these seasons of respiratory infections, which often occur during the early phases of leukaemia and may draw attention to the leukaemic process. The contrasting patterns between the U.S. and England and Wales, however, may reflect different seasonal distributions associated with enhanced recognition of leukaemia, increased host susceptibility to the leukaemic process, or specific environmental leukaemogenic factors.—I am, etc.,

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Epidemiology Branch,
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Bethesda 14, Maryland, U.S.A.

REFERENCE

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Infant Feeding During Ramadhan

SIR,—In reply to the queries made by Drs. Mary D. Ainsworth and Hebe F. Welbourn (November 2, p. 1129) I can speak from four years' experience in the Sudan.

Dispensation is allowed to pregnant women anyway. Since it takes the form of bidding the woman to make a fast in an equivalent way some other time during the year, she does not avail herself of it. She fasts at the time when others in the family are doing so. Pyelitis is a common result.

More detailed communication between religious and medical leaders might result in more suitable education towards a solution of these social habits so detrimental to these women and their children. Total dispensation is evidently necessary.—I am, etc.,

CHRISTINE KIRBY.

London N.W.8.

Periodic Health Examination

SIR,—Your correspondence columns have often been amusing, but are becoming ludicrous. In your issue of October 26 (p. 1066) the honorary secretary of the Cancer Information Association suggests that an annual examination in shortened form would take a mere 20 minutes.

If we assume that a G.P. works only six days a week (no Sunday surgeries) and takes two weeks' holiday a year, then he can examine 2,500 people a year by spending only an extra two and three-quarter hours every working day on these examinations (or 3 hours 20 minutes for 3,000 patients). For those who work in town practices, and may work from 9 a.m. to 9 p.m. with a short break for lunch, these extra hours may save their patients' lives—but will certainly shorten the doctor's.

The idea, of course, is praiseworthy, but to try to implement it would seem to threaten further to reduce the dwindling supplies of general practitioners by earlier death. Can nobody suggest a more practical approach?—I am, etc.,

MICHAEL R. BOUNDY.

London N.W.11.

The E.M.O. Inhaler and the Ambu Bag

SIR,—The E.M.O. quantitative inhaler¹ and the Ambu bag,² including the Ruben one-way valve for giving artificial respiration, were designed quite separately to meet different situations. These are now sometimes combined by anaesthetists, and they are held in reserve in many countries for emergencies, when they are likely to be used by less skilled personnel. A word of warning must therefore be given on the use of these in curarized patients.

As at present constructed the Ambu bag can be attached only to the inlet of the E.M.O. (see Fig.). If any rebreathing

occurs at the Ruben valve a comparable volume of gas passes back through the E.M.O. into the bag, and on inflation it passes yet a third time through the E.M.O., each time increasing the vapour concentration. Our experiments^{3,4}

show that in fact a very considerable amount of rebreathing does occur, and that the volume increases when ventilation is performed by an untrained person.

The obvious dangers are:

- (1) A higher anaesthetic vapour concentration than the pre-set concentration.
- (2) Hypoxia, if air only is used as the vehicle.
- (3) CO₂ accumulation.

It must be pointed out that the E.M.O. was designed for use with the Oxford inflating bellows (O.I.B.) which is interposed between the inhaler and the patient. In this way the air is drawn through the inhaler into the bag at a relatively low pressure. This ensures that the O.I.B. becomes filled with the pre-set concentration of anaesthetic vapour. Firm compression of the distended bellows to inflate the patient in no way influences the concentration of vapour.

If the Ambu bag (or the O.I.B.) is attached to the inlet of the E.M.O. the firm compression necessary to inflate the lungs subjects the inhaler to a greater pressure than that for which it is designed. The result is that the inhaler delivers a concentration of vapour in excess of that indicated.⁵ It is evident, therefore, that with controlled ventilation the combination illustrated in the Figure will deliver concentrations of vapour considerably greater than the pre-set concentration. In two of our recent cases of gastric resection anaesthetized with halothane, for which agent the E.M.O. was designed, the result caused anxiety, and the result might have been unhappier still had the patients been less fit.

The danger of overdose would be excluded if the Ambu bag were to be placed between the inhaler and the

patient. This would necessitate minor modifications to the inlet of the bag.—I am, etc.,

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University Clinic of Surgery,
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Enuresis

SIR,—I must agree with my former chief, Dr. Ian G. Wickes (November 9, p. 1199), that every effort should be made to help children with enuresis, but surely no one can agree when he says, "Not one single enuretic . . . will be helped . . . unless doctors . . . teach them to be dry by means of the buzzer."

I have about 12 children a year with enuresis brought to me during my very busy surgeries, and over the past eight years I cannot off-hand recall one single failure of treatment, and without using the buzzer—and most of these children showed great improvement within a week.

My treatment, basically, consists of establishing rapport with, and sympathy for, the child; obtaining the trust and confidence of the parent; a simple bedtime routine; and perhaps tabs. amphetamine sulphate at night to lessen the depth of sleep. Above all, the doctor must be able to "sell" the cure to the child and the parent.

In other words, the main agent in curing the child is not the tablets, nor the routine, nor a buzzer, but the doctor himself.—I am, etc.,

BASIL SELTZER.

Whitecraigs, Renfrewshire.

Portal Phlebothrombosis in the Puerperium

SIR,—In their report of three cases of this condition Mr. J. S. W. Chambers and Dr. R. A. Goodbody (November 2, p. 1104) make a plea that similar cases be reported. The following case occurred recently in this hospital.

A married woman of 31 attended the hospital antenatal clinic during her second pregnancy in 1963. Her first pregnancy three years before was complicated in the puerperium by a deep-vein thrombosis of the right leg, treated with anticoagulants for two weeks. The present pregnancy was uneventful until the 38th week, when an unexplained intrauterine death occurred. The onset of labour was spontaneous one week later and she was delivered normally of a macerated foetus on June 14. In the early puerperium she complained of epigastric discomfort after food which she had also noticed in the last week of her pregnancy. The only physical sign at this time was some tenderness in the epigastrium. A barium

meal was booked and she was discharged on June 23.

She was readmitted on June 29 as the epigastric pain had continued and become more severe. She had vomited once. She was apyrexial and there was only moderate epigastric tenderness without signs of peritonitis. Over the next 48 hours, however, her pulse rate rose and she developed signs of a generalized peritonitis. At laparotomy on July 1 she was found to have gangrene of the middle 3 ft. of the small bowel and gross oedema of the mesentery due to thrombosis of the mesenteric veins. Good pulsation was felt in the mesenteric arteries. The infarcted bowel was resected.

Intravenous heparin 10,000 units six-hourly and tetracycline were commenced immediately post-operatively. The heparin was discontinued on July 15 because the patient had three melaena stools. She made a good recovery and was discharged on August 10. Two months later she was symptom free, having one bowel action a day, and had maintained her weight.

This case seems worth reporting because it illustrates:

(1) The duration of symptoms before infarction of the bowel occurs—in this case four weeks.

(2) That with timely resection of infarcted bowel and immediate post-operative anticoagulant therapy survival is possible.

(3) That the condition may begin in the later weeks of pregnancy, and may in this case have contributed to the intra-uterine death.

We are grateful to Mr. A. F. Clift, F.R.C.O.G., and to Mr. C. F. Swinton, F.R.C.S., who performed the operation, for permission to report this case.

—We are, etc.,

J. B. CARDOZO.
T. DUNCAN.

Mayday Hospital,
Thornton Heath, Surrey.

Lung Cancer and Bronchitis

SIR,—In your leader (November 9, p. 1144) you refer to the acknowledged link between cigarette smoking and cancer of the lung on the one hand and chronic bronchitis on the other. You note that, despite this association, there has been a disproportionate increase in the incidence of lung cancer compared to chronic bronchitis. Although I agree with you that there is a strong association between cigarette smoking and the two conditions in question, I feel sure that there is a clear explanation for the failure of chronic bronchitis to keep pace in incidence with cancer of the lung.

It is generally acknowledged that both conditions are multifactorial in origin. As well as cigarette smoking, air pollution and other factors may play a part, albeit a small one, in cancer of the lung. In chronic bronchitis it is likely that recurring pulmonary infection with or without the development of the structural changes of bronchiectasis must play an important role. The dramatic effect of antibiotics in combating pulmonary infection over the past 20 years must have had an important beneficial effect on the

incidence of chronic bronchitis, despite a considerable increase in cigarette smoking during this time. That a major reduction in pulmonary infection is the reason for the failure of chronic bronchitis to keep pace with lung cancer is supported by one's impression that overt bronchiectasis is considerably less common in clinical practice to-day.—I am, etc.,

RISTEARD MULCAHY.

Dublin 2.

Jejunal Biopsy in Childhood

SIR,—We were interested in Dr. Margot Shiner's criticisms of the use of the Crosby-Kugler capsule to obtain a mucosal biopsy from the small intestine in children (November 9, p. 1200).

A Crosby capsule has been used here on 93 children under the age of 16, and 22 of these were under the age of 1 year. All of these biopsies were obtained with an adult Crosby capsule except for 11 of those under 1 year. For these, a specially made 7-mm. capsule was used with a 3-mm. port. This smaller capsule has now been abandoned as the specimens were often too small for careful orientation and the capsule was too easily blocked by mucus. College Park Instruments (U.S.A.) now produce an 8-mm. capsule commercially, but we do not know the size of the port in this model.

In none of these 93 cases were any complications detected and in none were muscle coats seen in the biopsy specimen. None of these patients have been screened at all, but some have had a plain abdominal x-ray to show the position of the capsule. The details of the technique have recently been published in detail.¹

We agree with Dr. Shiner that, whatever method is used, the technique requires skill and a complete understanding of the maintenance and function of the instrument. It is probably this which is important, and not the instrument itself. We also agree with Dr. Shiner that the Crosby capsule is simple and technically superior. In our experience it is also safe, requires less sedation, requires little or no irradiation, and is certainly more comfortable for the young adult patient—one of us has personal experience of both techniques.—We are, etc.,

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GEORGE D. MORRISON.

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REFERENCE

- ¹ Burman, D., *Clin. pediat. (Bologna)*, 1963, 2, 581.

Naming of a Syndrome

SIR,—Dr. J. C. Belisario has pointed out to me that I have perpetuated an injustice to Professor Touraine by using in a recent paper (August 17, p. 435) the name Peutz-Jeghers syndrome. Dr. Belisario in a letter to the *Medical Journal of Australia* earlier this year¹ drew attention to the fact that Touraine

described the association of pigmentation of the lips and polyposis of the intestines in 1945² and elaborated the description further with Couder in 1946,³ whereas Jeghers's paper was not published until 1949.⁴ In 1957⁵ Klostermann stated that the name Jeghers should be omitted because he had merely reviewed Touraine's work.

Though it is true that the main work on the syndrome was not published by Jeghers until 1949, a reference is made in that article to an earlier paper by Jeghers published in 1944.⁶ This was a long review of the causes of pigmentation of the skin, and buried in it is a good description of two patients seen at the Boston City Hospital who had "exhibited a curious syndrome of pigmentation of the skin associated with intestinal polyposis." Jeghers goes on to give a description of pigmented dots on the lips and fingers and to comment that the condition was familial. He also referred to Hutchinson's⁷ twins with the disease, though he had not at that time discovered the work of Peutz. It appears, therefore, that if strict account of the date of publication of the descriptions is taken Peutz-Jeghers syndrome is correct, but since there are already many three-barrelled eponyms honour might be satisfied by the title Peutz-Jeghers-Touraine syndrome.—I am, etc.,

I. B. SNEDDON.

Sheffield 10.

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Griseofulvin and Filariasis

SIR,—I hesitate to write to you about a single observation in a singular case, but I think it may perhaps be the best way of obtaining further information.

A young Englishman on holiday from West Africa was recently referred to me on account of toenail dystrophy. He suffered periodically from the effects of filariasis, for which he received treatment with diethyl-carbamazine ("banocide"). On every occasion this treatment led to hot, tender swelling of one leg with fever and malaise.

This summer he was mistakenly diagnosed as having ringworm infection of the toenails and was therefore given griseofulvin to take by mouth. Within 24 hours his leg swelled up, became hot and tender, and he developed fever. The condition settled down after a few days. The whole clinical picture was identical with that produced by treatment for filariasis.

Griseofulvin has been tested against a wide range of helminths and protozoa, but not (so far as I know) against the four filarial parasites. Fungus infection and filariasis co-exist in many parts of the world, and I wonder if any of your correspondents have had similar experi-