haps fair to point out that the significance of certain signs referred to by Dr. Wright—for example, the elevated right diaphragm—has been known for a very long time, and it is difficult to find a better account of the diagnosis and management of hepatic amoebiasis than that of Sir Leonard Rogers and Sir John Megaw.¹

With regard to management, these authors stress the danger of exploratory puncture of the congested liver before a course of emetine (or at least a few grains) has been given. Puncture is, as they say, very rarely a matter of urgency and often unnecessary, and it is remarkable how quickly a liver that has been enlarged, even for many weeks, may subside after a few injections of the drug. For example, an Italian patient had been in hospital for two months because of high fever, loss of weight, and an enlarged liver. When he was seen at the end of that time his liver was palpable four fingerbreadths below the right costal margin, but it subsided long before the course of emetine was completed, and so did his pyrexia. Similar cases could be cited. I have no regrets at having ordered emetine for a patient who had a considerably raised temperature and an enlarged liver but who proved to have metastatic carcinoma.

While agreeing with Dr. Wright that precise diagnosis is desirable, I think those who have experience of hepatic amoebiasis will agree that it is the condition *par excellence* in which very much more is likely to be lost than gained by withholding a specific drug in the hope, often vain, of confirming the diagnosis.—I am, etc.,

Peppermint Grove,
Western Australia.

GERALD C. MOSS.

REFERENCE

- ¹ Rogers, Sir Leonard, and Megaw, Sir John, *Tropical Medicine*, 2nd ed., 1935. Churchill, London.

Diurnal Enuresis

SIR,—I wonder if the following case, which one might report under the heading of "Enuresis diurna," would be of interest to readers of the *B.M.J.*

It concerned an otherwise perfectly normal boy of 9 who had never in his life wetted his bed but was always wet during the day, whether at home or at school. Many remedies, educational and pharmaceutical, had been tried without any effect. The mother, having recently moved into this district, and worried about the boy's standing at school, decided to try yet another doctor. Finding nothing abnormal whatsoever either in the boy's general health or in his psychology or in his environment or family background, I decided to give him 10 mg. of amitriptyline t.d.s.

Almost from the first dose on this boy, who during all the nine years of his life had been wet every day, became dry. The mother, understandably pleased with this result, thought after a "dry" fortnight that all was now well and—without informing the boy—reduced the dose by about one-half. The diurnal enuresis recurred at once but disappeared as soon as the full dose was restored. I should be interested to hear whether colleagues have seen similar cases.—I am, etc.,

Pinner, Middlesex.

E. ELKAN.

Treatment of Ulcerative Colitis

SIR,—In view of recent reports in your columns on ulcerative colitis the following case, recently under Dr. S. Locket's care, may be of interest.

A girl aged 19 presented with a history of colicky central abdominal pain and general malaise for one month, diarrhoea (with four soft brown stools a day containing no blood or mucus) for three weeks, pedal oedema, and occasional spotting of fresh blood from the rectum for one week. She had lost 1 st. (6.4 kg.) in weight in the past month. Her previous health had been good. She was anaemic (Hb 58%) and thin (weight 6 st. 1 lb.: 38.6 kg.). She had a clean tongue and a slightly protuberant abdomen with some tenderness in the left iliac fossa. Gross ankle oedema and a raised jugular venous pressure were noted. No rectal bleeding was observed while she was in hospital. A tentative diagnosis of ulcerative colitis was made. Subsequently, electrolytes were repeatedly normal and blood cultures were sterile, but plasma protein values were: albumin 2.0 g./100 ml., globulin 2.6 g./100 ml. Sigmoidoscopy was normal to 20 cm. A barium enema showed a polypoid appearance in the descending colon, suggestive of a polypoid type of ulcerative colitis. Steroid and antibiotic therapy was started and a blood transfusion given. At first she improved symptomatically, but mild diarrhoea continued and her weight fell to 4 st. 10 lb. (29.9 kg.). Six weeks after admission a further blood transfusion became necessary. A swinging pyrexia now developed, and she was transferred to Mr. W. D. Park's care for surgery.

At laparotomy the whole colon from the caecum to the mid-pelvic colon was thickened and inflamed, and the colonic mucosa was extensively ulcerated and showed pseudopolypi; the distal pelvic colon and rectal mucosa were normal. Total colectomy and ileo-rectal anastomosis was performed. The histology of the colon was consistent with ulcerative colitis. Post-operative progress has been reasonably satisfactory.

The case is unusual in that there was only mild diarrhoea of short duration, with the passage of no mucus and very little blood, and yet gross pathological changes were found at operation. In addition the rectum was not involved in the disease process, and it will be interesting to see if this remains so.—I am, etc.,

Oldchurch Hospital,
Romford, Essex.

CARYL W. DARBY.

Disorder of Differential Growth

SIR,—Sir Denis Browne in his letter (21 May, p. 1298) mentions that sterno-mastoid torticollis is a "disorder of differential growth."

It is in fact due to the pressure of the foetal head and neck against the promontory of the sacrum, which flattens the ear and interferes with the growth of the neck muscles. This occurs when the head engages unusually early and deeply. The forehead on the opposite side presses against the symphysis pubis, giving the characteristic flattening.

Babies are frequently born with a slight flattening of the ear on one side and of the forehead on the opposite side, but without

a torticollis—that is, a milder, incomplete picture.—I am, etc.,

Johannesburg.

G. P. CHARLEWOOD.

REFERENCE

- ¹ Charlewood, G. P., *J. Obstet. Gynaec. Brit. Emp.*, 1947, 54, 499.

Syringe-transmitted Hepatitis and Heroin Addicts

SIR,—There has recently been an epidemic of syringe-transmitted serum hepatitis among heroin addicts in this country. This would appear to be spread by the practice of sharing syringes. Most of the cases have appeared in the past eight months. Dr. O. Ben-Arie and I have so far traced 22 such cases but have heard of other cases among addicts from the patients we have seen.

It would be very helpful if anyone who has seen such a case recently could contact either Dr. Ben-Arie or myself at this hospital, or Dr. Vincent Marks at West Park Hospital, as we would like to trace this epidemic more fully.—I am, etc.,

Tooting Bec Hospital,
London S.W.17.

T. H. BEWLEY.

Suture Removal Forceps

SIR,—Standard suture removal forceps seldom prove adequate for grasping very fine sutures, particularly the fine monofilament nylon used in plastic surgery or ophthalmic surgery. The forceps shown in the Figure are produced by Chas. F. Thackray Ltd. and are made on the model of forceps

specially designed by and used by me. They have been in use for some years and have proved ideal for the removal of fine sutures. The blades of the forceps have longitudinal grooves, which allow the finest stitch to be grasped firmly, without fear of it slipping through serrated edges as in the standard type of suture removal forceps.—I am, etc.,

Ballochmyle Hospital,
Mauchline, Ayrshire.

J. C. MUSTARDÉ.

Treatment of Club-foot

SIR,—Over 40 years ago I described¹ a very simple method of treatment with a malleable iron splint.

Provided this was carried out from the moment of birth by the same operator throughout a cure could be expected.—I am, etc.,

London W.1. B. WHITCHURCH HOWELL.

REFERENCE

- ¹ Howell, B. W., *Brit. med. J.*, 1925, 1, 1031.