only in this position and even slept in this manner. This was not an individual habit and had not been present before the onset of this illness. The only other physical signs were in the abdomen, where there was slight general distension and a characteristic tumour palpable in the left iliac fossa. Rectal examination was normal.

Laparotomy was performed that evening, and an easily reducible caecocolic intussusception was found, which, owing to partial spontaneous reduction, was in the left hypochondrium. Numerous enlarged lymph nodes were found in the mesentery, and histological examination of one of these showed reactive hyperplasia. The child made an uneventful recovery.

The position adopted by this child clearly relieved his pain, and in view of the anatomy in this particular case it would seem likely that the child was unconsciously using gravity in an attempt to reduce the intussusception. This sign does not feature in textbooks and is obviously unusual. It was not encountered in any of 67 cases described in clinical detail by Kark and Rundle.¹ However, although unusual, the sign is a dramatic one and should alert one to the diagnosis at a glance if its significance is appreciated.

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¹ Kark, A E, and Rundle, W J, *British Journal of Surgery*, 1960, 48, 296.

Fear of ECT

SIR,—What is "inexplicable" (28 August, p 526) to me is that no responsible medical body appears to have made any attempt to allay the fear engendered among filmgoers by the demonstration of punitive, unmodified ECT in "One Flew over the Cuckoo's Nest."

L ROSE

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"Market research"

SIR,—I have recently received from a market research company a request to fill in a questionnaire about each drug company representative visiting me in the month of September, the drugs which they offer, and those which I prescribe. The paltry bribe offered for doing this very detailed work is a book or record to be chosen from a given list.

An obvious purpose which this might have is to get me to gather information about drug companies' sales methods, presumably for some client among the various drug companies. This in other fields is a known form of industrial espionage. I consider this approach impudent and the method distasteful, and I am sure that many GPs will agree with me.

SHEILA J HANDEL

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Lymphoma in dermatitis herpetiformis

SIR,—We would like to report a case of dermatitis herpetiformis associated with the development of lymphocytic lymphoma of the skin. Although the association between adult coeliac disease and lymphomas developing outside the gastrointestinal tract is well recognised,¹ this appears to be only the second

confirmed case of dermatitis herpetiformis with villous atrophy in which lymphoma subsequently developed.²

The patient, a man aged 59, presented after three months' progressive dyspnoea. His chest x-ray appeared to show fibrosing alveolitis with fibrosis around a cavity in the right apex. Because of the association between fibrosing alveolitis and gluten enteropathy^{3,4} the following investigations were performed: rheumatoid screen, positive; sheep cell agglutination test and reticulocyte antibody, negative. Tests for avian precipitins, and those for *Aspergillus fumigatus* and *Micropolyspora faeni* were also negative. Pulmonary tuberculosis was excluded by a weekly positive tine test and negative sputum cultures.

He had had treated dermatitis herpetiformis for seven years, and jejunal biopsy showed subtotal villous atrophy. Steroids were given for the severe breathlessness and produced a short-lived dramatic improvement without change in serial chest x-rays. He was also started on a gluten-free diet. He remained ill, and although lung biopsy was considered, this remained impracticable owing to his breathlessness. Shortly before his death he developed widespread papillomatous skin lesions which on biopsy proved to be lymphocytic lymphoma. He died from septicaemia and no necropsy was held.

This is the second case report of a lymphoma developing in dermatitis herpetiformis, giving added weight to the hypothesis that adult coeliac disease and dermatitis herpetiformis are prone to the same complications. We also feel that the appearance of fibrosing alveolitis and the cavity in the chest x-ray might represent a cavitating lymphomatous tumour. This is speculative as unfortunately permission for a post-mortem examination was refused.

J M FOWLER
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¹ Harris, O D, et al, *American Journal of Medicine*, 1967, 42, 899.

² Goodwin, P, and Fry, L, *Proceedings of the Royal Society of Medicine*, 1973, 66, 625.

³ Berrill, W T, et al, *Lancet*, 1975, 2, 1006.

⁴ Robinson, T J, *British Medical Journal*, 1976, 1, 745.

Misleading chest x-ray film in psoriasis

SIR,—A 30-year-old man was recently admitted here for treatment of long-standing psoriasis. During his stay we had reason to take chest x-rays, which were reported as showing multiple calcific foci in soft tissues and overlying the lung fields. These were consistent with cysticercosis. Further views were taken of the thighs and buttocks, but these were normal.

Closer investigation showed that the initial

films had been taken after application of a standard preparation of dithranol in Lassar's paste (zinc oxide 24%, salicylic acid 2%, starch and white soft paraffin to 100%) to the psoriatic plaques on the chest. However, these areas did not match the x-ray appearances, being far greater in size and distribution. There were no palpable subcutaneous nodules.

It was later realised that Tubegauze had been applied as a protective "vest" after treatment and this was later seen to cause the formation of balls of Lassar's paste by frictional movement. The latter were the opacities seen on x-ray, a repeat film minus Lassar's paste being normal. The doctor's lesson is always to x-ray patients with skin disease before the application of topical medicaments, an oversight in this case leading to unnecessary worry and extra investigations.

G A R PRICE

Department of Dermatology,
Liverpool Royal Infirmary,
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School pregnancies

SIR,—In your leading article on this subject (4 September, p 545) you state that a girl under the age of 16 years cannot marry. This is not so. The Registrar General's annual statistics record the number of marriages of women under 16 years of age and the numbers of such are often over 1000. The reason is that in Northern Ireland the legal age of marriage is 15 years, and every year many girls who are over 15 and under 16 and who become pregnant go to Northern Ireland for three weeks and are then able legally to marry.

It is a strange thing that very few people in Great Britain are aware of this—except parish priests. I have asked bishops, barristers, MPs, a judge, and even registrars if a girl under the age of 16 years can marry and the answer is always, "certainly not."

D W G BARTLETT

Leafield, Oxford

Home treatment of convulsions

SIR,—Even today some patients are left in convulsions for some considerable time before being given effective treatment.

May I suggest that suitable prepacked syringes of, say, diazepam be made available to the parents or relatives of patients at risk? With careful instructions and graded dosages to suit all ages the risks of such a scheme would seem to be minimal.

A STEPHEN

Bingley,
W Yorks

Iodine content of food

SIR,—We recently expressed our concern over the indiscriminate contamination of common foods with iodine and the possible harmful consequences (14 February, p 372). It is illustrative of the complexity of dietary management that we now find ourselves concerned that over-reaction to the dangers of excess iodine may lead to ill-considered intervention. We are led to believe, for example, that in some states of Australia a complete ban on the use of iodophors in the dairy industry has been considered.