ankles were swollen and aching and she was again vomiting repeatedly. The vomitus became blood-stained and by the next morning she was vomiting almost pure blood. She had frequent bouts of abdominal colic with bloody diarrhoea.

On bed rest and clear fluids only she appeared to recover, but 10 days later there was a recurrence of petechiae on the legs, painful swollen ankles, vomiting of blood-stained fluid, and abdominal colic with bloody diarrhoea. She was well again after four days but had recurrent episodes of painful and swollen ankles with petechiae on both legs, sometimes accompanied by vomiting, but there was no further blood loss from stomach or bowel. These milder episodes recurred every four to eight days, becoming less and less severe. On one of these occasions there was also aching of the elbow joints and petechiae on both forearms. Her last day of symptoms was 7 November.

Her urine was consistently free from albumen until 12 November, when there was moderate albuminuria. At this stage she was admitted to hospital under the care of Dr. E. Allibone. After a week on clear fluids and absolute bed rest she felt and looked well, but the albuminuria was unchanged. Prednisone, 15 mg. daily, was then commenced, continued at this dose for one month, and then gradually withdrawn over a period of three weeks.

After three weeks of prednisone therapy her urine became free of albumen.

She is still Cushingoid but there has been no return of albuminuria to date.

—I am, etc.,

Leeds 7.

G. W. LEWIS.

Replacement Arthroplasty

SIR,—The report of the annual general meeting of the British Association of Physical Medicine (26 March, p. 794) is not accurate in attributing to me the conclusion that replacement arthroplasty of the hip is the treatment of choice in the hip affected by rheumatoid arthritis. In fact excision arthroplasty is probably the treatment of choice at the present time. There is a place for Smith-Petersen cup arthroplasty in certain selected cases of secondary osteoarthritis superimposed upon the rheumatoid process, and total replacement with articulated prostheses of the McKee type may become the treatment of choice in the future.

In the knee synovectomy has proved to be valuable in the early stages of the disease before significant joint destruction has occurred. Tibial osteotomy to correct valgus or varus instability is likewise useful in a small number of patients. A combined synovectomy and tibial osteotomy is rarely indicated and it would be unwise to do both procedures in one operation.—I am, etc.,

Guy's Hospital,
London S.E.1.

W. A. CRABBE.

Complication of Contact Lenses

SIR,—In refreshing contrast to the alarming headlines in national newspapers reporting the recent analysis of 50,000 contact-lens-wearing patients in the U.S.A., your leader on complications of contact lenses (26 March, p. 751) deserves high commendation for its objectivity.

It is, of course, true that a contact lens combining all of the desirable qualities you mention is not yet available, though present-day lenses, when skilfully fitted, periodically

checked, and hygienically cared for are capable of excellent performance over many years.

To your list of possible causes of complications I would add neglect by the patient of the practitioner's advice to attend for regular aftercare, for the absence of untoward symptoms tends to create a degree of confidence beyond reasonable justification. I welcome, therefore, your emphasis on the importance of aftercare and of strict attention to hygiene in lens handling and maintenance.

We recommend that the fitting of lenses should be preceded by reaction tests to determine the suitability of the eyes for this form of correction, and that the initial fitting should be followed by frequent inspection of the eyes and lenses for one year. Subsequently, an annual re-examination is advised.

Your suggestion that the development of contact-lens technique calls for cooperation between the medical and optical professions is timely and will be endorsed by all engaged in this work. The International Society of Contact Lens Specialists, which includes in its membership ophthalmologists, optometrists, and opticians, was founded some 15 years ago for the advancement of contact-lens technique and research. I intend to draw the attention of our members to your valuable article at our forthcoming congress in Mexico City, 20–24 April.—I am, etc.,

FRANK DICKINSON.

Secretary,
International Society of
Contact Lens Specialists.

St. Annes-on-Sea,
Lancs.

Follow-up

SIR,—The job of a consultant is, by tradition, to be consulted by a practitioner about a patient. Except in a few specialties, and for purposes of research, it is not necessary for a consultant to do extensive personal follow-up. This is the job of the family doctor, by tradition, who can always seek the further opinion of a consultant when necessary.

Follow-up by or repeated visits to a consultant are sometimes necessary nowadays only in obstetrics, psychiatry, and in the "newer" specialties such as cardiac surgery. If consultants were freed of the chores of which Mr. Rowntree complains they would have more time for new consultations and so shorten the outpatient waiting-lists.

Finally, there is no reason why any doctor should have to do routine work on Saturdays when the vast majority of our patients only work a five-day week.—I am, etc.,

London N.W.11.

D. S. NACHSHEN.

SIR,—Your correspondent Mr. T. Rowntree (19 March, p. 738) can be assured that he will get no angry stream of abuse from at least one general practitioner. For years I have fought an uphill battle to retain my patients under my own care and to use the consultant service as it should be used. My experience after 18 years in general practice is that consultants in the main are not the least bit interested in the early return of patients to their own doctor's care.

It is accepted without question by the Government and all medical authorities that

the consultant establishment is seriously undermanned. My own experience of the attitude of consultants to follow-up cases leaves me to seriously doubt that this is so.—I am, etc.,

London W.13.

JOHN H. SWAN.

Foetus in Hernia

SIR,—I should like to relate to your readers a case of an unusual obstetric presentation.

The woman in question was gravida five, with the first three pregnancies normal deliveries and alive, but the fourth was a normal delivery with stillbirth.

She presented at full term with the gravid uterus herniated through a large rectus abdominis deficiency and so anteverted that in the erect position the fundus lay at the level of the knees. The head was presenting but not engaged. The uterus was reducible to the vertical position.

She was offered operative treatment in which the child could be removed by caesarean section and repair of the rectus deficiency effected. This she refused on the grounds that she had attained normal delivery under these circumstances before, and she could do it again. We were doubtful about her ability to do this but had no alternative.

When she went into labour she got one of her relatives to hold the uterus up in a vertical position and delivered without any difficulty.

She was offered a repair of the hernia subsequently, but again refused, saying, "This is how God made me, and this is how I am going to stay."—I am, etc.,

Kabale, Uganda.

R. A. JONES.

Misdiagnosis of Dysphasia

SIR,—I was most interested in Dr. N. Berlyne's letter on this subject (12 February, p. 421), agreeing with him that where it is a question of urgent or active general medical or neurological treatment most psychiatric hospitals would probably not be very suitable places; but admission there later, in the residual or longer term therapeutic stage, is neither inappropriate nor uncommon. Not only are long-term neurological and general medical beds probably in relatively short supply, but the latter would be less suitable than a psychiatric hospital on grounds of medical and nursing psychological understanding, from which such patients clearly benefit.

There is another aspect of "misdiagnosis" in dysphasia, however, to which attention should also be drawn, involving the cerebral pathophysiology of speech function. Thus Dr. J. D. Spillane's patient¹ with left temporal lobe abscess showed left fronto-temporal brief dysrhythmia when unable to speak, but posterior temporal dysrhythmia when unable to understand, the E.E.G. in fact proving superior to morbid anatomy in localization of dysfunction.

I have made a somewhat similar observation on a patient nursed in this psychiatric hospital, whose clinical details have been described elsewhere.^{2,4} His death here (9 January 1965) due to cerebral haemorrhage, four years after the only other vascular

accident, which had led to his admission with dysphasia (to the local general hospital initially, where his hypertension and associated symptomatic epilepsy had previously been under surveillance), enables a comparison to be made of morbid anatomical and E.E.G. findings.

The latter (16 June 1961) revealed bursts of high voltage 1-2 cycles/second activity clearly localized over the left fronto-temporal region, suggestive of a space-occupying lesion deep in the hemisphere.

The brain, on the other hand (Fig.), showed a large ragged-walled brownish cyst in the left cerebral hemisphere, above and lateral to the ventricle and extending from anterior to posterior horn. It was maximal in cross-section at the middle cut illustrated, which was taken down the central sulcus

(leaving the temporal lobe intact). Superimposed on these long-standing changes, recent haemorrhage had occurred into the cyst and ventricle posteriorly, and upwards into surrounding tissues anteriorly as far as the superior cerebral cortex. Macroscopically no major artery was thrombosed, and both left temporal lobe and whole right cerebral hemisphere appeared normal.

I am indebted to Mr. H. A. Milne for the photograph.

—I am, etc.,

Dartford, Kent.

J. P. CRAWFORD.

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Infections of the Hand

SIR,—I have recently read the observations of Dr. H. R. Shepherd (25 December, p. 1550) on the treatment of paronychia.

I think there are two points to be made. If the standard teaching of the late Dr. Alan B. Kanavel is in question, his name should have been spelt correctly.

I think he would have agreed with the method Dr. Shepherd is advocating as entirely adequate for infections confined to the nail-fold. Unhappily, some infections have already progressed beyond this limit, and pus is present under the nail and sometimes even in the pulp space. Standard teaching for these infections has continued to insist on removal of the nail base and drainage of the pulp in cases which demand it.—I am, etc.,

The Infirmary
Stockport.

HAROLD BOLTON.

Prevention of Heart Disease

SIR,—I would like to associate myself with Dr. A. R. Southwood's letter (29 January, p. 296) stating that little has been said about the prevention of ischaemic heart disease. The lack of interest in this aspect of the subject is shown in the aim of the Cardiovascular Research Unit recently set up by the Medical Research Council. "Particular emphasis will be on research into the care of patients after coronary thrombosis and into methods for improving diagnosis and treatment" (29 January, p. 305). No mention, however, is made of prevention.

My interest in this problem was stimulated by a special study of the climacteric. On several occasions I expressed the view^{1,2} that the menopause is not only the phase of a woman's life when menstruation ceases but the time when the ageing processes develop and so lead to the degenerative diseases of old age. One of these is coronary heart disease.

P. D. White,³ the American cardiologist, labels arteriosclerosis an epidemic disease. The most effective results in the field of epidemic diseases were achieved not by treatment but by prevention. Some cardiologists suggest that the failure in the prevention of coronary heart disease is the result of a lack of knowledge about the aetiology of arteriosclerosis.

Some progress has been made in that field of research, three aspects of which are: (1) the study of the serum cholesterol and other lipids; (2) the capillary fragility of the vasa vasorum; (3) the role of oestrogens.

Although no proof exists that cholesterol plays a role in the causation of arteriosclerosis, one cannot overlook the fact that the cholesterol content of the blood in people with ischaemic heart disease is actually raised. It has also been shown that lipids reduce the fibrinolytic enzyme normally present in blood, thus contributing to coronary thrombosis.⁴

It has been suggested that fragility and resulting haemorrhage of the coronary capillaries (vasa vasorum) play an important role in the causation of coronary thrombosis, and that atheromatous plaques are the product of the degeneration of the extravasated blood.⁵⁻⁹

There is evidence that cessation of ovarian activity leads to an increase in the incidence

and severity of ischaemic heart disease, and to an increase of cholesterol and lipid levels in the blood.¹⁰ Women who have had bilateral oophorectomies in early life have a four times higher incidence of coronary heart disease.¹¹ Significantly fewer cases of coronary arteriosclerosis are found in men who have received oestrogen for treatment of cancer of the prostate compared with similar untreated patients.¹² The incidence of abnormal electrocardiographic tracings were lower in hormone-treated castrates than in untreated women.¹³ Recent controlled studies suggested that the lives of men and women with previous coronary thrombosis might be lengthened by oestrogen administration compared with those who received only placebos.^{14,15} There is also some evidence that oestrogen deficiency is responsible for capillary fragility causing unexplained bruising and bleeding.¹⁶⁻¹⁸

Apart from some preventive measures suggested by Oliver and Stuart-Harris,¹⁹ replacement of sex hormones by implants of oestrogen and testosterone in women and men during the climacteric may be an important factor in the prevention of coronary heart diseases.

London W.1. E. SCHLEYER-SAUNDERS.

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Bradykinin

SIR,—The following sentence, "... this leads to the activation of the enzymes kallikrein and bradykinin," in your leading article (18 December 1965, p. 1448) is incorrect. Kallikrein is an enzyme which is present in an inactive form of blood, pancreas, and small intestine and in an active form in saliva and urine. The substrate for kallikrein, which is an α_2 -globulin, is present in blood, lymph, and colostrum. Kallikrein releases kallidin-9 (or bradykinin) from this substrate. Kallidin-9 (or bradykinin) is not an enzyme; it is a polypeptide (nonapeptide) which accounts for almost all the pharmacological activity of kallikrein.—I am, etc.,

K. D. BHoola.

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