closely resembling what was then called haematoporphyrin—was made in an article in the *Lancet* in 1890.¹

I fully agree with the retrospective diagnosis suggested by Dr. Ida Macalpine and Dr. Richard Hunter in their article, which is a historical document of outstanding importance.—I am, etc.,

Paris.

R. GARCIN.

REFERENCE

- ¹ Ranking, J. E., and Pardington, G. L., *Lancet*, 1890, 2, 607.

Complications of Intrauterine Devices

SIR,—Intrauterine devices are being used extensively in India. I have fitted 1,500 Lippe's loops in my practice, which consists mostly of tea-garden workers. Breast feeding is the rule in this community up to two or three years. Sometimes the amenorrhoea continues into another pregnancy. In these cases it becomes very essential to select the proper time for the insertion of the "loop." An attempt is made to fit the device four to six weeks after delivery, or soon after the menstrual period. Follow-up checks are attempted after one month and again after two months, but usually this is impossible owing to the objection of these women to repeated examinations.

In spite of all these precautions there were cases in which the "loop" was inserted in early pregnancy, sometimes resulting in an abortion, though in many cases the pregnancy continued to full term and normal delivery. The "loop" was found embedded in the margin of the placenta in two of these cases. In two others the "loop" was apparently embedded in the uterine tissue and in one case resulted in pregnancy and delivery of a healthy child at full term.

I think in these cases the loop gets embedded in the uterine decidua and is rendered harmless. In some of these cases the loop may work its way out of the uterus into the abdominal cavity and give rise to further serious complications. I give below a case in which the loop migrated into the pelvic cavity and had to be removed surgically.

A 36-year-old woman, para 8, whose last menstrual period was on 22 September 1965, was given a Lippe's loop size "C" on 29 September. She complained of bleeding off and on between her periods, which was controlled with calcium and vitamin K. She had to be admitted, however, to the hospital on 25 March 1966 with "flooding." The cervix was one finger dilated and the loop could be felt under the decidua in the post-vaginal wall. On 28 April operation was performed by Lieutenant-Colonel S. C. Chatterjee. The uterus was retroverted and had the remains of an incomplete abortion. The loop, which had penetrated into the pouch of Douglas, was removed by a posterior colpotomy.

I am sure many of your readers have come across such complications in the use of intra-uterine devices. It only stresses the importance of proper selection of cases to be given Lippe's loops, especially in India, where mass campaigns to popularize such devices have been launched. After all, Lippe's loop is not so harmless.—I am, etc.,

S. P. NANDA.

Assam,
India.

Neonatal Goitre

SIR,—I wish to report the occurrence of a goitre in an infant born to a mother who was taking iodides during pregnancy.

A female infant was seen immediately after birth, as she was cyanosed and having difficulty in respiration. This was confirmed on examination (Fig. 1), when it was seen that she had a large goitre causing her symptoms. The swelling embraced both lobes of the thyroid and the isthmus. She was intubated, suction was applied, and she improved. Following the tube's removal her respirations were satisfactory and she had good air entry into her lungs provided

FIG. 1

FIG. 2

she lay on her side with her head held backwards. No other abnormality was found on examination. Her x-ray revealed a large soft tissue swelling with possible displacement of the trachea forwards (Fig. 2). On questioning, the mother stated that for the past 10 years she had taken "Eupinal" nightly for bronchitis. This contains 6.87% ammonium iodide.

The child was placed in an incubator and kept under observation in the special baby-care unit. She was started on L-thyroxine, 0.02 mg. twice daily. With this treatment the goitre gradually regressed. She was discharged home at 1 month of age in satisfactory condition. She was seen a month later in the outpatient department, when the goitre was still present but quite small.

Neonatal goitre has been reported by Louw¹ and other authors.^{2,3} These have been drug-induced, mainly due to iodides taken by the mother during pregnancy, but have also been seen after P.A.S. ingestion. Affected infants have had large goitres with com-

pression of the trachea causing obstruction to respiration. Subtotal thyroidectomy has been advocated as the treatment of choice in those goitres causing respiratory obstruction. Tracheotomy has been tried but found to be unsatisfactory.^{1,2}

Our patient's goitre subsided with medical treatment, though we had a few anxious moments.

I feel that the importance of this case is in the fact that Eupinal can be obtained over the counter in chemists' shops. Probably, of people taking this expectorant during pregnancy, only a few have children so affected. The importance of this occurring with possibly serious results needs to be publicized.—I am, etc.,

General Hospital,
Wakefield.

C. S. LIVINGSTONE.

REFERENCES

- ¹ Louw, J. H., *S. Afr. med. J.*, 1963, 37, 976.
² Norris, W. J., and Pollock, W. F., *Amer. J. Surg.*, 1955, 90, 345.
³ Parmelee, A. H., Allen, E., Stein, I. F., and Buxbaum, H., *Amer. J. Obstet. Gynec.*, 1940, 40, 145.

Preclinical Curriculum

SIR,—A proposition I would like to put forward for consideration at a time when a Royal Commission is considering medical education is that preclinical teaching as carried out at present should be replaced by a course of at least two years in the study and understanding of health, to be followed by the study of disease. Such a course would include physiology, biochemistry, and anatomy more fully related to the function and maintenance of the healthy body, and also genetics, development, growth, and psychology, with attendance at clinics concerned with preventive medicine, health education, and early diagnosis of illness.

Upon such a foundation I believe both a rational curriculum and a more effective medical service could be established.—I am, etc.,

JAMES H. SCOTT.

Department of Anatomy,
Queen's University, Belfast.

Diet and Diverticulitis

SIR,—In your leading article (14 May, p. 1186) on diverticular disease of the colon you make no mention of certain facts that appear to us of decisive importance. We refer to the virtual non-existence of this disease in Africans living tribally in Africa, whereas in many of their urbanized cousins, especially the negroes in the United States, the disease is as common as in the whites. In a recent joint work¹ we show, for example, that in the Charles Johnson Memorial Hospital of 600 beds, in one of the native reserves of Natal, no case of diverticulitis has ever been seen. Whereas the following personal communication from Dr. Donald Kozell (1965), physician to the Cook County Hospital, Chicago, shows the position in the United States: "We see every complication of diverticulitis with equal frequency in both races. I would cite a reference to you by Kocour, 1937,² in which he comments on the rarity of diverticulitis in the U.S. negro. However, you will notice that the reference goes back to 1937, and the picture has changed since then."

This remarkable difference between Africa and the United States can be explained, both

logically and simply, by the entirely different diet in the two groups of negroes. In the first group the carbohydrates in the diet are unrefined, consisting of the coarsest maize, with very little sugar; whereas in the second group the carbohydrates are now those of the white man, consisting mainly of white flour and sugar. The first diet results in two soft stools a day,³ whereas the second diet, through the massive removal of fibre, results in the marked slowing of the passage of the colonic contents so characteristic of the Westernized nations. This colonic stasis incidentally affords a natural explanation of the muscular hypertrophy in the colonic wall to which you refer.

It should be added to the above that the diet in the United States negro once also consisted of unrefined maize (hominy), but the consumption of maize in the United States shows the following decline over the years⁴:

Year	Maize Products Available to Retail Markets (lb. per year per head)		
1889	..	..	117.0
1899	..	..	103.3
1909	..	..	53.0
1924	..	..	32.4
1932	..	..	26.5
1942	..	..	19.8
1950	..	..	11.8
1961	..	..	7.2

There is of course nothing specific about maize: it is just an example of unrefined grain. Meanwhile the consumption of sugar in the U.S.A., as in all the Westernized nations, has shown a very great rise in consumption over this period.

As long as the approach to diverticular disease smacks of the assumption that the body is built wrongly, instead of being used wrongly, so long does the disease appear likely to continue to be the menace that it has become. A very considerable restoration of the carbohydrates to their natural unrefined state alone points to any great success in prevention and arrest.—We are, etc.,

T. L. CLEAVE.

Fareham, Hants.

G. D. CAMPBELL.

King Edward VIII Hospital,
Natal.

REFERENCES

- Cleave, T. L., and Campbell, G. D., *Diabetes, Coronary Thrombosis, and the Saccharine Disease*, 1966. Bristol.
- Kocour, E. J., *Amer. J. Surg.*, 1937, 57, 433.
- Dodd, H., *Lancet*, 1964, 2, 809.
- Antar, M. A., Ohlson, M. A., and Hodges, R. E., *Amer. J. clin. Nutr.*, 1964, 14, 169.

Labelling Drugs

SIR,—I have previously commented¹ on the problem of drug nomenclature in clinical practice, complicated as it is by the tedious nuisance and even danger of there being more than one name for each drug. On the one hand we have the fairly simple two- or three-syllable, not very meaningful, proprietary names, and on the other hand there are the more complex, often polysyllabic approved names, which are not always much more informative.

But, Sir, both the proprietary and approved names do at least specify a particular drug. Unfortunately the same cannot be said for the third category—namely, "The Tablets." Though pharmacologists

and some clinicians may not always agree on the relative merits of "proprietary" versus "approved" names, yet surely they should combine in damning this anachronism which allows potent medicaments to be dispensed in what amounts to virtually unlabelled containers, with resulting confusion, danger, and waste. When will it become required pharmaceutical practice to label containers meaningfully unless the prescribing doctor specifically directs otherwise? Rat poison bought as such must be properly labelled, but not if dispensed into a bottle to be kept in the family medicine chest or on the mantelpiece.—I am, etc.,

C. D. NEEDHAM.

Aberdeen.

REFERENCE

- Needham, C. D., *Brit. med. J.*, 1963, 1, 330.

Osteomalacia in Asian Immigrants during Pregnancy

SIR,—Drs. D. J. C. Felton and W. D. Stones's article (18 June, p. 1521) prompts me to record a different manifestation of calcium deficiency accompanying pregnancy in a woman of similar racial and cultural background.

The patient, a multiparous Pakistani woman, was delivered in St. Mary's (Manchester) district about June of last year. She had had two or three full-term normal deliveries, and was therefore booked under the care of the district midwives. She attended the district clinic regularly, and was seen by either the midwives or one of the resident medical staff.

Pregnancy progressed normally and no complaints were recorded. She went into labour at term and had a normal delivery of a healthy child. As lactation was becoming established on the third and fourth postpartum days she began to complain of tingling, and then cramp-like pains in the hands and feet. A houseman was taken to see her on the fifth day. The pains were much worse, and there was some spasm in the hands and feet, the thumb being held opposed across the palm of the hand. The houseman, to his credit, diagnosed latent tetany due to hypocalcaemia, precipitated by lactation. Chvostek's sign and Trousseau's sign were positive. The serum calcium was below normal levels. She was treated with 10 ml. calcium gluconate intravenously, followed by oral calcium and vitamin D. Lactation was suppressed. The following day she was free from symptoms and remained so.

On inquiring about the diet it was found that she took no milk, little protein, and had not taken her vitamin tablets. For the latter part of the pregnancy she had lived mainly on chappatees, prepared from non-fortified flour and ghee obtained at the local Indian store.

This patient had developed some calcium deficiency in the latter part of pregnancy. It had not persisted long enough to produce osteomalacic symptoms. The sudden demand for calcium, associated with the onset of lactation, had produced the symptoms and signs of latent tetany.—I am, etc.,

Hope Hospital,
Salford 6, Lancs.

W. O. GOLDTHORP.

Rickets in British Children

SIR,—The leading article on rickets (5 March, p. 558) is a good pointer to a need for the clinical reappraisal of nutritional standards in Britain, but it does not indicate the extent of evidence of this disease and of malnutrition generally amongst younger age groups in Britain.

For the past four years I have been examining Army recruits aged 17 to 18 years, with a particular interest in assessing their standard of physique and nutrition, and have been surprised to find much evidence of old rickets, poor physical development, low weight, and other signs of malnutrition. I can confirm that a high proportion of those who are underweight are also anaemic, but I do not agree that large families are a necessary cause of rickets; out of a group of 51 soldiers with signs of old rickets, 23 were the first child.

I have found no evidence to suggest that rickets did disappear during the later post-war years, and much that it continued, particularly in social groups IV–V. Recent examinations of young children, primary and secondary school boys, and of boys joining a junior leaders' unit of the Army indicate that it has been present all the time during the 50's and 60's, but unrecorded. The official assumption that there was no malnutrition in Britain has perhaps discouraged attention being paid to it, and I believe there has been a tendency sometimes to regard rickety deformities as the province of the orthopaedic surgeons only.

Average height and weight records tend to support the official view unless original figures are looked at critically, when it will sometimes, or perhaps often, be found that the "average" represents a mean between two very far separated extremes—the underweight and the overweight—both of whom may be suffering from considerable nutritional defects. Maps giving places of upbringing show that the great cities of the Midlands, the North, London, and the towns to the east of it provide most of the rickety and underweight young men; the smaller county boroughs and country towns provide the better built, but rural Eire provides the best of all.

In addition to the planned investigations advocated in your leading article, which will take some years, as a more immediately effective measure I would suggest that every young person after leaving school should have an assessment of nutriture by doctors who have some skill in this field, at fixed intervals up to 18 years of age. If there appears to be a shortage of such doctors in the existing services, many might be found among those who have come home from H.M. Overseas Civil Service, or from missionary work in various parts of the world.—I am, etc.,

Yeovil, Somerset.

R. Y. TAYLOR.

Amoebiasis—a Diagnostic Problem in Great Britain

SIR,—The physicians and surgeons who allowed Dr. R. Wright (16 April, p. 957) to publish their experience of hepatic amoebiasis are to be commended. But it is per-