Comment.—The diagnosis in our patient was delayed for four days because retroperitoneal hematoma was not considered, despite the classic clinical manifestations and because a good neurological examination, especially testing the strength of the quadriceps and testing the knee jerk, was not carried out. Computed tomography can reveal the presence of a retroperitoneal hematoma early, and one does not have to wait until swelling in the iliac fossa appears. With conservative treatment, a good recovery of this type of femoral neuropathy has been reported in hemophilic. Therefore, we wonder whether surgical evacuation of the hematoma is at all necessary. Although the majority of reports recommend early surgical drainage, at present, the data of surgery vs conservative treatment are inadequate to draw any conclusions.

We urge all physicians treating patients with anticoagulants to be aware of this complication. While receiving anticoagulant therapy, if the patient experiences severe pain, severe pain in the groin, hip, or anterior thigh, the anticoagulant therapy should be withdrawn immediately, even in the presence of normal prothrombin time. Next, the function of the femoral nerve should be evaluated carefully so that early diagnosis of retroperitoneal hemorrhage can be made, thereby possibly avoiding surgery and permanent femoral nerve dysfunction.

Cryoprotein Antigen Test

To the Editor.—In their CLINICAL NOTE “False-Negative Cryoprotein Antibody Test” (Stamm and Poli [1980; 244:1330]) point correctly that prostate zones may occur in the slide latex agglutination (SLA) test for cryoprotein antigen in both serum and CSF specimens. Bloomfield et al in describing the test, did not advise against diluting CSF before testing, and in our subsequent 17 years of experience with SLA testing, we have observed a very occasional prozone reaction in CSF. Our current practice is to dilute all specimens through 1:16 in screening for cryoprotein antigen. Of course, if cryoproteins are seen in India ink preparations, the diagnosis is made regardless of serologic results, although we certainly agree that “a CSF specimen with positive findings in India ink examination but negative results for the LA test should be diluted and retested” for both confirmation and prognosis. We admit to some concern about the discontinuation of antibiotic therapy for the cited patient when the antigen titer fell to 1:80. In our experience the persistence of detectable antigen at any titer has been a harbinger of eventual relapse.

We have heard of occasional false-positive results in the SLA test of spinal fluid, but those can be virtually eliminated by heating the CSF in a boiling water bath for three minutes before testing. False-positive results may occur in serum specimens that contain high-titered rheumatoid factor, but these are readily eliminated by treatment with dithiothreitol.

The Ceiling-Retractable Service Column

To the Editor.—The design of any piece of equipment for the initial resuscitation of the critically ill or injured must be functional and instantaneously available. During the conceptual period of the development...
of the Emergency Medicine and Trauma Center at Oklahoma Memorial Hospital, concern was raised about the difficulty of maneuvering around a critical patient inundated by many tubes, wires, and intravenous (IV) lines. Frequently, it is almost impossible to move from the left side of the stretcher to the right because of the suction tubing coming from the wall behind the patient's head, the ECG monitor position on the right side, the oxygen lines from the left side, and IV tubing dangling from the ceiling. It was decided, therefore, to design life support and resuscitation areas for the critically ill and injured that would allow for the majority of tubes and wires to approach the patient from one area. The use of a ceiling mount that would extend and retract and supply various outlets appeared to be the best solution.

A centralized, overhead, service outlet retractable column was purchased and certain modifications carried out to allow for two oxygen lines, two suction lines, four monitoring channels, and two 115-V jacks to be available directly from the ceiling-retractable column.

One oxygen outlet is available for a 15-L oxygen flowmeter with face mask, and the additional oxygen outlet was fitted with a demand valve and face mask. The two suction outlets were set up so that one line supplied a flexible suction catheter and the other line was fitted with a rigid tonsillar suction tip. Rigid and flexible suction is immediately available. The four monitor lines allow for ECG and pressure monitoring with the oscillographic screen mounted on a wall just behind the patient.

Two electrical 115-V outlets are also present in the column, should additional electrical apparatus be needed. Figure 1 illustrates the support column with the equipment in place before receiving a patient. The various outlets and devices are easily seen. Figure 2 illustrates the lines and tubings as they approach the stretcher. This arrangement directs all of the lines to the patient from either the right or the left shoulder and allows for general mobility around the stretcher. The ability to raise and lower the ceiling support outlets allows for easy attachment of the lines and the opportunity to raise them out of the way. Not only does this ceiling-retractable column allow for easy movement around the patient, but it also provides the availability of two immediate sources of oxygen and two immediate sources of suction at that of utmost importance for resuscitation of the critically ill or injured patient.

In the Emergency Medicine and Trauma Center of Oklahoma Memorial Hospital, six life-support areas are now in use with these ceiling columns. Numerous resuscitations have been performed. The design has proved functional and has provided simultaneous access to oxygen, suction, monitor, and electrical outlets. The lines to the patient directed from one area did provide greater ease of movement around the patient and stretcher.

Gastrointestinal Disorders in Runners

To the Editor.—Gastrointestinal disturbances were recently described in two long-distance runners, one of whom had bloody diarrhea (1981; 243:1740). I wish to describe two additional instances of the latter and to caution that the entity may mimic acute appendicitis and Crohn's disease.

Report of a Case.—Case 1.—A 17-year-old man ran a competitive 1.6-km race in 4:23 despite feelings of fatigue for the previous two weeks. He rested a day and then did vigorous anaerobic training (20 sets of 160-m dashes, each under 30 s, with the exercise pulse rate of 210 beats per minute and the recovery rate of 170 to 180 beats per minute) in preparation for a state tournament competition. That evening he had transient crampy abdominal pain, gas, and light brown diarrhea. The next day he did three 0.8-km runs (2100 m each) and two 1.6-km runs (4352 m each). Mild diarrhea was noted in between the 0.8-km runs. Over the next two days he noted persistent dull, aching epigastric