At operation the tumour was found to have infiltrated the renal vein. Six months later he developed a left-sided hemiplegia, dyspnoea, and cyanosis. Six weeks before he died x-ray showed massive infiltrations of the left lung.

At necropsy (0-480/65) the left adrenal presented as a tumour about 10 cm. in diameter. Histology showed a carcinoma of the adrenal cortex. The left pleura was thickened and the cavity occluded. The resultant mass was up to 6 cm. thick and could be seen to infiltrate the lung tissue. Histology showed a mesothelioma of the pleura. This tumour had not penetrated the pericardial sac, but a tumour of about 1 cm. in diameter protruded from the myocardium. Histology this time showed a rhabdomyosarcoma. A tumour about 2 cm. in diameter was found on the surface of the right parietal lobe. Histology—a malignant ependymoma. In addition he had a myoma of the stomach wall.

Here are five histologically distinct patterns, all showing criteria of malignancy. There are at least four possible explanations:

(1) They may represent one primary—the metastases showing different morphology.

(2) The kidney tumour may have been of mixed type—the other tumours metastases from this.

(3) This may be a chance association of primary tumours with no common aetiological factor, or

(4) an association of primary tumours with a common aetiological factor.

The first idea is unlikely, as (a) the cardiac, adrenal, and meningeal tumours showed areas of transition from normal structure to malignant tissue, and (b) the combination of cell types involved speaks against a common origin. The second possibility is also unlikely because of (a) above. The third possibility cannot be ruled out, but the rarity of some of the tumour types and the short interval over which they presented makes it, too, unlikely. The fourth hypothesis deserves consideration in view of recent experimental work on the polyoma virus, which may call forth the multiple tumours both benign and malignant, usually, but not only, of mesenchymal origin, in a variety of sites including the heart.¹

The present case may thus be an example of a virus at work in human pathology. If so, the surprising thing is not that multiple tumours have been produced—but that this does not happen more often. What was different about this patient that caused him to react in this way? Viewed in this light the aetiology of the tumours themselves is of little significance. The control mechanism that prevents such cases from becoming commonplace is more important.—I am, etc.,

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REFERENCE

- ¹ Stanton, M. F., and Otsuka, H., *J. nat. Cancer Inst.*, 1963, 31, 365.

Umbilical-vein Exposure for Transfusion in Newborn

SIR,—I was somewhat surprised to read in the letter by Dr. A. F. Doss (11 September, p. 645) that in his experience the umbilical vein is not serviceable after 24 hours for exchange transfusions. He then goes on to describe a method of exploring the vein above the umbilical stump.

In my experience, and I am sure most paediatricians in this country would agree, one is able to use the umbilical vein for exchange transfusion for periods up to about a week after birth. I find that the vein is generally fairly easily entered, particularly when a repeat transfusion is necessary on the third, fourth, and fifth days of life.

It is possible that with the different climatic conditions in Ceylon the stump shrinks more quickly, which would make it necessary for Dr. Doss to go in for this rather complicated method.—I am, etc.,

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Respiratory Failure

SIR,—In my letter of 10 July (p. 107) I wrote that certain observations about obstructive airways disease were “first reported from the London Hospital some eight years ago and subsequently published in 1959.” I had intended to convey the meaning that the first of a series of reports from the London Hospital (and not the first report ever) was made eight years ago. That this sentence can easily be construed as a claim to ultimate priority is now made plain by Dr. W. K. C. Morgan in his letter of 28 August (p. 534). This was certainly not my intention, nor, if it had been, would it have received much support from my own paper in 1959,¹ where I gave even earlier references to a number of these observations. In particular, I quote at length one of the first accounts (by Baldwin and her colleagues) of a patient falling into the category so aptly described by Professor Dornhorst as the “blue bloaters.”² The object of my letter was simply to draw attention to the omission of several pertinent references from an important review. The object of Dr. Morgan’s letter—if not the tone—would seem to be similar to my own.—I am, etc.,

Liverpool.

COLIN M. OGILVIE.

REFERENCES

- ¹ Ogilvie, C., *Thorax*, 1959, 14, 113.
² Dornhorst, A. C., *Lancet*, 1955, 1, 1185.

Safety of Oral Contraceptives

SIR,—Dr. J. G. Oddy calls for evidence that oral contraceptives do not increase the risk of intravascular thrombosis (28 August, p. 535). I too would like to see this, although my personal belief is that there has been selective reporting and that an increased incidence is unlikely.

General practitioners realize that nobody is interested in a report of one case of thrombophlebitis in a woman who is *not* taking the pill. And as in the vast majority of cases the venous thrombosis settles rapidly there is no reason to refer such a patient to the specialist units who are prepared to write up the cases in which an association does exist. I certainly have had two cases in the last year in which there was no association, and although I have between 50 and 100 women on Anovlar and Gynovlar, including women who have a history of thrombosis before starting the pill and women who have varicose veins, I have not yet had an associated case myself. But such figures prove nothing; and neither does a report of a com-

parable number of cases in which the contraceptives have been taken.

Family doctors are repeatedly asked about the safety of this form of contraception, and I have several pregnancies amongst women who conceived within a month of ceasing the tablets “because my husband read in the paper that they were dangerous.” One must remember that pregnancy is probably quite as risky as contraception from the point of view of thrombo-embolism, but it would be a great help if an authoritative body could carry out a prospective trial which was as valid as the M.R.C. assessments of tuberculous drugs, so that we knew the risks of both pregnancy and contraception.—I am, etc.,

Bletchley, Bucks.

GEOFFREY RIVETT.

Subdural “Haematoma” in Infancy

SIR,—I agree with Mr. Kenneth Till (4 September, p. 590) that there are many unexplained aspects of subdural-fluid accumulation in infancy, and the aetiology of a collection may often be obscure.

However, of the 25 cases I reported (21 August, p. 446) 19 showed fresh blood or heavily blood-stained fluid at the initial needling. One older child, who had burr holes made, had a solid blood-clot on one side and xanthochromic fluid on the other. The remaining five showed xanthochromic or clear fluid; three of these children had associated limb or skull fractures and were considered to be “battered babies” and so likely to have had subdural bleeding initially. It therefore seemed justifiable to entitle the series “subdural haematoma.”

Possibly these findings are accounted for by the fact that many of the cases had a short history, and were seen initially as acute emergencies following admission from casualty or in the maternity department and not on referral to a neurosurgical department. In most cases as daily needlings proceeded the fluid became xanthochromic and then clear: at this stage it would certainly seem more appropriate to label the fluid collection a subdural effusion.—I am, etc.,

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Splints to Prevent Foot Drop

SIR,—Elderly patients are very prone to develop a heel pressure-sore or/and a foot drop, more especially in a paralysed leg, or in the remaining leg where the other has been amputated. In fact a heel pressure-sore can