trivial, I would like to point out that dracunculiasis is not acquired either by ingesting or by contact with snails but by drinking water containing infected *Cyclops* species, which are small (1-2 mm) freshwater crustaceans. In man the mature female worm discharges first-stage larvae (not eggs) at the surface of the skin, usually when the affected part of the body (commonly the foot and lower leg) comes into contact with water. These first-stage larvae are extremely active and can live for four to seven days; their further development, however, depends on their being eaten by a predatory species of *Cyclops*. The larvae penetrate the gut of the *Cyclops* and after two moults in the haemocoel reach the infective third stage.¹ Dracunculiasis today is mainly a disease of rural communities.

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¹ Muller R. *A manual of medical helminthology*. London, Heinemann, 1975.

St Joseph's Hospice

SIR,—Unbalanced though it was, the programme on St Joseph's Hospice did not justify the strictures of your correspondent AS (15 December, p 1579).

Factual errors show that AS is out of touch with the running of St Joseph's and therefore with its singular lack of religiosity. Ministers, parsons, priests, and rabbis are familiar and welcome visitors, but proselytisation is unknown. If conversions occur, they do so in accordance with Johnson's dictum on imminent death. Certainly, there is nothing to suggest that Catholic or Christian patients are favoured more than those of other (or no) religion.

It would be very sad if AS succeeded in dissuading doctors, nurses, or patients from accepting what St Joseph's offers. I know because I have worked there; I am an Anglican with sceptical tendencies.

B SYMONDS

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Resuscitation of the newborn

SIR,—Few articles and even fewer chapters in books of neonatal medicine give any specific details of the techniques that are necessary to resuscitate newborn babies effectively and safely. Dr H B Valman's article (24 November, p 1343) is exceptional in giving an outline of this subject with which all midwives and paediatricians should be familiar. However, there is one aspect of his instructions on endotracheal intubation which I think needs immediate correction.

The epiglottis is a sensitive and fragile tissue and the blade of the laryngoscope should not be placed over it or be used to press it against the tongue. Instead the tip of the laryngoscope should be advanced slowly over the tongue from the right side of the mouth and positioned in the vallecula, anterior to the epiglottis. In this position the epiglottis swings anteriorly when the laryngoscope is gently raised. There can then be no doubt about the site of the entrance to the larynx even when it is obscured by secretions or meconium. Failure to intubate is frequently due to unnecessary urgency, which leads to an incomplete identification of the anatomy of

the upper airway. This is made more difficult when the laryngoscope is advanced too far. Soft-tissue injury of the upper airway, including trauma to the epiglottis, is a common finding after frequent attempts at intubation by inexperienced personnel. Mechanical stimulation of the epiglottis can also cause reflex laryngeal spasm, making intubation even more difficult.¹

Another common mistake which adds to the difficulties encountered during intubation is the idea that the baby should be placed on a sloping surface with the head much lower than the feet. Dr Valman quite rightly states that the infant should be placed supine on a flat (horizontal) surface. In this position the head should be slightly elevated *without extending* the neck.² Unfortunately, the picture in Dr Valman's article shows a baby on a tilted surface on which some babies will slide, making intubation even more difficult.

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¹ Johnson P. In: RR Robinson, ed. *Proceedings of the Francis E Camps International Symposium on Sudden and Unexpected Deaths in Infancy*. Toronto: Canadian Foundation for the Study of Infant Deaths, 1974:231-241.

² Klaus NH, Fanaroff AA. *Care of the high-risk neonate*. Philadelphia: WB Saunders Company, 1979:31-3.

Breathing difficulties in the newborn

SIR,—In his article in the *BMJ* of 8 December (p 1483), Dr H B Valman states that the cause of the respiratory distress syndrome is a deficiency of pulmonary surfactant.

While I would not dispute that a deficiency of surfactant *correlates* with the respiratory distress syndrome, precipitating *causes* are observable daily during hospital management of preterm infants. Every intervention, such as heel-pricking with needles, weighing on metal scales, insertion of nasogastric tubes, and especially insertion of rectal thermometers, causes an observable disturbance of respiration, and is frequently followed by a sustained increase in respiratory rate.

The distress which these regular and painful procedures cause the infants can only be expressed physically. This distress may be lessened by nurses who are aware of the babies' feelings, who talk and handle them sympathetically, and who stay a while with the babies when the procedures are over, talking and touching in a non-painful way and giving the babies something to suck—that is, holding the whole baby in mind.

If one's only contacts with other humans are painful, one's hope and one's will to survive are bound to diminish. No one who takes time and trouble to observe these babies will fail to see what I have described above.

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Multiple sclerosis: what can and cannot be done

SIR,—The contribution of Professor E J Field and Greta Joyce (15 December, p 1571) is rightly published under the heading "For debate" and we hope that a lively discussion

will follow. Otherwise readers could get the wrong impression that multiple sclerosis has become a disease easy to diagnose and to prevent. Except for point (1)—that there is no cure for clinically established MS—all statements made by the authors are unproved or misleading.

Work with coded material has shown that the erythrocyte unsaturated fatty acid (E-UFA) test is non-specific¹ and by no means better than other laboratory parameters (immunoglobulin ratio, oligoclonal bands of the cerebrospinal fluid, etc). The results of other authors who could not confirm the test^{2,3} cannot be ignored. Seaman *et al*⁴—given as reference for the test's validity—could reproduce the results for clinically confirmed cases, but not for patients "with minimal neurological findings." That means that even if the test turns out to be reproducible in other laboratories we are still left with the difficulty of early diagnosis and often have to wait for dissemination in space and (indispensable not "wasted") time.

From several well-controlled studies we know that high doses of polyunsaturated fatty acids may mitigate or shorten a bout,^{5,6} but do not influence the overall prognosis.^{7,8} To speak of an "inborn anomaly in the handling of unsaturated fatty acids" as if this were a proved fact rather than a speculative hypothesis is not only a doubtful scientific manoeuvre: it creates a lot of anxiety in patients and their relatives. The pattern of familial multiple sclerosis is hardly compatible with Professor Field's assumption, apart from the fact that the process of myelin building is very little influenced by nutritional factors.

The E-UFA test is under investigation world wide because of its interesting pathogenetic mechanisms, which are far from being understood. The practical implications it might have are still doubtful.

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¹ Field EJ, Joyce G, Bauer HJ, Wikström J. *Lancet* 1977;ii:658.

² Forrester JA, Smith WJ. *Lancet* 1977;ii:453-4.

³ Hawkins SA, Millar JHD. *Lancet* 1979;ii:165-6.

⁴ Seaman GVF, Swank RL, Tambllyn CH, Zukoski CF, IV. *Lancet* 1979;ii:1138-9.

⁵ Millar JHD, Langman MJS, Payling Wright H, *et al*. *Br Med J* 1973;ii:765-8.

⁶ Bates D, Fawcett PRW, Shaw DA, Weightman D. *Br Med J* 1978;ii:1390-1.

⁷ Bates D, Fawcett PRW, Shaw DA, Weightman D. *Br Med J* 1977;ii:932-3.

⁸ Paty DW, Cousin HK, Read S, Adlaka K. *Acta Neurol Scand* 1978;58:53-8.

SIR,—Professor E J Field and Greta Joyce (15 December, p 1571) quoted Seaman and his colleagues,¹ who, using a slightly modified Field's E-UFA (erythrocyte unsaturated fatty acid) test, were correct in all 65 patients with established multiple sclerosis. However, Seaman *et al* found the test negative in all four early cases, which would not support Field's claim of being able to identify latent MS and children at risk. A positive test would seem to be due to a secondary phenomenon rather than an inborn anomaly in the handling of unsaturated fatty acids.

Two trials^{2,3} have shown a marginal benefit for MS patients taking at least 17 g of linoleic acid daily. Eight capsules of Naudicelle daily were of no benefit whatever, possibly owing to the low dose of linoleic acid (3 g daily) and γ -linolenic acid (340 mg daily).³ The theoretical claim that γ -linolenic acid would be more