Birefringence is, of course, exhibited by both urate and calcium pyrophosphate crystals. Differentiation between the two requires identification of the sign of birefringence, urate being strongly negative, calcium pyrophosphate weakly positive. Proof of the identity of urate crystals is by uricase digestion.

We have had the opportunity of examining synovial fluids from 22 patients with radiological calcification of joint cartilage. In general our findings have given less clear-cut answers than anticipated, and a number of specimens contained more than one type of crystal. In one patient with associated hyperparathyroidism the synovial fluid on two occasions was found to contain crystals which exhibited strong positive birefringence and had an extinction angle of 30°. Histochemical studies showed the presence of calcium. The other radical has not yet been positively identified, but we are impressed with the resemblance of these crystals to calcium oxalate.

It may well be that gout and pseudogout can co-exist in the same person. One patient in this series is regarded as suffering from classical uric-acid gout, yet on one occasion fluid from his inflamed knee-joint yielded typical calcium pyrophosphate crystals.—We are, etc.,

H. L. F. CURREY.
K. V. SWETTENHAM.

The London Hospital,
London E.1.

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Hospital at Bath

SIR,—The Royal National Hospital for Rheumatic Diseases at Bath, the third oldest voluntary hospital outside London, has just reopened after almost complete rebuilding. The first hospital in the world to devote itself to the treatment of arthritis, it was bombed in 1942, but it still has many interesting records and incidentally two fine pieces of Roman mosaic in its foundations. We are now anxious to build up a small museum, and if any readers have for disposal such relics as cupping-glasses, leech tubes, bone or wooden stethoscopes, blood-letting sets, etc., I would be very interested to hear from them.—I am, etc.,

Bath, Somerset. GEORGE D. KERSLEY.

Acute Hepatitis

SIR,—Since the investigations of Allen and Sayman¹ and more recently by Mirick *et al.*² in the United States, it has become increasingly clear that the risk of post-transfusion hepatitis, particularly in recipients aged over 40, is considerable. The incidence of post-transfusion hepatitis can be significantly reduced by the judicious selection of patients for transfusion, by concurrent administration of gamma-globulin, or by the use of hepatitis-free plasma infusions. It is evident that the supplies of human gamma-globulin would not allow its free use with blood transfusion, and our need for hepatitis-free plasma for replacement therapy is thus more urgent.

In this country an estimate of the size of the problem of hepatitis cannot be made since hepatitis is not notifiable on a national basis. Before we can begin to undertake any preventive measures the first step should clearly be the notification of hepatitis and the establishment of a follow-up system for patients who have received blood transfusions.—I am, etc.,

A. J. ZUCKERMAN.

Department of Bacteriology and Immunology,
London School of Hygiene and
Tropical Medicine,
London W.C.1.

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Otogenic Tetanus

SIR,—The case of otogenic tetanus described by Drs. I. T. Boyle, W. C. Brown, and E. A. Richardson (10 July, p. 89) prompts us to record a further case.

The patient was a boy aged 9 who was subject to repeated attacks of bronchitis and who had suffered from an intermittent discharge from the right ear from the age of 4. This ear, which had been dry for nine months, became painful and started to discharge eight days before admission to Pembury Hospital. Three days before admission he fell into a duck pond, and on the day before admission he complained of a stiff neck and difficulty in opening his mouth. Spasms developed on the day of admission and rapidly became frequent and severe. In the past he had probably received antitetanus serum for a laceration of the wrist, but there was no record of the administration of toxoid either then or later.

On examination at Pembury Hospital the patient was obviously suffering from severe tetanus, with marked trismus and opisthotonos, and severe spasms. His temperature was 100° F. (37.8° C.) and the pulse rate was 120/min. Pus was discharging from the right ear, but there was no tenderness, swelling, or oedema over the mastoid. A bacterial swab taken at this time subsequently grew *Clostridium tetani*.

The patient was given 2 mega-units of crystalline penicillin and sedated with bromethol. In view of the short period of onset (12 hours) and the probable shortness of the incubation period (three days), he was anaesthetized and paralysed with D-tubocurarine, and a cuffed endotracheal tube was inserted. Ventilation was controlled by hand during the journey to Hammersmith Hospital and subsequently was maintained by an East-Radcliffe ventilator. Shortly after transfer a tracheostomy and right mastoidectomy were performed. 100,000 units of A.T.S. were given intravenously before the surgical intervention, and the spasms were controlled with intermittent injections of D-tubocurarine (30 mg. intramuscularly). Sedation was given at night, but not during the day. Total paralysis was maintained for 16 days, but during this time the patient managed to communicate with the nurses by squeezes of the hand. The progress of the disease was checked at intervals by withholding curare until definite spasms occurred. A right middle lobe collapse, which was present on admission, cleared rapidly with physiotherapy and there were no other complications. Weaning from the ventilator was commenced on the 17th day (sedation being maintained with promazine and quinalbarbitone) and the tracheostomy tube was removed seven days after discontinuing the curare. Ten days later he was able to start walking and the residual muscle stiffness had disappeared. Apart from complete deafness in the right ear, the patient made an uninterrupted recovery.

Immunization with tetanus toxoid was commenced before leaving hospital.

The interest of this case lies in the possibility of contamination of the ear by submersion in the duck pond. If infection entered at this time the shortness of the incubation period may be related to the shortness of the route between the middle ear and the central nervous system.

We are grateful to Dr. N. M. Jacoby, consultant paediatrician, Pembury Hospital, for details of this case.

—We are, etc.,

M. K. SYKES.

J. A. DAVIS.

Departments of Anaesthesia
and Child Health,
Hammersmith Hospital,
London W.12.

Poisons Information Centre

SIR,—Earlier this year the 7505 United States Air Force Hospital at Burderop Park, near Swindon, completely closed down, so the Poisons Information Centre, to which you refer in your leading article (24 July, p. 185), is no longer operational. This centre readily and freely offered its services to British doctors, and in this context it is opportune to mention that this was just one of many examples of the excellent liaison and friendly co-operation which existed between American and British doctors in this particular area.

With the closure of American air bases and the 7505 U.S.A.F. Hospital, the Oxford Group of the Anglo-American Medical Society has, regrettably, had to be dissolved, but the Society continues to meet in the Cambridge and London area. The Anglo-American Medical Society was founded in 1961 to "meet the great need that obviously existed for an organization through which British and American doctors could obtain a clearer knowledge and better understanding of each other." Contact was made through regular scientific programmes and social meetings, and I know from discussions I have had with my colleagues, and from letters I receive from American doctors who have now returned to the United States, that the aims and ideals of the Anglo-American Society were attained to the mutual and, I believe, lasting benefit of both communities.—I am, etc.,

A. G. FREEMAN,
Past Chairman,
Anglo-American Medical Society
(Oxford Group).

Swindon,
Wiltshire.

Thoracic Actinomycosis

SIR,—I wish to report a further interesting case of actinomycotic infection, having read the letter of Dr. B. Bissu (24 July, p. 231) attracting attention to this disease.

A labourer aged 20 years was admitted to Whipps Cross Hospital on 22 April 1965 with a history of an injury to his right loin sustained eight weeks previously in a fight. He had had pain in his right chest on breathing for three weeks before admission and had lost about 3 st. (19.1 kg.) in weight since his injury; he also complained of anorexia and had been sweating at night but had no cough. On examination he was febrile (101° F. (38.3° C.)) and looked ill, showed no obvious dental caries, had a dorsal scoliosis to the left, and there was a tender

swelling over his right fifth and sixth ribs anteriorly, overlying which there was some skin erythema. His right lung base was dull to percussion and air entry and breath sounds were diminished here. Haemoglobin was 69%, and total white cell count 11,700/c.mm. (polymorphs 82%, lymphocytes 17%, monocytes 1%); E.S.R. was 65 mm. in one hour. The differential diagnosis of the swelling was considered to be fibrosarcoma or osteomyelitis.

Following a blood culture he was started on oral ampicillin therapy, 500 mg. six-hourly, on the same day, and this was altered to intramuscular crystalline penicillin, 1 mega unit twice daily, on 3 June, and then to oral penicillin V, 500 mg. six-hourly, on 14 June, which he continued for a further two weeks. He was afebrile by 27 April and remained so. Biopsy of the mass over his right chest carried out on 30 April was typical of actinomycosis, actinocolonies being present. On 16 June tests showed: haemoglobin 93%, and total white cell count 5,900/c.mm. (polymorphs 65%, lymphocytes 25%, monocytes 10%); E.S.R. was 5 mm. in one hour. Right basal shadowing present on admission had persisted on chest radiograph, but was slowly subsiding. When seen in the out-patient department on 30 July he was very well and had gained 2 st. (12.7 kg.) in weight since his hospital admission.

I wish to thank Dr. J. T. Wright for permission to publish this case of actinomycosis involving the right chest wall.

—I am, etc.,

Whipps Cross Hospital, JULIAN VERBOV.
London.

"Kiss of Life"

SIR,—I would like to fully endorse Mr. E. E. T. Taylor's remarks (7 August, p. 366) about the use of the term "Kiss of Life." Surprisingly enough, I have heard this term used by experienced doctors and it has sounded all the more distasteful.

We have a whole list of dramatic terms in relation to this form of artificial respiration now. May I suggest that the term "rescue breathing," a phrase coined by Surgeon Captain Stanley Miles in his book *Underwater Medicine*, covers all contingencies.

The only way of standardizing a phrase of this sort is for M.O.s who lecture in first aid to impress that phrase on to their listeners and accept none other from them.—I am, etc.,

Chard, Somerset. MICHAEL GLANVILL.

Side-effects of Pertofran

SIR,—I have been using Pertofran (desipramine) since its introduction in the treatment of depressive illness and until recently I have had no complaints of any gross side-effects.

Within the past month I have put two patients on this effective antidepressant drug and both of them have had a grand mal type of epileptic seizure shortly after starting treatment. In neither case was there a family history or a previous personal history of epilepsy. Briefly the histories are as follows:

One was a woman aged 51 with a two-year history of a recurrent depressive type of illness. She had a cyclothymic premorbid type of personality but until two years ago did not have any serious psychiatric disorder. Eight days after being put on Pertofran she had a grand mal seizure. (This was described in detail by her husband and the patient was examined within minutes by her family doctor.) She recovered

slowly over a period of a few hours and has not had a recurrence.

The other patient was a girl aged 22 who has been having psychiatric treatment for several years as an out-patient. Basically she presents with depressive symptoms in a person of sub-normal intelligence (just below normal). Three days after going on to Pertofran she had a grand mal type of seizure and was seen shortly afterwards by her family doctor, who received an objective, accurate description of the fit from a relative.

E.E.G.s are being arranged for both these patients and it is possible that these will reveal "underlying latent epileptic tendencies."

Both of these patients were receiving Pertofran 50 mg. t.d.s. and neither of them had had an M.A.O. antidepressant in recent months. In a short account of Pertofran issued by Geigy Pharmaceutical Co., Ltd., it is noted under "Precautions" that "caution is advised in the administration of Pertofran to epileptic patients."

I would be grateful to hear if any of my colleagues using this drug have had this particular side-effect and whether or not there was any history of epilepsy.—I am, etc.,

Harrison Hospital, E. S. LAMONT.
Dorchester, Dorset.

Fish-hook in Ano

SIR,—You may care to publish this interesting case.

I was called to a female patient aged 70 who gave a history that she was slightly constipated. When she went to defecate she felt a tearing in her back passage, and then as if something was hanging on to it. She put her hand to her anus and gave a little pull; when she looked at what she held she saw a small fish-hook. On questioning her, there were no children in the house to have placed the fish-hook on a chair, but she remembered that about five days ago she had eaten conger eel, and that three days ago had eaten jellied eels, but otherwise had eaten no fish where the hook could have been concealed.—I am, etc.,

London S.E.13. R. G. WIGODER.

Royal Commission on the N.H.S.

SIR,—I am writing to give further support to the proposal, ably backed by Dr. E. R. C. Walker in his recent letter (7 August, p. 365), for a root-and-branch examination of the National Health Service, the political and social principles on which it is founded, its tangled structure, and its cumbersome administration. This should be done by a Government-sponsored and appointed body like a Royal Commission in order to carry full weight in all quarters. When their policies are under heavy criticism Governments and parties tend to confine their re-examinations, if any, of these policies to their own ranks away from public gaze, and announce the results in policy statements or manifestos. This need not be so when a major matter of public importance is involved. The Government appointed the Spens Committees on remuneration in a publicly organized medical service, the Guillebaud Committee on the cost of the N.H.S., the Platt Committee on Hospital Staffing Structure, the Royal Com-

mission on Doctors' and Dentists' remuneration, and, most importantly in the context of this proposal, the Robbins Committee on Higher Education. There is now a Royal Commission on Medical Education. All these committees and commissions devised and advised policies which the Government accepted in whole or in part as guides to political or administrative action because the subjects were of such great public importance at the time.

The N.H.S. is of the greatest public importance, and goodness knows it is shot through with controversy, inside and outside the medical profession. The time could not be more appropriate for its fundamental examination by a committee or commission like those named above. As for this being used as a delaying tactic—we have waited for 17 years for some sense; surely we can wait another two or three years if there was a prospect of the mess being cleared up.—I am, etc.,

Edinburgh.

J. G. M. HAMILTON.

The New Zealand System

SIR,—The motion passed at the A.R.M. in Swansea relating to payment by the patients of fees for items of service, recoverable in whole or part from the State, resulted in a reference to the similarity to the New Zealand system of payment of doctors. The New Zealand system may not be clearly understood by many, having been altered by experience since its inception. An explanation of its origin and present usage is outlined here. One of the writers is on leave from active practice in New Zealand.

About 1940 the New Zealand Government decided to introduce a scheme of free medical benefits based on a panel system. A date was announced when this scheme would commence, but owing to determined opposition from the B.M.A. in New Zealand the number of doctors prepared to work the scheme was less than 30. The New Zealand public found themselves paying their social-security tax and still paying the doctor as before. In consequence the Government were forced to approach the B.M.A. for an alternative scheme.

After much consideration the B.M.A. decided to approve a scheme the basis of which was that any money the doctor received from the Government was accepted as a subsidy on behalf of the patient. The B.M.A. also insisted that the doctor must maintain the right to charge each patient a fee which the doctor considered his personal service was worth. The money paid by the Government would be a subsidy to the patient towards this fee. This principle has remained in force ever since, the Government paying a sum of 7s. 6d. as a fee for an item of service. At the introduction of the scheme this sum was often accepted by the doctor in full settlement. With the steady fall in purchasing power of the pound the doctor has charged the patient a further fee dependent on what value he places on his services.

There are two methods of payment from the Government:

(1) *The Schedule System*—where a doctor fills in the name and address of the patients he has attended on a form with a code for the service for which he is