pharmacology and psychiatry to such relatively neglected geriatric compounds may yield better practical results.

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¹ Yesavage, J A, *et al*, *Archives of General Psychiatry*, 1979, **36**, 220.

² Yesavage, J A, *et al*, *Journal of the American Geriatric Society*, 1979, **27**, 80.

What are accident and emergency departments for?

SIR,—The accident departments that claim to have become an alternative to the surgery deserve our sympathy (6 October, p 837). I have worked for 20 years as a clinical assistant in a casualty department where the relationship between consultants and general practitioners is excellent and few patients abuse the system.

One problem is that in hospital technical expertise is not always combined with an awareness of social problems. How many accident consultants have visited their patients' homes or factories, know when the weekly bus from outlying villages runs, or know the facilities of the local surgeries?

I believe that such knowledge is essential for effective as well as humane care. Satisfactory home conditions as well as strict medical criteria are necessary before a child, for instance, is discharged home after a minor head injury. The intelligence of the mother, the proximity of a telephone, and the willingness of the general practitioner are just three factors to be considered.

Patients are sometimes brought back to the hospital when they might easily have been referred to their own doctor. A few years ago a mother and son died in a car crash near here when the latter was asked to return to a hospital 10 miles away to have sutures removed. His doctor, I know, would willingly have done this simple task for him.

General practitioners working in casualty departments can see that these social factors are not forgotten and help to narrow the gap between hospital and home care.

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Disasters, flying squads, and immediate care

SIR,—The Inter-service Co-operation and Disaster Planning Subcommittee of the British Association of Immediate Care Schemes (BASICS) is currently engaged in a study of major accident plans and is reassessing the planned disaster intervention.

The article by your special correspondent (20 October, p 973) mentions the need for standardisation. We plan to standardise and clarify the expected response to a disaster situation from the medical and paramedical (ambulance) services. For example, a recent edition of the journal *BASICS* carried a summary of the role of the site medical officer. Clear guidance is urgently needed now to clarify terminology and the designation of doctors to certain duties. Another urgent requirement is for standardisation of triage and casualty labelling. Every hospital and ambulance service seem to have their own ideas.

I should like to ask if readers responsible for area health authority and hospital major accident plans would be prepared to send me copies of their plans for the BASICS library, and also to enable us to extract the many good ideas and systems which have been developed locally and which deserve much better publicity. Any other comments pertaining to the medical response to a major accident would similarly be much appreciated.

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Appendicectomy during caesarean section in a developing community

SIR,—I cannot agree with the opinion of Mr W O Chukudebelu and Dr W B Onuigbo (18 August, p 423) that appendicectomy during caesarean section in a developing community is worthwhile, nor do I believe that they have shown it to be safe.

Appendicitis is known to be extremely uncommon in the rural African woman taking a traditional diet, which has a high fibre content. My own experience in Malawi confirms this in that I saw only one case of appendicitis in pregnancy from approximately 200 000 pregnancies from which such cases would have been referred over a period of years. To see an appendicectomy scar was also a rarity.

As regards the safety of appendicectomy, the series reported included no cases of paralytic ileus and apparently none of severe puerperal sepsis. But such cases are bound to happen from time to time, especially in developing communities, and if appendicectomy has been carried out it will be a source of danger when ileus does occur, and a source of diagnostic difficulty where there is sepsis and abscess formation. Mr Chukudebelu and Dr Onuigbo have shown the supposed safety of the procedure under teaching hospital conditions with the operation performed by a consultant obstetrician and gynaecologist. It has to be remembered that the great majority of caesarean sections in developing communities are carried out by district medical officers or mission doctors who are non-specialists and only part-time surgeons. Appendicectomy in these conditions must be less safe, and in any case such doctors have many more valuable things to be doing with their time.

To show convincingly that appendicectomy at caesarean section is worthwhile and safe it would be necessary to measure the morbidity and mortality from appendicitis in a population of adult women, and show to what extent that could be diminished by appendicectomy at caesarean section, account being taken of the morbidity and mortality associated with the procedure. This would need a series of many more than 100 cases.

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Appendicectomy and family history

SIR,—In their letter (20 October, p 1003), Mr Lionel Gracey and Dr Stuart Sanders relate their unusual experience of operating on a pair of twins for acute purulent appendicitis on the same day, and they draw attention to the interesting fact that whereas in one of the twins a

faecolith was present (acute obstructive appendicitis) this was not so in the other (acute non-obstructive appendicitis.)

I would like to suggest the strong possibility that the only reason why no faecolith was found in the one case was that it had slipped back into the caecum before the operation; a faecolith fugax. Many years ago I had the rare experience of feeling such a faecolith slip back into the caecum at operation, without any encouragement on my part, and before I had made any attempt to mobilise the caecum and appendix. But for this observation the appendix would have been regarded as another example of acute non-obstructive appendicitis, a pathological concept which I have since come to regard with suspicion.

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Fulminating meningococcal septicaemia

SIR,—This clinical condition described in your leading article (20 October, p 953), known as the Waterhouse-Friderichsen syndrome, has salient features of sudden onset, fever, collapse, haemorrhages in the skin, and bilateral adrenal haemorrhage. This last grave feature was overlooked in your article, and there was no mention also of any post-mortem findings in another contribution dealing with 10 deaths from this condition in young children (25 August, p 468) or of corticosteroids being used in their treatment, but the authors quite rightly emphasise the urgency of treatment and suggest that the medical attendant should bring the victim to hospital in his car without delay. The presence of petechiae and large ecchymoses in the skin is diagnostic in a very ill patient and the practitioner should not be misled by the absence of meningismus. The other condition that might simulate this is typhus fever.

When serving as a resident medical officer at a large infectious diseases hospital during the cerebrospinal epidemic in 1940, I saw nearly 300 cases, among them six of the fulminating variety. Although treated immediately on admission with sulphathiazole and deoxycortone acetate, they all died within a few hours of admission.

Even after nearly 40 years my clearest recollection is of the post-mortem findings—massive haemorrhages into the suprarenals, liver, and other organs being the most striking features. We undertook our own laboratory work and I succeeded in demonstrating diplococci, two or three pairs in every high-power field in a blood film from one of these fatal cases; the memory of the technique of this escapes me, but as evidence of the overwhelming septicaemia it would appear to be unique.

The only hope of a recovery lies in early diagnosis and immediate treatment with suitable antibiotics together with steroids and treatment of shock; one should not delay by undertaking a lumbar puncture or waiting an hour for the result of a limulus endotoxin assay mentioned in a letter from America (7 April, p 953). In the unlikely recurrence of a countrywide epidemic of cerebrospinal meningitis, one would expect to have an incidence of 1-2% of the fulminating variety and not many medical practitioners would come across one.

Incidentally the cerebrospinal fluid in these fatal series was either clear or slightly hazy, death ensuing before the development of a frankly purulent meningitis; thus meningism was not a clinical feature.

I noted that the condition was not included in your excellent medical emergencies series, but, despite its rarity, it deserves a place in any future series.

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Hong Kong dog and the Tokyo trots

SIR,—In the *BMJ* (4 August, p 316) there is a query asking if the writer may take a small dose of sulphaguanidine when visiting Hong Kong. No doubt he has the Hong Kong dog in mind and I note that your correspondent thinks that he should not take the drug.

This puzzles me, as in my travels around the world I have become familiar with the Hong Kong dog, the gippy tummy, the Trinidad dog, the Tokyo trot, and several other strange animals that can ruin a week of one's holiday, and I have never failed to cure it in 12 hours or less with three or four four-hourly doses of Guaninycin (sulphaguanidine, dihydrostreptomycin sulphate, and kaolin) or Streptotriad (sulphadiazine, sulphadimidine, sulphathiazole, and streptomycin sulphate). Not only in civilised areas but also on archaeological digs at some of the wildest camp sites in Egypt, Sudan, and the Middle East, it works equally well in people who, otherwise healthy, have been stricken with the dog, which can come like a bolt from the blue and lay a man low in a very short time. The victims of the dog have always regarded it, as I have done, as a gift from the gods, so I wonder greatly why you do not recommend such marvellous, wonderful, and almost instant health-giving remedies as Guaninycin and Streptotriad for this vicious animal.

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Primary anaerobic peritonitis

SIR,—In his article on anaerobic peritonitis (13 October, p 903) Mr Philip Matthews comments that his reported case appears to be the first such case of primary origin recorded in the literature. We should like to report a recent fatal case from the Western Infirmary, Glasgow, which shows some notable similarities.

A 16-year-old girl with no previous medical problems and no recent illness developed epigastric pain, vomiting, and diarrhoea. The illness was associated with a fever and was initially thought to be of viral origin. However, the symptoms progressed and by the third day she was severely ill and showed signs of peritonitis. She was transferred from an island off the west coast of Scotland to the Western Infirmary, Glasgow, where she was found to be gravely ill, being semi-comatose with a blood pressure of 80/100 mm Hg, pulse 160 beats/min, and a temperature of 39.5°C. Her abdomen was slightly distended, resonant, and silent, with widespread peritonism, notably in the right iliac fossa. Some mottling of the lower legs was noted. X-rays showed free gas under the right diaphragm. Full blood count showed a profound neutropenia with a total white cell count of $2.5 \times 10^9/l$ in spite of severe dehydration. The complement of white cells was composed mostly of premyelocytes.

Despite intensive resuscitative measures to

improve her general condition prior to any surgery, including rapid fluid replacement and the administration of gentamicin and metronidazole, her blood pressure remained low and unstable. Four hours after her admission and despite her grave condition it was decided to operate as a definitive step to remove the source of the presumed septicaemia. At laparotomy, the presence of free air was confirmed and a large quantity of straw-coloured intraperitoneal fluid was present. The lower ileum, caecum, and ascending colon were grossly oedematous and discoloured, although not frankly gangrenous. All retroperitoneal tissues in the right flank were swollen and crepitant. The liver was enlarged and also contained gas. There was a general peritonitis, although the appendix and pelvic organs were otherwise quite normal. Unfortunately, but not unexpectedly, the patient had a cardiac arrest during surgery and could not be revived.

At the necropsy the next day the body showed advanced decomposition. The operative findings were confirmed and showed the absence of any pathology either within the abdomen or in other tissues to account for the origin of the infection. In particular there was no evidence of disease of pelvic organs. The bacteriologist reported a heavy pure growth of *Clostridium oedematiens* from the intraperitoneal fluid.

The above case is similar in several respects to Mr Matthews's reported case. Notably, both patients were 16 years old and were otherwise healthy with no precipitating factors. The organisms in the two cases differed. The clostridium found in the present case probably accounts for the irreversible shock, profound neutropenia, and ultimate death. The severity of this terminal infection was out of keeping with the three-day history and may indicate that the original infection was more mixed—in Mr Matthews's case infection with a fusobacterium was accompanied by a leucocytosis of $27.6 \times 10^9/l$ despite a history of only 24 hours.

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Treatment of hyperhidrosis

SIR,—We read with interest the paper by Dr I A MacFarlane and others (13 October, p 901) confirming previous reports of the effectiveness of aluminium chloride hexahydrate in absolute alcohol for the treatment of hyperhidrosis.

We have treated three patients with this condition for up to 18 months with 20% aluminium chloride hexahydrate in industrial methylated spirit with excellent results. The cost of absolute alcohol is currently £4.47 per 100 ml including excise duty. The cost of industrial methylated spirit is 7.5p per 100 ml.

If, as seems likely, this preparation is to become the first-line therapy for hyperhidrosis, we think that it should be prescribed in industrial methylated spirit, as we can think of no justification for using the vastly more expensive absolute alcohol.

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Penis captivus

SIR,—The fascinating review by Dr F Kräuph Taylor (20 October, p 977) on the emotive subject of penis captivus deserves to be

followed by a spate of anecdotal correspondence. Perhaps I might make a small contribution.

While serving with the RAMC in the Gold Coast in 1941 I became aware of an African publication known as the *Ashanti Pioneer*. I cannot recall whether it was published daily or weekly but its content had a Rabelaisian flavour that endeared it to some of the European expatriots. I was shown a paragraph cut from the paper and carefully preserved by its delighted owner. It described a case of penis captivus with a wealth of detail, including the name of the remote village where the affair took place and the difficulty in hoisting the embarrassed couple on to a lorry for 30 miles of bumpy transport to the nearest government medical officer. His use of chloroform for the woman resolved the situation.

It is, of course, possible that the episode was a journalistic fabrication but the naming of the village and of the doctor concerned made me feel at the time that the event had indeed taken place. It is probable that others of your readers who have worked overseas will be able to add other cases to the few records collected by Dr Taylor.

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Medicine in the USSR

SIR,—As a doctor who qualified in the USSR, I feel obliged to challenge one of Dr Michael Ryan's conclusions (20 October, p 979). On the basis of one case of poor prescribing and another case of a hernia being missed he arrives at the alarming conclusion that "By British standards, these [Soviet medical education and practice] appear to leave a lot to be desired. . . ." Surely, as one who claims knowledge of the scientific method, Dr Ryan should know better. These cases do reflect badly on Soviet medicine but are insufficient evidence to justify the conclusion reached. Isolated cases of laziness, lack of attention to detail, or even frank incompetence on the part of doctors can be found everywhere, including Britain. I have recently been associated with a case of missed femoral hernia and yet I have not concluded that British doctors cannot diagnose hernias.

Statistics were introduced into medicine to curtail prejudice and encourage logical conclusions. If Dr Ryan seriously thinks that Soviet medical education and practice are inferior, he must come up with scientific evidence to prove it. I found his article very prejudiced.

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Lack of flexibility in vocational training?

SIR,—I write to say how profoundly I agree with Dr D P Brown's letter (27 October, p 1078). The best general practitioners are born, not made. By a combination of instinct and insight they know already much of what many vocational training courses seek to spell out so laboriously today. One encountered the same instinctive ability in good grammar school masters between the wars, who did not need three years' instruction at a teachers' training college to become good teachers.