child to hospital if it seems possible that it has been deliberately injured, whether by parents or baby-minder or older sibling. The child is then in a "place of safety" and can be kept there, as the B.P.A. memorandum makes clear. But once it is there, the best interests of the baby and the rehabilitation of the parents are not contradictory aims: they are joint ones, and the apparatus for dealing with both is available.—I am, etc.,

Whittington Hospital,
London N.19.

SIMON YUDKIN.

Trusses for Femoral Hernia

SIR,—The facts of anatomy will not support even the very limited approval of femoral trusses expressed by Mr. R. J. McNeill Love (12 March, p. 673).

The sac of a femoral hernia descends at first vertically and lies between rigid structures—the pubic bone and the inguinal ligament. Here it is not susceptible to influence by any form of external truss. The sac is always elongated and relatively narrow in its first part. When it turns forward into the femoral triangle after escaping from under the inguinal ligament it may have a substantial globular fundus. More often it does not but remains a relatively small sac surmounted by a thick cap derived from the pro-peritoneal fat and fascia. Sometimes the fundus of the sac remains deep in the femoral canal, and the swelling, which can be seen or palpated, consists entirely of fatty cap.

When the hip-joint is fixed a truss can be made to exert continuous pressure on the femoral triangle and on any swelling in it, but from the foregoing it follows that no truss can prevent the first part of the femoral sac from being filled from above, and this precisely constitutes the danger of femoral hernia. A truss in this condition is as efficient as an inguinal truss, which presses on the external ring when the hernia has escaped from the internal ring—that is, it is totally inefficient.—I am, etc.,

Birmingham 15.

F. WELSH.

Umbilical Hernia

SIR,—At the first Commonwealth Medical Conference held in Edinburgh in October 1965 it was agreed that young doctors should be encouraged to undertake a tour of service in the developing Commonwealth countries. Apart from various emergencies such as injuries, together with other diverse sudden misfortunes, some more interesting cases face the young doctor, such as the one reported below—the most interesting of a number of

cases during my first year at this district hospital. Such cases are not uncommon, but I thought this one to be worth recording for the interest of prospective young doctors in the developing countries.

A 27-year-old Tumbuka female was admitted to this hospital with complaints of "swelling" of the abdomen since the birth of her third child five years before. She had borne two more since then. Her general health was good. There was a pyriform swelling 10 in. by 5 in. (25 cm. by 12 cm.) in the umbilical region (Fig.). The skin over it was stretched, obliterating the position and evidence of the umbilicus. The veins over the swelling were prominent (O), and there were trophic ulcers (X) on the most dependent part of the swelling. The swelling was soft and tympanitic. It reduced completely in the recumbent position, leaving a puckered ulcerated flap of skin.

The patient refused to travel the 400 miles to Blantyre for the attention of the surgical specialist.

A repair was performed as follows: The mass was reduced and the redundant skin clamped by means of occlusive intestinal clamps. An incision was made parallel to the rectus muscle on either side, and the redundant ulcerated sac excised, leaving an incision 6 in. (15 cm.) long with a gap similar to one in an ordinary midline laparotomy incision. The redundant sac had a capacity of 250 ml.

The recti muscles were defined; the right tucked under the left and their edges secured.¹ The skin was closed with interrupted sutures.

The patient recovered uneventfully, and was discharged 10 days later. She reported on 15 January 1966 for a check-up.

I wish to thank the Secretary for Health, Malawi Ministry of Health, for permission to publish this case, and the hospital staff for their assistance.

—I am, etc.,

District Hospital,
Mzimba, Malawi.

Y. H. MISOMALI.

REFERENCE

- ¹ *Rose and Carless Manual of Surgery*, 1960, 19th ed. London.

Serum Leucine Amino Peptidase Activity in Carcinoma of the Stomach with Metastases

SIR,—A modification of the method of Goldbarg and Ruttenburg¹ for the determination of leucine amino peptidase is described in the *Sigma Technical Bulletin No. 250*. Reference was found to the levels of serum leucine amino peptidase in various diseases, the highest values being found in carcinoma of the head of the pancreas, 450–1,270 G.R. units.

A man aged 65 years was admitted to this hospital with a history of confusion, vomiting, and back pain. A provisional diagnosis of carcinoma of the pancreas was apparently supported by a serum leucine amino peptidase of 1,000 G.R. units and an alkaline phosphatase of 44 K.A. units. The presence of metastases was suggested by the serum phosphohexose isomerase of 290 i.u./l. rising to 470 i.u./l.² The barium meal demonstrated an ulcer high up on the greater curve of the stomach, which at necropsy was shown to be malignant, with secondary deposits in the liver. The pancreas was normal.

It is interesting that in this case a greatly elevated serum leucine amino peptidase was found in the presence of a carcinoma not arising in the pancreas. The diagnostic

value of this enzyme may perhaps be limited.—We are, etc.,

W. H. S. GEORGE.
K. J. GURLING.
I. MACKENZIE.

Derbyshire Royal Infirmary,
Derby.

REFERENCES

- ¹ Goldbarg, J. A., and Ruttenburg, A. M., *Cancer*, 1958, 11, 283.
² Bruns, F. H., and Jacob, W., *Klin. Wschr.*, 1954, 32, 1041.

Home Treatment of Pulmonary Tuberculosis

SIR,—Dr. K. M. Citron's (12 March, p. 657) list of tuberculous patients unsuitable for home treatment can be reduced by at least one—namely, "Infectious patients with susceptible family contacts." Dormer and his colleagues¹ have shown that isoniazid is an excellent prophylactic for infants nursed by infectious mothers. It must be no less protective for other family contacts. My practice is to give isoniazid to all child contacts of infectious cases treated while remaining at work. Any children tuberculin negative six weeks after the start of prophylaxis are vaccinated with isoniazid-resistant B.C.G. under cover of isoniazid until conversion occurs.

Dr. Citron, in clearly setting out the undoubted merits of treatment at home and at work, regrettably repeats some traditional dogma concerning spread of infection. Infection is spread by airborne droplets, and there is no proof that bed linen, crockery, or dried sputum is ever involved. Disinfectants are as unimportant as rest, nutritious food, and fresh air.

A separate room is unnecessary. An adequate supply of handkerchiefs to cover the mouth during coughing should suffice.—I am, etc.,

Mullingar,
Ireland.

MICHAEL P. FLYNN.

REFERENCE

- ¹ Dormer, B. A., Harrison, I., Swart, J. A., and Vidor, S. R., *Lancet*, 1959, 2, 902.

Treatment of Sinusitis

SIR,—In his article on diagnosis and treatment of sinusitis (2 April, p. 834) Mr. J. D. K. Dawes does not mention nasal decongestants or steam inhalation.

Does this mean that he feels there is no value in either of these procedures?—I am, etc.,

Reepham, Norfolk.

A. S. GARRETT.

Post-vagotomy Neuroma

SIR,—In reference to your leading article on this subject (19 March, p. 694) a former senior house-officer of mine, Mr. E. J. Guiney, and myself reported a case of this condition in March 1960.¹

Our patient's major complaint was of dysphagia with a narrowed area demonstrable in the lower thoracic oesophagus; biopsy showed only inflammatory change. At thoracotomy the narrowing was found to be due to a small "stump neuroma" densely

adherent to the oesophagus. When the neuroma was dissected away the oesophagus filled out but none the less dilators were passed.

The "neuroma" had a cotton ligature incorporated in it. Since then I have ligated only the distal vagal end, sometimes burying it under a serosal suture to obviate (?) such stump neuromata.

The patient has had no recurrence of symptoms since. This case tends to support the view that stump neuromata may by themselves cause symptoms as suggested in your leader.—I am, etc.,

University College,
Galway.

E. N. MACDERMOTT.

REFERENCE

- ¹ Guiney, E. J., and MacDermott, E. N., *J. int. Coll. Surg.*, 1960, **33**, 297.

Prolonged Latent Period with *Plasmodium falciparum* Infections

SIR,—The letter from Dr. A. Mahmood (26 February, p. 544) reporting a recrudescence of *Plasmodium falciparum* infection in a pregnant Nigerian 16 months after leaving her country coincides with a similar case here. The lady is a Nigerian primipara, five months pregnant, who left Nigeria in March 1964. Her age is 20 years, her haemoglobin 6.8 g./100 ml., and her M.C.H.C. 27%. Her faeces shows a few *Entamoeba histolytica* cysts and a considerable number of *Ankylostoma* ova. Scanty ring forms but no gametocytes of *P. falciparum* have been found in the blood smear, which is routinely done when the haemoglobin is low. The interval between finding these parasites and the patient leaving Nigeria is over 20 months.—I am, etc.,

Devonport Laboratory,
London S.E.10.

G. L. ROBINSON.

Tonsillectomy

SIR,—The article by Dr. H. B. Holden and Dr. J. J. Maher (4 December, p. 1349) comparing blood loss in adenotonsillectomy under ether and halothane anaesthesia plus the numerous ensuing letters on tonsillectomy make interesting reading.

Dr. R. I. W. Ballantine (12 March, p. 676) makes the point that reflex disturbances can occur with light anaesthesia, but in neither the original article nor in later observations does the question of blood loss appear to have been considered in relationship to depth of anaesthesia.

Perhaps depth of anaesthesia plays a larger part in blood loss than is widely recognized. In 1955–7, to settle a difference of opinion on the conflicting claims for deep or light anaesthesia in dissection tonsillectomy with adenoidectomy, Mr. P. H. Golding Wood and I did a carefully controlled (unpublished) series of over 100 cases aged 5–8 years, all with the same team. We compared blood loss under deep ether and under light ether barely deep enough to tolerate the Boyle-Davis gag. Swabs were weighed and sucked blood measured. The operating conditions were better under deep ether, and this group lost on average approximately half the amount of blood of the group under light ether. We also compared a smaller number using suxamethonium

chloride, an endotracheal tube, trichloroethylene, and very small doses of gallamine. These gave similar blood loss results to the light ether group.

It would be of interest to know comparable blood loss figures with anaesthesia as light as Dr. E. V. Slaughter's ½% halothane and with halothane at an appreciably greater depth. It would also be instructive to compare the number of cases causing anxiety on extubation under these same conditions.

Mr. P. H. Golding Wood and I have, as a routine, largely discarded deep ether and the simple insufflating Boyle-Davis-gag technique only because, (1) induction is time-consuming, working single-handed, and operating and waiting-lists are long; (2) potential dangers arise if cautery or diathermy is used in following cases; and (3) the soporific effect on personnel is accentuated in a small hot operating theatre.

A few more factual series with strict controls would help give real perspective and perhaps do away with much conjecture and the often misleading personal opinion. My own preconceived notions were certainly proved wrong on the subject of adenotonsillectomy blood loss under light and deep ether.—I am, etc.,

Harrietsham,
Nr. Maidstone,
Kent.

C. H. BOYD.

SIR,—We have read with great interest all the recent correspondence concerning tonsillectomy and anaesthesia. With particular reference to Dr. D. C. Hughes's letter (19 February, p. 483), it may be of some interest to readers to learn that at St. James's Hospital, using endotracheal anaesthesia and the Doughty modification of the Boyle-Davis gag, we have measured the blood loss in 50 consecutive children under the age of 10 years.

The average blood loss for the 50 cases was 70 ml., as compared with the 128 ml. of the 50 cases studied by Holden and Maher.¹

The average blood loss for 30 adult tonsillectomies was 106 ml.

The presence of blood in the oropharynx as in tonsillectomy is an absolute indication for intubation, and the advantages are to the benefit of the patient, the surgeon, and the ward staff.—We are, etc.,

J. A. CLARKE.

St. James's Hospital,
London S.W.12.

A. W. HALFHIDE.

REFERENCE

- ¹ Holden, H. B., and Maher, J. J., *Brit. med. J.*, 1965, **2**, 1349.

Cot Deaths

SIR,—As a coroner I am of course concerned with the question of cot deaths, and one possibility which appears to have been omitted from every investigation is the possibility of an ante-mortem fall in body temperature.

In many cases the child has been in a cold bedroom or in a pram in the open air when it is found dead.

Investigation by the coroner into the question of room temperature or air temperature might be useful, but even more useful, particularly where the time of death can be approximately determined by other evidence,

would be a recording of the body temperature with a subclinical thermometer taken by the first doctor or nurse to see the body after death.—I am, etc.,

Stoke-on-Trent.

F. G. HAILS.

Contact Dermatitis from Spandex Yarn

SIR,—I was most interested to read about brassière dermatitis due to Spandex yarn in the letter from Dr. C. F. Allenby, Dr. V. Kirton, Dr. K. D. Crow, and Dr. D. Munro-Ashman (12 March, p. 674). I have investigated over the past few months four similar cases, all of whom had positive patch tests to Spandex. Three of these developed the dermatitis after approximately one month of wearing the brassière, the fourth within 24 hours, but the patient had been employed by the firm manufacturing the brassière, and presumably she had become sensitized to the antioxidant at work.

It seems likely that this type of dermatitis will become increasingly common with the widespread use of synthetic yarns.—I am, etc.,

Western Infirmary,
Glasgow W.1.

W. N. MORLEY.

Albustix Test for Urine Protein

SIR,—I refer to the letters by Dr. Phyllis Dagnall (4 December, p. 1369) and Dr. R. M. Emrys-Roberts (12 March, p. 677) on the subject of Albustix for detection of urinary protein. We have found that Albustix and Uristix frequently give false positives, so that in our routine testing in hospital the heat or salicyl sulphonic acid test is always applied when positives are obtained by the "stix" test.

However, I believe Dr. Emrys-Roberts is basing his false negative assertion on the false premise that the presence of proteinuria is a good screening test for urinary infection. It is common for urinary infection to be present in the complete absence of protein in the urine by the usual methods of detection, so that it is quite wrong to confirm or refute the existence of urinary tract infection on the basis of any test for the presence of protein alone.—I am, etc.,

DENIS M. FREEMAN.

Warrington General
Hospital,
Warrington.

Skin Pigmentation by Phenindione

SIR,—Dr. N. H. Silverton's interesting letter (12 March, p. 675) prompts me to report my personal experience of this peculiar phenomenon. I have been taking this drug in varying dosage for some ten months, and within the past three months have noticed recurrent pigmentation, presenting as circumscribed bright orange patches on the centre of the left palm and less commonly on the distal finger tips of right thumb and index finger.

I have confirmed that this can be produced by contact with the drug plus soapy water, though this combination had not previously appeared significant to me.

I had noticed that this pigment occurred when using half tablets and it appeared to be