LETTERS TO THE EDITOR

Painful rib syndrome

EDITOR,—The painful rib syndrome recently described by Scott and Scott is, in my opinion, a misnomer. Over the years I have seen numerous cases similar to the ones they report, and have found that the tender spots they allude to are not in the ribs but in the muscles. They are, in fact, myofascial trigger points. Pain develops because of trauma induced activation of nociceptors at these sites in what is now called the myofascial pain syndrome.1 These trigger points may be found in any muscle in the body. In the abdomen they commonly occur in the rectus abdominis and external oblique muscles. They do not only develop however, at or near to their insertion into the ribs, but also in their bellies and at lower attachment sites such as the iliac crest, inguinal ligament, and pubic bones.

The pain emanating from trigger points in this syndrome may be abolished by injecting a local anaesthetic into them.2 Recently it has been shown that pain is also relieved by stimulating A-delta nerve fibres at these sites with dry needles; treatment that is physiologically more rational and less being simpler, safer, and equally effective.3

Gastroenterologists must learn to recognise ‘trigger point pain’ because it is common and can be treated. The concept of the painful rib syndrome restricts the diagnosis to pain in the lower thorax and upper abdomen, as well as implying that there is no effective treatment other than reassurance. Trigger point pain may occur anywhere in the abdomen with additional sites in the perineum and back. The pain can be recognised easily so unnecessary investigations and operations are avoided. It usually responds quickly to acupuncture; further courses can be given if relapse occurs.

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Colonicoscopy surveillance in ulcerative colitis

EDITOR,—In a recent letter we commented that it would be sensible for doctors of all grades to undergo training in colonoscopy, and that this attitude should be reflected in the training of all future doctors.1 However, many doctors would not be satisfied with the current situation which often requires doctors to complete a fellowship or specialist registrar post to gain this clinical skill. We would argue that the introduction of a robust training and certification programme is essential and should be encouraged by our professional bodies.


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—Thank you for the opportunity of replying to Messrs Rutter and Leicester’s letter. We agree with much they say. In our paper we advocated long-term clinical follow

the term hypochondriacal flatulentuncum morbum.1,2

In Graeco-Roman times, hypochondria was considered a part of melancholia—what we today call depression. Today, the meaning of the word hypochondria has changed. In the eighteenth century, hypochondria still had the antique denotation.3 As hypochondria was (or is?) particularly common in England, it has been described as the English malady. I would like to suggest that Scott and Scott will find the aetiology of their syndrome when they obtain a medical history looking for signs of depression.

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3 Cheryn G. The English malady: or, a treatise of nervous diseases of all kinds, as sprees, vapours, lameness of spirits, hypochondrias and hysterical disorders, etc. London/Dublin: 1733.

Reply

—It is encouraging that others readily recognise the syndrome we described. It is also interesting that Dr Dyer sees this as part of a wider syndrome and it behoves all clinicians to keep this in mind when confronted with patients who have pain that does not readily fit other well defined categories. At the least it may prevent unnecessary investigations, and it may even lead to effective treatment. Our study did not look into the aetiology and Dr Dyer’s concept of myofascial trigger points is plausible. Although reassurance and explanation is probably sufficient for most patients, some remain troubled and for them acupuncture is possibly appropriate. We agree with Professor Feurle that depression possibly plays a part in this syndrome, but doubt that it is an important part. Clinical depression in myofascial pain is not a prominent feature among our patients at the time of examination although 28% gave a history of either depression or anxiety.

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