are degradable in the gut to monosaccharides might have been a factor—perhaps the most important factor—leading to reduced absorption of calcium in the bran-fed subjects studied by Mr Shah and others.

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¹ Vaughan OW, Filer LJ. *J Nutr* 1960;71:10-4.

² Hodgkinson A, Heaton FW. *Clin Chim Acta* 1965; 11:354-62.

³ Leman J, Piering WF, Lennon EJ. *J Clin Invest* 1968;47:60A.

⁴ Fournier P. *Path Biol* 1965;13:143-51.

Proctoscopy and sigmoidoscopy

SIR,—I was very pleased to see (23 August, p 561) the letter from my friend Mr C Patrick Sames regarding his "two-finger test." A constricted outlet is frequently associated with anal pathology.

The pathology most commonly associated with anal constriction is congestion of the vascular pads, described by Thomson,¹ which when congested become haemorrhoids with their well-known symptoms of bleeding, prolapse, pain, and thrombosis. Constriction can also be associated with papillitis, fissure, pruritis, and even fistula.

I would agree entirely with Mr Sames that if the two-finger test demonstrates constriction in the presence of anal pathology and symptoms dilatation is almost certainly indicated. I would, however, express a word of caution: in the female patient with a descending perineum that constriction, although perhaps abnormal, may be contributing to continence; and it need hardly be said that dilatation is never indicated in the absence of symptoms. With these minor reservations I would hope that the two-finger test, as described by Mr Sames, receives wide recognition and becomes part of the routine assessment of the patient with an anal problem.

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¹ Thomson WHF. *Br J Surg* 1975;62:542-52.

Percutaneous central venous cannulation

SIR,—We would endorse the comments of Mr J L Peters and colleagues (30 August, p 618) concerning the use of ultrasound for locating the subclavian vein. We have used a special ultrasound flow probe to aid cannulation of several other vessels and this equipment has proved especially useful in the obese or anatomically difficult patient.

Our design consists of a 10-MHz Doppler probe with the crystals mounted at an angle of 60° to the central axis of the handle (figure). A needle guide has been fitted to the probe parallel with the line of the focused ultrasound beam, the angled handle giving easy access for needle placement. Although 10 MHz has been used for our device, this is not critical and any frequency from 5 to 10 MHz is likely to be satisfactory. This special probe can be connected to most commercially available ultrasonic Doppler velocimeters.

In addition to its application for cannulating focal vessels, we have found the modified probe particularly useful in the field of anaesthesia, for local analgesia of the brachial plexus. We have gained experience with an anterior approach to the plexus, locating the cervico-axillary canal well below the clavicle by ultrasonic identification of the adjacent contained

subclavian artery and vein. With such accurate anatomical localisation of the plexus hazards of conventional approaches, such as pneumothorax, can be avoided. Our preliminary studies have shown it to be possible to produce successful blocks with lower volumes of analgesic agents.

Doppler probe with needle guide to aid cannulation.

Modern ultrasound devices are inexpensive and portable, and their general adoption for the type of indications discussed would appreciably reduce the unfortunate morbidity of some common procedures. Furthermore, the precision of anatomical localisation which this technique permits greatly reduces the time necessary to train anaesthetists in the techniques. We believe that such a device should be an essential part of the anaesthetist's armament.

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Unusual presentation of appendicitis

SIR,—Crepitant cellulitis of the right thigh due to ruptured retrocaecal appendix (16 August, p 495) is usually only diagnosed at necropsy. One 50-year-old man with the condition was in hospital for three weeks before the source of the pus was discovered. He died 16 days later.¹

Non-clostridial crepitant cellulitis is even more unusual, but two other cases are recorded. A 74-year-old man with a five-day history of pain in the right hip was admitted to an orthopaedic ward with a suspected intertrochanteric fracture.² Subsequently subcutaneous emphysema down to the knee was noted. Culture of pus aspirated from an air pocket grew *Escherichia coli*, *Aerobacter aerogenes*, and α -haemolytic streptococcus. Retroperitoneal rupture of the appendix with abscess formation was found at necropsy.

A 55-year-old diabetic woman was luckier.³ During incision and drainage of her right thigh pus was noted oozing through the femoral canal, and this prompted abdominal exploration. Her abscess was therefore drained promptly, and she survived. No clostridial bacteria were grown here either.

In all three cases abdominal symptoms and signs were notable by their absence.

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¹ Sampson LH, Pegg SP. *Med J Aust* 1977;1:406-8.

² Pierleoni EE, Johnson LC. *Gastroenterology* 1955; 29:308.

³ Nicell P, Tabrisky J, Lindstrom R, Peter M. *Surgery* 1975;78:555-9.

The prepregnancy clinic

SIR,—I am most interested in the comment from Dr Judith M Lumley and others (30 August, p 619) on the prepregnancy counselling service in Melbourne.

In my practice women have requested "pregnancy check-ups" since 1969. In the main these have been patients from social classes I and II where both husband and wife, when they choose to start a family, are concerned to achieve a high-quality baby. The most important feature of these consultations is taking an unhurried, detailed medical, genetic, social, and sexual history.

I feel that this service can now be considered an essential part of medical gynaecology and I look forward to the time when real family planning occurs at all family planning clinics, in hospital, in general practice, and in the community.

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Bone-marrow aspiration and trephine biopsy

SIR,—I wish to point out an omission from the articles on bone-marrow aspiration and trephine biopsy (19 July, p 204; 26 July, p 280).

Marrow biopsy is often indicated as part of reassessment of a patient who has been treated for Hodgkin's disease or non-Hodgkin's lymphoma. Where radiotherapy has formed part of the treatment it is important for the marrow biopsy to be taken from a part of the skeleton which has not been irradiated, otherwise a dry tap is likely to be the result. Erythropoietic marrow is likely to be absent from irradiated areas for at least several months and often much longer than that. If the irradiation has been to the "upper mantle" area the sternum should not be used; if it has been to an inverted "Y" field the posterior superior iliac spine should be avoided as this is likely to lie within the field.

In my experience haematologists are not infrequently caught out by this and the patient has to suffer a repeat of the procedure. I admit that the referring oncologist is often at fault by failing to mention that the patient has previously had radiotherapy.

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Is the emergency ambulance service abused?

SIR,—I would like to comment on your recent article on the abuse of the British ambulance service in the Birmingham area (12 July, p 121) and on the NHS review of the service.