pain on defaecation and rectal bleeding since the end of the trial. If such symptoms were reported, patients were asked about the number and duration of relapses. They were also asked whether they had sought medical attention and how their relapse had been treated. The questionnaire was administered to 41 patients. Follow-up interval was a median 28 (range 24–38) months. Outcome is shown in the figure. Of those reporting recurrent symptoms, five had only one episode and six had more than one. Five symptomatic relapses were of short duration (1–3 days), two settled spontaneously, and the other three were treated by a further course of GTN. In all three cases the GTN used was effective treatment for chronic anal fissure, healing over two thirds of patients after 8 weeks of treatment.1 It is thought that healing is mediated by increased blood supply to the site of the fissure after surgical or "chemical" sphincterotomy with GTN.2 However, unlike surgical sphincterotomy, treatment with topical GTN has no permanent effect on the internal anal sphincter and return to pretreatment pressures of the sphincter has been shown by 3 months after initial healing.1 Some investigators have expressed concern that return to high sphincter pressures means that the likelihood of relapse is high. No long term follow-up of patients treated with topical GTN has yet been reported.

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At the Instituto de Salud del Niño in Lima, Peru, most cases of pulmonary tuberculosis are diagnosed and referred to peripheral health centres for treatment. Tuberculosis, however, caused 137 admissions in 1996, of whom 45% were children younger than 5 years.1 Paediatric tuberculosis is difficult to diagnose, and is generally made on the basis of clinical and epidemiological criteria, including signs and symptoms, chest radiography, percussion and postural drainage, and, most importantly, history of close contact with a patient with pulmonary tuberculosis.2 Bacteriological confirmation, however, is more difficult. Children are commonly infected with a small load of Mycobacterium tuberculosis and generally they cannot produce an adequate sputum sample. For this reason, 50–60% of children may be diagnosed with pulmonary tuberculosis in the absence of a positive culture or sensitivity testing. Because there is no efficient way to confirm the diagnosis, uninfected children may be treated unnecessarily, especially in areas with a low prevalence. Alternative ways of obtaining bronchial secretions are used to improve the yield of culture results;