

have not been made generally available as they should be. They could easily be obtained by analysing the number of services provided by salaried psychiatrists. From my own observations I have little doubt that with our present fee-for-service schedules and salary schedules, if all psychiatric services were taken over by the government there would be a major increase in cost to the community with no compensating increase in services. However, I could be wrong. The point is that surveys of this type should be carried out comparing the productivity of fee-for-service with salary methods of payment.

The salary range is becoming so attractive that any psychiatrist on fee-for-service payment should seriously examine the possibility of working for the government for 36 hours per week (plus all fringe benefits) and trying to see as few patients as possible. It has been estimated by surveys in the United States that psychiatrists in public service generally spend only 50% of their time seeing patients. The rest of their time they are happily involved in preparing reports, attending meetings and generally diverting themselves by offering the community advice on how to run governments, how to bring up children and so on.

Until a salary scheme can be devised that carries a built-in system providing incentive for seeing as many patients as are seen on a fee-for-service scheme, it is my contention that the lowest cost service will remain the fee-for-service system.

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Unusual reaction to Trasylol

To the Editor: I wish to report an unusual reaction to Trasylol, a polypeptide proteinase inhibitor used in the treatment of acute pancreatitis.

The patient was a 53-year-old man who had suffered three episodes of acute pancreatitis over a period of six to nine months. After the third episode radiographs showed a nonfunctioning gallbladder; intravenous cholangiography demonstrated a relatively normal common duct, which narrowed towards its lower end.

At operation a thick-walled gallbladder with numerous calculi was removed. An operative cholangiogram confirmed the marked narrowing toward the lower end of the common bile duct. Exploration of the common duct failed to locate any calculi. However, only a #3 dilator could be passed into the second part of the duodenum. Transduodenal sphincteroplasty was therefore carried out and a satisfactory widening at the lower end of the common duct was thereby achieved. At operation the whole of the pancreas felt within normal limits of consistence; no gross thickening or other changes could be

identified. When the operation was completed the patient was returned to the recovery room in satisfactory condition.

Because of the history of recurrent attacks of pancreatitis and because there had been a certain amount of manipulation in the head of the pancreas during the procedure it was thought that prophylactic Trasylol would be of value. A solution of 200,000 units in a litre of 5% glucose and 0.2% saline was infused at 100 ml/h. After five minutes the patient suddenly complained of severe chest pain and within a few seconds he lapsed into coma. His pulse rate rose from 86 to 140 beats/min. An electrocardiogram showed no abnormality other than an accelerated sinus rhythm with low voltage. His peripheral reflexes were diminished, although his plantar responses were flexor.

Solu-Cortef, 1 g administered intravenously, produced no effect, and five minutes later nalorphine hydrochloride, 2 mg, was given, also intravenously. After about another 10 minutes the patient showed signs of return of consciousness and reacted to commands. His blood pressure over the next 30 minutes slowly rose from 60/0 to 105/64 mm Hg and his pulse gradually fell to 90 beats/min. One hour after the administration of Trasylol his state had returned to normal and he had a normal pulse rate and blood pressure; a second ECG was normal and there was no increase in serum glutamic-oxalacetic transaminase or lactic dehydrogenase values. Subsequently the patient had an uneventful recovery.

It is believed that the episode represented an anaphylactic reaction to Trasylol and it was reported as such to the Drug Reaction Centre in Ottawa. In the manual supplied by the distributors of the drug the possibility of allergic reactions is mentioned and a specific warning is issued.

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Absence of uterine adnexa

To the Editor: The incidence of developmental anomalies of the female genital tract is reported as ranging from 1:222¹ to 1:321.² Their not infrequent association with abnormalities of the urinary tract is hardly surprising since the development of the mesonephric system is closely integrated with that of the paramesonephric system.

Varino and Beacham³ described a case of left renal agenesis, true unicornuate uterus and total absence of left broad ligament, round ligament, salpinx and ovary.

Recently Sebastian, Baker and Cordray⁴ reported an incidental finding of absent adnexa for which the presumptive explanation was asymptomatic infarction of the ovary and distal portions of the fallopian tube. Georgy and Viechnicki⁵ added another such case where the calcified ovary was found in the cul-de-sac. The incidental finding

of absent adnexa has been mentioned^{6,7} but not reported, and a history of abdominal pain in childhood has almost always been present. Torsion of normal adnexa, most common in childhood, produces an acute abdomen requiring laparotomy.⁷

We report the incidental finding of absent adnexa at postpartum tubal ligation.

A 34-year-old woman, gravida V, para 5, underwent tubal ligation through an abdominal incision on the fourth postpartum day. The right ovary and uterine tube were delivered easily and tubal ligation was performed by Pomeroy's method. The uterus appeared normal. The left ovary, uterine tube, broad ligament and round ligament were absent. No mass was found in the pelvic cavity. Both kidneys were palpable.

She had had five spontaneous vaginal deliveries of healthy babies and all her pregnancies had been uncomplicated. She had no history of acute abdominal pain or of abdominopelvic surgery.

An intravenous pyelogram done three months post partum showed the presence of two kidneys with no abnormalities of the urinary tract. A hysterosalpingogram showed a normal uterus and absence of the left uterine tube.

The absence of the left adnexa in this patient remains unexplained. Asymptomatic infarction of ovary and uterine tube appears plausible but congenital absence cannot be ruled out.

The reproductive significance of unilateral absent adnexa is uncertain but probably inconsequential as seen in this patient. Of more importance is the exclusion of urinary tract anomalies, in view of the frequency of combined urogenital anomalies. "Hysterosalpingiography should be undertaken in all fertile women with congenital urinary tract anomalies and urography in all patients with genital malformations."⁸

Study of the vascular tree of the internal genitalia in this patient would be of interest but is not warranted because of the attendant risks.

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