Another equally harmless, and also common, eruption is seen over the upper third of the bicipital surface of the upper arm. This consists of an oval area of petechiae and perhaps some slight bruising, about $\frac{3}{4}$ in. (2 cm.) long. It is due to the child sucking himself, though most children will for some reason deny that they have done so.

Since vest purpura is not limited to young children, it may well be met in adults, but since Dr. Kibel and I are both paediatricians we have had less chance of seeing it in older subjects.—I am, etc.,

Bath, Somerset.

S. D. V. WELLER.

Hyponatraemia and Bronchial Carcinoma

SIR,—We were most interested to read the article on "Hyponatraemia and Bronchial Carcinoma" by Drs. A. L. Linton and I. Hutton (31 July, p. 277), as we recently had an example of this syndrome and agree that treatment presents certain problems.

The patient was a man aged 51 years with a tumour situated in the left upper lobe involving the mediastinum. At the time of admission for bronchoscopy he was confused, disorientated, and aggressive. Biochemical investigations revealed serum sodium of 110 mEq/l.; potassium 4.7 mEq/l.; chloride 76 mEq/l.; blood urea of 10 mg. ml. Intravenous sodium chloride (450 mEq) raised the serum sodium to 120 mEq/l., with improvement in the patient's mental state. Further investigations showed the urine to contain no glucose and no protein; the creatinine clearance 140 ml./min.; serum osmolality 230 m.osmoles/kg.; urine osmolality 400–500 m.osmoles/kg.; serum cortisol 15 μ g./100 ml.; rising to 45 μ g./100 ml. after an intravenous infusion of A.C.T.H. (35 units). Serum

antidiuretic hormone 25–50 μ U./ml.; blood volume 110 ml./kg.; skull x-rays and x-rays of pituitary fossa normal. Despite intravenous and oral sodium supplements and the addition of 9 α -fluorohydrocortisone (1 mg./day) the serum sodium could not be raised above 120 mEq/l.

The mental state in this condition of inappropriate secretion of antidiuretic hormone is due to the low serum osmolality and is similar to that associated with acute water intoxication. As Schwartz *et al.*¹ point out, these symptoms occur when the serum sodium falls to between 110 and 115 mEq/l. The treatment as suggested by Schwartz *et al.*,¹ Ivy,² and Bower *et*

al.,³ consists of restricting fluid intake to 700 ml./day. The accompanying graph shows the rise in serum sodium and fall in body weight, the rise in serum standard bicarbonate, and the rise to normal levels of blood urea from the sixth day of admission. To demonstrate the inability to excrete a water load the patient was given 1 litre of water to drink over 30 minutes. Two hours later the patient became unconscious and the serum osmolality had fallen to 215 m.osmoles/kg.; a dramatic improvement was obtained by giving 300 mEq of sodium chloride intravenously.

As the tumour was radiologically inoperable, deep x-ray therapy (3,000 r) was given over two weeks commencing on the eighth day after admission. On discharge from hospital, the fluid intake was increased to 1 litre per day, and the patient's mental state remained normal until death on 18 July 1965.

We therefore suggest that the syndrome of inappropriate secretion with antidiuretic hormone associated with bronchial carcinoma should be treated by fluid restriction rather than by sodium supplements and 9 α -fluorohydrocortisone. Once the primary tumour has been dealt with by surgery, radiotherapy, or cytotoxic drugs, and the secretion of antidiuretic-hormone-like activity has diminished, fluid intake may be increased provided the patient does not gain weight and the serum sodium does not fall.

We wish to thank Mr. J. Leigh Collis for permission to publish details of his case and Dr. A. R. Daniel, Department of Pharmacology, The University of Bristol, for kindly performing the plasma antidiuretic hormone-like activity bioassay.

—We are, etc.,

S. GLICK.
B. HULME.

Queen Elizabeth Hospital,
Birmingham 15.

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Scared to Death?

SIR,—Dr. D. Trevor Thomas (21 August, p. 480) asks if there have been any cases of recovery from the Waterhouse-Friderichsen syndrome "since the advent of more potent bactericidal agents, cortisone, etc." The answer is "Yes." Following reports of the remarkable effect of cortisone in this condition by Newman¹ and Nelson and Goldstein,² I and my colleagues reported two cases in

1952.³ Since then I have had at least two further cases, which responded satisfactorily.

Incidentally, the value of the steroids is not confined to fulminating meningococcal infections, where adrenocortical exhaustion is prominent and haemorrhage in the suprarenals is usually demonstrable at post-mortem. It applies to the whole range of viral and bacterial infections as well. All my cases of severe reaction to infection receive steroids intravenously or orally, or both, depending on the urgency of the situation.

It is interesting to note the decline of meningococcus as a cause of meningitis. Before the war one could almost assume that a case of meningitis was meningococcal, unless proved otherwise. To-day the majority of cases are viral in origin, and of bacterial cases *Haemophilus influenzae* would appear, if anything, to be the most frequent cause. It looks as if the sensitivity of meningococcus to penicillin and the sulphonamides is resulting in its gradual eradication from the British nasopharynx.—I am, etc.,

South Middlesex Hospital,
Isleworth,
Middlesex.

G. E. BREEN.

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At Gallipoli

SIR,—I cannot allow the note on the Gallipoli Campaign (24 April, p. 1134) to pass without comment. Whoever was responsible for it must have been very very young in 1915. Perhaps he was not even born. Has he never heard of the word Anzac? After all Australian and New Zealand troops did have some small part in the operations. Lancashire Landing, to which this note evidently refers, was only one part of the assault on the peninsula, and took place a good many miles along the coast from Anzac Cove.—I am, etc.,

Palmerston N.,
New Zealand.

J. S. MONRO.

** We regret that in the publication of a brief note on the R.A.M.C. at Gallipoli, and the part played by Lieutenant-General Sir Frederick Harris (then Captain Harris), the gallant role of the Australian and New Zealand troops went unmentioned.—Ed., *B.M.J.*

Estimation of Serum Enzymes

SIR,—During the past six months an intensive quality control programme has been instituted in this laboratory. Among other things the quality control sera have been used as enzyme controls, some values for which have not been included by the manufacturer.

These results may be of interest to other laboratories.

The serum enzymes determined were hydroxybutyrate dehydrogenase¹ and lactate dehydrogenase,² isocitrate dehydrogenase,³ and aldolase.⁴ The quality control sera used were Baxter

Results

Serum Enzyme	Serum Control	No. of Determinations	Mean	Standard Deviation
Hydroxybutyrate dehydrogenase	Abnormal	123	260 I.U./l.	46
Hydroxybutyrate dehydrogenase	Enzatrol	13	393 "	—
Lactate dehydrogenase	Abnormal	20	390 "	55
Isocitrate dehydrogenase	Abnormal	4	12 "	—
Aldolase	Abnormal	4	4 units/ml.	—
"	Normal	4	1.7 "	—
"	Enzatrol	7	7 "	—

Laboratories Ltd. Abnormal No. 368×60, Normal 369×45 and 369×41, and Enzatrol.⁶

The standard deviation for both the hydroxybutyrate dehydrogenase and lactate dehydrogenase is perhaps large, and this is in part accounted for by a gradual fall off in enzyme activity observed once the control has been made up and stored at -20° C. The control sera were usually in use over a 5-6 day period with repeated freezing and thawing. In view of the fall-off in activity in future aliquots of the prepared serum will be stored at -20° C. and one tube used as required.

Isocitrate dehydrogenase and aldolase have only recently been determined in this laboratory and are included so that it may be recognized that values can be obtained with the quality control sera mentioned.—I am, etc.,

WILLIAM H. S. GEORGE.

Department of Chemical Pathology,
Derbyshire Royal Infirmary,
Derby.

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- ¹ Elliott, B. A., and Wilkinson, J. H., *Lancet*, 1961, 1, 698.
- ² Wróblewski, F., and LaDue, J. S., *Proc. Soc. exp. Biol. (N.Y.)*, 1955, 90, 210.
- ³ Bell, J., and Baron, D. N., *Clin. chim. Acta*, 1960, 5, 740.
- ⁴ Aldolase Test. C. F. Boehringer, Mannheim.
- ⁵ Enzatrol, Dade Reagents, Inc., Florida.

Action in Brighton

SIR,—I trust that the three writers of a letter under the above heading (28 August, p. 538) will agree when I say that it amounts to little more than a preliminary and discursive survey in which facts are in danger of being hidden in a mass of esoteric words.

Two facts seem to emerge: that unity within the profession is essential and without this, as they state, the 18,000 resignations are so many scraps of paper; on the question of unity there can be no argument. Their second statement is that the national alternative financial scheme produced by the B.M.A. is impractical and can never be otherwise unless modified and run on a divisional basis, and that it would involve the employment of an administrative staff of 20,000. I would suggest that two issues are being confused—resignation and an alternative scheme. Whilst resignation is very much in the profession's stable, an alternative scheme may not be, for such a scheme assumes that the Government would be willing to wash its hands of the whole matter of insurance and to hand it over to the profession in the event of the 18,000 resignations becoming kinetic.

I would argue that this is a very unlikely eventuality and that ultimately it will be for the Government and not the profession to formulate an alternative scheme, and that if politics are to continue to hold sway this is what must happen. If there is any substance in this argument then it follows that any attempt by the B.M.A. to put an alternative scheme into action would be to step into unnecessarily deep water in which it might well founder.—I am, etc.,

Exeter.

F. E. GRAHAM-BONNALIE.

New Zealand System

SIR,—The clear exposition of the New Zealand Health Service by Dr. R. C. Gordon and Mr. G. E. Moloney (21 August,

p. 483) should surely help our profession to realize the wisdom of the decision of a large majority of the Representatives at the recent A.R.M. In the years 1943 to 1948 some of us besought our colleagues to secure a N.H.S. on the lines of the New Zealand Service, and, had this been done, I, for my part, would not have resigned. Our efforts, however, were in vain, and resignation from the general-practitioner N.H.S. was the only way to secure my freedom and the happy life which I have since enjoyed. Many of us are now convinced that the Government could secure both contented general practitioners and contented patients, and could thereby stop the drift away from this country and its N.H.S., provided that it was prepared to cast doctrinaire politics aside and put forward a scheme which gave to those doctors who so desired the right to charge their patients the fees which they considered their personal services were worth.

At the same time those who wished could be paid by capitation fee, salary, or some other method. Why must there be uniformity in method? Patients and doctors are individuals and not mass products of the same shape, size, and mentality. The failure to adopt now common-sense and varied methods of remuneration is not likely to produce mass resignation, but may well result in the individual resignation from the N.H.S. of those who feel sincerely that they desire freedom to give to their patients the services in which they are experienced and to be rewarded according to the quality of their work.

Be assured that those with these characteristics are not just out for money—money—money, but for freedom to earn their living happily.

1911—1948—1965. This may well be "For the third and last time of asking!"—I am, etc.,

Dorking, Surrey.

CYRIL E. BEARE.

Image of Nursing

SIR,—In reply to Dr. Margaret D. Baber's letter about the image of nursing (21 August, p. 481), I would say that it is unlikely that many aspiring nurses would be conceited enough to place the possibility of being held in high esteem very high on their list of reasons for becoming a nurse. The provision of genuine service with warmth and care is still an attraction to most nurses. Again, because they lay greater emphasis on human values, they are not continually looking for financial benefits, but in terms of the hard facts of everyday living it is clear that this must be greater soon, especially in the earlier years and just after qualifying as an S.R.N.

The "cultural and recreational facilities" are, of course, important, but they are meagre, even in the teaching hospitals. Moreover, until the nursing profession itself learns to organize off-duty better few nurses can definitely say that they can play hockey, say, next Saturday, or, worse still, even two days before a date be unable to say "Yes." This happens all too often. It is one thing to provide facilities for recreation, but quite another to encourage their use. In general this is not done.

Girls of the calibre required for nursing are not likely to take it up because someone will do their laundry or other personal service

which they would, in general, rather do for themselves. Thus as soon as girls are State-registered nurses they get together and share flats near the hospital, which they fully maintain themselves. They are only too glad to be free of the over-rigid discipline and squalid architecture that is found all too often in nurses' homes.

It has already been hinted that part of the solution to the problem lies in the hands of the matrons. What happens to the girls who are regularly rejected, though academically suitable, from the teaching hospitals year by year? Most of them are lost to nursing because there does not appear to be sufficient follow-up and encouragement. The image and initiative of the provincial hospitals must be improved and given credit for the good nursing that commonly exists. Girls must not feel they are getting an inferior training but rather a different type of training.—I am, etc.,

Oxford.

G. R. CLARKE.

S.H.M.O.s Without the Allowance

SIR,—No doubt, like myself, most S.H.M.O.s in the above category have received notice that their posts are now graded Medical Assistant, though they may still use the title S.H.M.O. and enjoy the "privileges" of that grade.

In my own case the regional board did not upgrade my post and my appeal failed at regional level in 1962, yet the Wright Committee later recommended an additional consultant for this unit based on the work I personally submitted. A new consultant has now been appointed, so that it will be more difficult for me to maintain that I am doing consultant work should a personal interview for upgrading take place.

I know that my case is not an isolated one and hope that others who are in a similar position will write about their case and support me in protesting against the treatment meted out to them.—I am, etc.,

Paisley, Renfrewshire. ARCHIBALD SMELLIE.

Health Centres

SIR,—Please may I reply again to Dr. N. S. Barnett (28 August, p. 536)? In his first letter he attacked health centres. Now he says, "Cottage hospital modifications or centres are well suited to special circumstances and can be left aside." I am sure that every centre has special circumstances and has been built because of special needs. Of course the health centre is not the answer for every town and village or for every general practitioner, and in this area we finance and run a group-practice centre five miles away from the Hythe centre.

Dr. Barnett asks for equity. I would rather ask for mutual support. He says we are subsidized. We are more aware of working rather harder at the same income but perhaps doing a better job in an improved environment.

Remaining also on the side of my 20,000 colleagues.—I am, etc.,

The Medical Centre,
Hythe, Southampton.

HUGH WARRICK.