

solution constituting concentrations of bacteria from 10^8 to 10^7 /mL. These samples were presented in a randomized fashion for examination to two of us who have had much experience with this microscopic method. Excellent results were obtained as indicated on the graph. At a bacteria concentration of 10^8 /mL, the test was 100% sensitive, and at lesser concentrations, only few readings were positive. Thus, this method, which circumvents the variabilities of urine centrifugation and is easier to prepare than a Gram-stained slide, is an accurate technique for the clinician who desires to quickly make decisions concerning the presence of an important amount of bacteriuria.

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Clinical Trial of Rectal Self-examination

To the Editor.—To test the adequacy and acceptability of rectal self-examination, I asked ten physicians and a medical technician to perform the maneuver on themselves. The results show that this method may improve the five-year survival rate of rectal and prostate cancer, which has changed little in the past 20 years.¹⁻³

Three of the physicians felt that the examination was comparable in adequacy to that performed on patients. Two physicians judged that, though they could not palpate as much in themselves as in a patient, they still were able to feel much of the rectal wall and part of the prostate. A sixth

physician was not able to use his middle finger because of rectal spasm, but could perform a partial examination with his little finger. The medical technician had no difficulty palpating his entire rectal wall and prostate. The four remaining physicians refused to try the examination.

This clinical test indicates that at least a part of the general public could be taught rectal self-examination. This could be accomplished by means of simple written instructions. Readily available lubricants, such as petroleum jelly, should be used on the middle finger (with fingernail trimmed). Alternately, a soap without added deodorant or perfume can be first applied to the finger, though this may be irritating to some individuals. The rectal wall should feel smooth and moist without hardened areas or warty growths; the prostate should have a smooth, regular texture without hardened areas or swellings, and the urge to urinate should occur when the prostate is being palpated. These instructions and criteria of normalcy could be supplemented by an uncomplicated drawing of the region (Figure). After regular, repeated examinations, the average individual should become well-acquainted with the feel of the normal anatomy and thus able to detect the occurrence of even the smallest lesion. Those lesions that are detected early are most likely to be cured.

Unfortunately, elderly individuals with the greatest incidence of rectal and prostatic cancer will have the most difficulty with rectal self-examination because of their diminished agility.^{4,5} But even these persons should be encouraged to attempt the maneuver, if only to detect early cancer of the anus. This disease, though easily discovered in the course of normal body hygiene, is now discovered at a very late stage by most patients, probably on account of their great reluctance even to touch the anal region.

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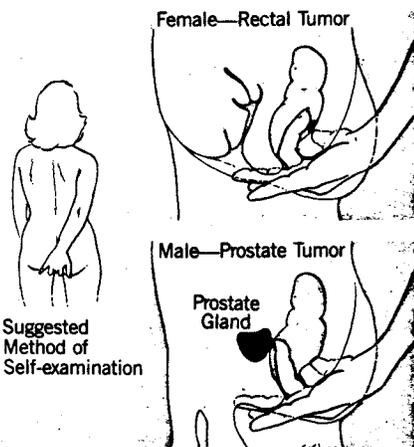
Coffee Consumption

To the Editor.—As a heavy coffee drinker, I was reassured by the article by Heyden et al in the October ARCHIVES (138:1472-1475, 1978) demonstrating that mortality from all causes was not higher in people who consume large amounts of coffee. However, one of my patients with an unusual coffee intake did seem to suffer important symptoms because of coffee consumption.

Report of a Case.—A 24-year-old man came for evaluation of persistent nervousness, tachycardia, sweating, headaches, and chest discomfort. The patient had undergone a left adrenalectomy two years before for "pheochromocytoma." Despite the operation, his symptoms persisted. Coronary artery catheterization was normal. Review of the hospital record revealed that prior to the operation, the urine vanillylmandelic acid (VMA) level was 13 mg/24 hr (normal, 0 to 12 mg/24 hr) and the urine catecholamine level was 305 μ g/24 hr (normal, 15 to 140 μ g/24 hr). The blood pressure during his hospitalization was never elevated but his pulse rate was 120 beats per minute.

Results.—Results of physical examination revealed his pulse rate to be 104 beats per minute and his blood pressure was 130/90 mm Hg. There was no orthostatic fall in blood pressure. The skin was warm and moist and there was slight hand tremor. The thyroid was diffusely enlarged to 1½ times normal size.

We noted a bizarre urine volume of 5,000 mL/24 hr when the patient returned his urine for assay. We then learned that the patient had been drinking between 30 and 40 cups of coffee daily since the age of 16 years. His VMA level was 9.9 mg/24 hr (normal, 0.7 to 6.8 mg/24 hr) and his urine metanephrine level was 0.5 mg/24 hr (normal, 0.3 to 0.9 mg/24 hr). The serum free thyroxine index was 1.5 (normal, 1.1 to 3.4); serum 3,5,3'-triiodothyronine radioimmunoassay, 125 ng/dL (normal, 50 to 150 ng/dL); serum thyroid-stimulating hormone radioimmunoassay, 2.1 μ U/mL (normal, < 8 μ U/mL); and the 24-hour sodium iodide I 131 uptake, 15%. His cholesterol level was 287 mg/dL, and the serum triglyceride level was 215 mg/dL (normal, 30 to 150 mg/dL). The baseline plasma cortisol level was 5 μ g/dL (normal, 5 to 25 μ g/dL) and 30 minutes after cosyntropin injection, it increased to 20 μ g/dL (normal rise,



Method of rectal self-examination.