proliferation of swollen, "epithelium-like" endothelial cells in thick layers, often obliterating the lumina (Figs. 2 and 3, $\times 500$; Fig. 4, $\times 125$, which is a detail from Fig. 1). Lesions of this type are known seriously to interfere with the absorptive capacity of the lymphatics, and to provoke fibrosis of the surrounding soft tissues. The blood vessels, however, showed comparatively insignificant changes. Distally a normal right bundle branch and partially damaged roots of the left were found. Thus the chronic lymphangitis was primarily responsible for the heart block.

The extreme rarity of these findings is not, in my opinion, the only reason for interest in the present case. Possibly the atrioventricular node and bundle, which are sometimes very rich in lymph vessels,⁴ might undergo considerable changes up to sclerosis because of prolonged obstruction to drainage of lymph from the heart. Disease of the cardiac lymph-vessels might therefore explain some of the hitherto ill-understood lesions of the conducting system.—I am, etc.,

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- ¹ Lenègre, J., *Mal. cardiovasc.*, 1962, 3, 311.
- ² Moreau, P., Gerbaux, A., and Lenègre, J., *Arch. Mal. Cœur*, 1963, 56, 609.
- ³ Rossi, L., and Lévy, A., *ibid.*, 1958, 51, 674.

The Oesophagus

SIR,—In his review (18 April, p. 1036) of my book *The Oesophagus*, Professor P. R. Allison takes me to task for saying para-oesophageal hernias are invariably congenital and lie on the right side of the oesophagus; and adds that the statement "could easily be refuted by radiographs showing them on the left." It depends, of course, to whom he shows them: not to me, I hope, for we are speaking of different things. Indeed on page 99 of the book is just such a radiograph as he offers together with a clear definition of my terms.

Applied to any sliding hernia in which the fundus happens momentarily to roll up beside the oesophagus the term "para-oesophageal" is meaningless and might justly be castigated as jargon. I have tried to make it meaningful by reserving it for a particular variety of hernia.

Much the same applies to the use of the word "cardia," and here I cannot do better than urge him to read Mr. John Hayward's lucid account (*Thorax*, 1961, 16, 36) entitled "What is the Cardia?"—I am, etc.,

London W.1. GEOFFREY FLAVELL.

Surgery for Peptic Ulcer

SIR,—Further to your leading article on the surgical treatment of duodenal ulcer (22 February, p. 448) and the subsequent letter by Mr. A. C. B. Dean and Dr. M. K. Mason (7 March, p. 627) we would like to comment on the extent of pyloric mucosa in the stomach. It is true that this mucosa may extend high up in the stomach, especially on the lesser curvature, and that the junction of pyloric and fundic mucosa may take the form of an irregular "dentate" line. The distribution of pyloric mucosa, which is alkali-secreting, can be determined accurately at operation by the use of suitable electrodes

and a pH meter.¹ Classically in patients with duodenal ulcer the zone of pyloric mucosa is small, extending for 3 to 4 cm. from the pylorus. Clearly in such cases the standard subtotal gastrectomy will remove "the antrum" and a substantial portion of the parietal-cell mass. If antrectomy is done along with vagotomy then the amount of stomach resected need be very small, having been accurately demarcated first of all. It is when there is added stenosis that extension of pyloric mucosa is particularly observed, and the alkali-secreting zone may occupy much more than half the stomach mucosal surface. Nevertheless it can be mapped out accurately. This pre-operative demarcation of the distribution of pyloric mucosa is preferable to chance resection and subsequent histological check.

For 12 months we have been subjecting resected specimens obtained by the above technique to gastrin assay. Preliminary studies have indicated that gastrin is present in the extract obtained from the alkali-secreting zone of the pyloric mucosa. The extract obtained from the mucosa immediately on the fundic side of the junction line contained little or no gastrin in the specimens so far investigated.—We are, etc.,

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REFERENCE

- ¹ Capper, W. M., Laidlaw, C. D'A., Buckler, K., and Richards, D., *Lancet*, 1962, 2, 1200.

Peritoneal Dialysis

SIR,—We read with interest the paper of Dr. W. B. Thomson and his colleagues on peritoneal dialysis (11 April, p. 932). Our technique and experience are similar, but while the procedure awaits general acceptance some further comments and the report of a further complication may be of value.

We have thought peritoneal dialysis to be particularly indicated in patients whose cardiovascular systems are unsuited to withstand the haemodynamic upset inevitable with haemodialysis, whether arteriovenous or veno-venous and however carefully controlled. This is the situation in acute renal failure in the elderly patient and after myocardial infarction. Other recent indications included renal failure after cardiac surgery and combined renal and cardiac failure due to Weil's disease with myocarditis.

Peritoneal dialysis avoids the systemic heparinization of haemodialysis. The alternative, regional heparinization of the extracorporeal circulation, has proved tedious and difficult to control both in our hands and elsewhere.¹ Thus peritoneal dialysis is valuable in renal failure after recent trauma or operation where there is coincident bleeding—for example, from a peptic ulcer or a bleeding tendency as in liver disease. We have uneventfully dialysed by the peritoneum a man who had had an acute subdural haematoma evacuated 24 hours previously and a chronic uraemic with a haemopericardium. The ease of management allows the simultaneous dialysis of several patients and yet frees medical staff for routine work. Previously our resources were strained if three or more patients each required frequent haemodialysis.

We do not put prophylactic antibiotic in the dialysate, preferring to examine and

culture the fluid every 12 hours and to treat any infection which arises. An increase in the cell count of the dialysate may indicate developing infection before culture becomes positive. The risk of infection increases considerably after 48 hours' dialysis. Our policy is to limit each dialysis to this time unless there are compelling reasons to continue. In 4 out of 48 dialyses positive cultures were obtained, in each case before there was clinical evidence of peritonitis.

Our technique has been to remove the abdominal catheter after each dialysis, reinserting it if further dialysis is required. Some difficulty has been encountered in third and fourth insertions because of the formation of adhesions. After the fourth dialysis of a chronic uraemic awaiting renal transplantation a faecal fistula developed. Presumably the bowel had been perforated with the catheter or the trocar. This hazard is more likely to occur when the bowel is bound down by adhesions. It may be preferable to leave the catheter *in situ* when further dialysis is contemplated in acute renal failure, as has recently been shown to be feasible in chronic failure.²—We are, etc.,

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REFERENCES

- ¹ Maher, J. F., Lapiere, L., Schreiner, G. E., Geiger, M., and Westervelt, F. B., *New Engl. J. Med.*, 1963, 268, 451.
- ² Palmer, R. A., Quinton, W. E., and Gray, J. E., *Lancet*, 1964, 1, 700.

Heroin Addicts

SIR,—Many will agree with the view of certain foreign observers that British drug policy helped to keep down the number of addicts and the extent of the illicit trade. The number of addicts (to the "dangerous drugs") still remains relatively small, despite the recent slight increase (Dr. A. J. Cameron, 7 March, p. 594), and despite estimates given (rightly or wrongly) by some addicts that for every one or two "known" (or as they wrongly call it, "registered") addicts there may be another one who is not known to the Home Office. However, in contrast to the favourable prophylactic effect of this policy its apparent lack of emphasis on attempting to cure the person who has become addicted must give rise to misgivings.

Some addicts will probably never recover, but others might be helped provided they could be motivated to come for, and to persevere long enough with, institutional treatment. An addict may be a focus of infection; he commonly manages to get more drugs than he requires himself which, for some reason or other, he may sell to newcomers. That there is a reservoir of vulnerable people at risk—especially among the young—is clear from the increasing number of young people abusing amphetamines (e.g., "drinamyl") (28 March, p. 792) and smoking reeferers. In the last few weeks we have come across three youngsters who, while searching for "kicks," were first introduced to amphetamines and cannabis and later to opiates and cocaine.

It must be extremely difficult for a practitioner to determine the minimum amount which an addict "needs," or whether indeed he could learn to live without the drug, with-

out the addict's admission to hospital for a lengthy period of observation. Yet addicts cannot be compelled to enter hospital, nor to stay there. Addicts often discharge themselves prematurely from hospital, even if the doctor feels that with longer stay there may be a good chance of a recovery. Any wish on the patient's part to rid himself of his addiction may not prove strong enough to withstand the knowledge that he can easily obtain the drug as soon as he leaves the hospital. One also meets the addict who leaves hospital after his dose has gradually been much reduced, only to demand the original amount again outside hospital, leaving him in possession of much more than he requires for himself.

In 1961 the Interdepartmental Committee on Drug Addiction made certain strong recommendations.¹ One wonders whether, in the light of experiences in the meantime, it might not be advisable to put teeth into these recommendations and not just leave them at mere suggestion—quite apart from the need for research into prevention and treatment of addiction.—I am, etc.,

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REFERENCE

- ¹ *Drug Addiction: Report of the Interdepartmental Committee, 1961.* H.M.S.O.

SIR,—Few of us would attempt to define normality, but surely no experienced clinician or scientist would designate as normal those who require therapeutic agents to enable them to seem normal to themselves and others. Drugs are the equivalent of crutches and those who require them are suffering from a disability. There is a world of difference between a person who is reasonably happy, efficient, well adjusted, and symptom-free and one who is only temporarily in such a condition while under the influence of a drug. But few will disagree with the real point which Mr. R. Lefever (4 April, p. 911) makes—namely, that it is in the addict's best interests that the doctor should waive meticulous adherence to the ethic of "privacy of consultation" and check his prospective patient's history with the Dangerous Drugs Department of the Home Office before prescribing for him.—I am, etc.,

London W.1. ELLIS STUNGO.

Hodgkin's Disease at 83

SIR,—Although any disease may apparently be encountered amongst the aged it is unusual to meet examples of Hodgkin's disease in later life. The following case history shows that this condition may occur.

Mrs. A.B., a widow of 83, was referred to Queen's Hospital, Croydon, in December 1963 on account of weakness, fatigue, and anorexia. She gave a history of operations for hernia and cholecystectomy during the past 10 years. On examination she was mentally clear. Physical signs detected were few. There was some pallor; poor air entry at the base of the left lung; an apical systolic murmur; a blood-pressure of 125/85 mm.; and a palpable left lobe of the liver. Glands were palpable in the right supraclavicular fossa. The following investigations were completed before death. Haemoglobin was 64%; blood film showed slight polychromasia with hypochromia; the sedimentation rate (Westergren) was 42 mm. in 1 hour. Blood urea

was 66 mg. per 100 ml. The stools showed one positive result for occult blood. The provisional clinical diagnosis before necropsy was carcinoma of the stomach with secondary deposits in the liver and lymph nodes.

Necropsy.—At post-mortem examination the lungs showed basal congestion with some purulent bronchitis. There was slight atheroma of aorta and coronary arteries. The left ventricle was hypertrophied, with fibrosis in the upper part of the septum. The spleen was large and firm, with grey nodules in a dark red pulp. The liver also showed similar nodules. There were enlarged lymph nodes (to a size of 5 by 3 cm.) at the carina, the lower paratracheal group, the right supraclavicular area, and the head of the pancreas. Histology indicated that glands, liver, and spleen presented the appearance of Hodgkin's disease.

It is usually considered that Hodgkin's disease is commonest in young adults. Although it may occur later little is written about its upper age limit. The condition is rarely mentioned in textbooks of geriatric medicine. A. Mueller Deham quotes ten cases between 60 and 83 years old.¹ R. G. Monroe noted 16 cases in his series of 7,941 subjects.² All but five of these were between the ages of 60 and 70, while the oldest was 76. In Piggot's series of 2,221 subjects aged 65 and over, only two cases were found.³ One of these was a female aged 82, in whom the condition had been diagnosed some 22 years previously; the other was a male of 72. The present case, therefore, is one of the oldest recorded.

My thanks are due to Dr. D. J. O'Brien, pathologist to the Croydon group of hospitals, for his help in the morbid anatomy and histology of this case.

—I am, etc.,

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² Mueller-Deham, A., and Rabson, S. M., *Internal Medicine in Old Age*, 1942. Williams and Wilkins, Baltimore.
³ Piggot, A. P., personal communication.

Sulthiame in Epilepsy

SIR,—During the past three years we have carried out a trial of "ospolot" in the treatment of epilepsy and reported¹ briefly on the results in a group of 22 epileptic, subnormal in-patients, comparing the incidence of fits for a period of a year before and after the addition of ospolot to their previous treatment with phenobarbitone and/or phenytoin. The diagnostic categories were very similar to those of Drs. H. Garland and H. Sumner (22 February, p. 474): brain damage, 7 cases; hemiplegia, 2; idiopathic, 9; Sturge-Weber, 2; temporal lobe, 2.

Over the period the total annual number of fits fell from 338 before ospolot was added to 156 afterwards. In two cases of brain damage there was an increase in the number of fits. In this series the environment was kept as stable as possible during the trial. No side-effects were observed and most patients appeared to be more socially adaptable. Since then we have used the drug routinely in over 50 cases of epilepsy, always combined with phenobarbitone, with similar results.

It would have been helpful if Garland and Sumner had given more information about their patients, such as intellectual level,

environmental circumstances, personality, etc., in that such factors must be considered in assessing the efficacy of any treatment, rather than to regard such treatment as an exercise in toxicology.—We are, etc.,

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REFERENCE

- ¹ Davies, T. S., Leyshon, M. W., *Lancet*, 1963, 2, 939.

Factitious Strokes

SIR,—The recent letter (14 March, p. 697) by Dr. T. Lehoczy and Dr. D. Williams's paper "Vertebro-basilar Ischaemia" (11 January, p. 84) prompt me to record a case of factitious stroke.

A white woman, aged 63 years, was sent for admission as a case of right hemiplegia. By the time of her arrival at the hospital all weakness of the right side had disappeared, and an extensor plantar response was the only neurological abnormality noted. Retinal exudates were present, and the apex beat was displaced into the anterior axillary line. There was no evidence of valvular disease of the heart, and it was obvious that the recorded blood-pressure of 105/60 was incongruous with the cardiac size and retinal changes. E.C.G. examination revealed left ventricular hypertrophy, and transaminase was not elevated.

The blood-pressure rose spontaneously and the plantar response became flexor within 24 hours. The patient was rapidly mobilized. Further questioning revealed that she suffered from headaches, and for this complaint took some tablets which she had had by her for some years. Often she had transient weakness or blackouts after taking these tablets, and it is odd that she persevered with them. They had been prescribed for hypertension some years previously, and fortunately she remembered the name—"ansolysen" (pentolinium tartrate), 40 mg.

The blood-pressure stabilized about the 190/110 level, and there was no residual neurological deficit, but there was evidence of chronic nephritis.

It is felt that with potent medicines left lying in the bathroom cupboard for subsequent use in trivial complaints we must be on the lookout for new and bizarre syndromes—not iatrogenic in the usual sense, but the consequence of earlier medical endeavour.—I am, etc.,

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Day-attendance Centres

SIR,—May I support Dr. T. C. N. Gibbens's suggestion for day-attendance centres as a means of reducing the number of persons remanded in custody for psychiatric reports (14 March, p. 691)? In 1960 Dr. D. J. West and his colleagues¹ published a valuable study in which matched samples of offenders, remanded for reports to prison and to London clinics, were compared and followed up. Their data showed *inter alia* that the choice between bail and custody was often arbitrary in relation to the characteristics of the individual offender. Just over a third of the prison cases were first offenders, the choice seemed particularly arbitrary for the less serious sex offenders. An incidental finding was that first sex offenders remanded to prison did better in terms of reconviction than their clinic counterparts. The study