of the skin, post-mortem examination revealing massive haemorrhages in the suprarenal glands in all cases. Death occurred so rapidly that involvement of the meninges appeared to have no time to occur and in only one case can I recall the cerebrospinal fluid being slightly opalescent.

There is obviously in this syndrome an overwhelming bacteraemia, and in one case I was able to demonstrate diplococci in a blood film, at least half a dozen being visible in each field; these were easily identified and were not artifacts. Diagnosis is exceedingly difficult unless there is an epidemic of cerebrospinal fever at the time and the medical attendant is aware of this fairly uncommon syndrome. Confirmatory diagnosis by blood culture is much too late.

A letter appeared in your correspondence columns during 1941¹ describing what would appear to have been a fairly typical case of Friderichsen-Waterhouse syndrome occurring in the West Country and labelling it malignant measles. About six months earlier an article had appeared in the *B.M.J.*² giving a full description of the disease under discussion.

It would appear that this unfortunate woman was incubating a fulminating meningococcal infection on her admission to hospital, the extensive haemorrhages into the suprarenals causing her rapid deterioration and fatal termination.

It would be very interesting to learn whether there were any cases of cerebrospinal meningitis in the community at the time of this woman's death, the size and nature of the community, and the season of the year.

Only chemotherapy and deoxycortone acetate (D.O.C.A.) were available in 1940, and it would be of interest to learn whether there have been any cases of recovery since the advent of more potent bactericidal agents, cortisone, etc.—I am, etc.,

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REFERENCES

- ¹ Baker, Audrey Z., *Brit. med. J.*, 1941, 1, 380.
² Hughes, J. F., *ibid.*, 1940, 2, 353.

Diet and Ischaemic Heart Disease

SIR,—I should like to comment on the paper by Dr. G. A. Rose and others (12 June, p. 1531).

In the United States we have just concluded the first phase of the National Diet-Heart Study, which involved several thousand men. Two years of intensive discussion and planning preceded the study. During these discussions consideration was given to the thought of studying patients who had had actual heart attacks. For several reasons such an undertaking was not approved. Among the reasons were the following:

(1) The statisticians advised us that a very large number of subjects would be necessary in order for findings to have any possible statistical significance.

(2) By the time a man has a heart attack there is a large probability that the nature of his pathology will be essentially irreversible regardless of what one may do; that is, one is dealing to a large degree with fibrocalcific

lesions which would have little likelihood of responding to diet. Another way of stating this is that if one wishes to evaluate the effect of diet upon atherosclerotic lesions the time to do so is many years before the lesion has become symptomatic.

I believe that I am correct in saying that the data presented by Dr. Rose and his collaborators have no statistically or biologically significant meaning. It is unfortunate that they may mislead many people.—I am, etc.,

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Jaundice in Severe Infections

SIR,—With reference to the article by Mr. A. Eley and his colleagues (10 July, p. 75), reporting five cases of jaundice associated with severe infections, in some places it is commonplace. For example, I remember in Bulawayo, Rhodesia, not a malarial area, that many previously apparently healthy young African adults with acute pneumonia developed jaundice, and also in some the jaundice was seen before the physical signs in the chest developed. Clain and Gelfand¹ investigated a few of such cases without finding evidence for haemolysis or cholestasis.—I am, etc.,

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REFERENCE

- ¹ Clain, D., and Gelfand, M., *Centr. Afr. J. Med.*, 1964, 10, 217.

Beds for the Dying

SIR,—One of the sad results of the shortage of beds at teaching hospitals is the break in the doctor-patient relationship which occurs when one of their terminal carcinoma cases becomes in need of care. It is very undermining for some of the patients, especially those in the younger age group, to find that when they have to be admitted into hospital because of increasing pain or necessity for nursing they must often go to another hospital without previous warning.

One such patient recently reached one of my beds. She was only 45 years old, and it was some time before the Emergency Bed Service could find a suitable bed. One realizes that it is absolutely essential to give priority to carcinoma patients needing treatment, and in whom there is a possibility of response, before these terminal patients. Wouldn't it be possible for them to be admitted into a medical bed as an emergency, as is done, for instance, with acute bronchitis, and if necessary be moved to a terminal home from the parent hospital? Or, alternatively, more use could be made of the waiting-list for these homes by almoners in co-operation with the relations before the need arises.

The present situation is one that general practitioners find distressing, and it might be that more cases would be sent to the teaching hospitals if this difficulty was overcome. Surely sometimes personal concern for the comfort of the patient is as important as

treatment of the disease. The hospital concerned in this case, and in others in which the problem has occurred before, are always kind and helpful in other respects, and it seems only the fear of a blocked bed which brings about such decisions. However, to the patients, their doctor, and their surrounding friends and relations the rejection at the end of the road seems especially unkind if it has been preceded, as it often has, by much kindness and care, and doesn't help the image of the hospital.—I am, etc.,

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BARBARA G. MORTON.

Image of Nursing

SIR,—It was surely not necessary to do a social survey to discover that the public image of nurses as "very overworked" (26 June, p. 1626) is bad for recruitment, nor that the Royal College of Nursing's emphasis on higher education must have the same effect.

It is true that nurses work very hard, but they have many compensations. Apart from the high esteem in which they are held (quite rightly) by the general public, nurses have many facilities for cultural and recreational activities, and they lead a life which is rich in companionship. They do not waste their time and energy in travelling to and from work, nor do they have to clean their rooms, do their own laundry, or cook meals. These points should be emphasized and would do much to offset the drawbacks inherent in the provision of a 24-hour nursing service.

Similarly every doctor knows that the Royal College of Nursing's policy of increasing academic standards to those of university level is deterring suitable girls from entering the nursing profession. Many who have the necessary qualities of character and humanism fear they are "not clever enough."—I am, etc.,

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Synovial Fluid in Gout

SIR,—Dr. W. P. U. Jackson and Dr. F. Harris (24 July, p. 211) have had the good fortune to examine synovial fluid from a patient suffering from hyperparathyroidism, hyperuricaemia, arthropathy, and calcification of articular cartilage. Such fluids are of particular interest for the light they may shed on the mechanism of arthropathy in these patients, who are candidates, not only for gout and "pseudogout" but also for arthritis secondary to underlying bone disease.

Their case report describes attacks of acute arthritis affecting, *inter alia*, the right hip-joint and a big toe. This would suggest that more than one mechanism was operating, for hip-joint involvement in classical gout (especially during the first five years) is exceptionally rare, while podagra has yet to be described in pseudogout. Unfortunately the crystals have not been positively identified in this case, and the suggestion that the joint fluid contained crystals of two different compounds must be very tentative.