all the micro-organisms commonly responsible for such lesions. We find it surprising that no mention is made in his paper of the genus of anaerobic Gram-negative bacilli, the *Bacteroides fusiformis*, various species of which have been reported in cerebral abscesses, particularly those occurring in association with chronic infections of the middle ear, respiratory sinuses, and respiratory tract, and in cyanotic congenital heart disease.^{1,2} The particular importance of the *Bacteroides* organisms isolated from these abscesses is that they are usually resistant to penicillin. During the past five years in this hospital of approximately 50 patients with cerebral abscesses 11 patients yielded *Bacteroides* on culture, and of these 10 were *Bacteroides fragilis*—a species which is highly resistant to penicillin.^{3,4} Treatment of infections due to penicillin-resistant *Bacteroides* with penicillin in high dosage has usually been unsuccessful.^{1,5} We therefore suggest that in cerebral abscesses arising from chronic foci or associated with congenital cyanotic heart disease it would be desirable to employ in addition to penicillin an antibiotic such as chloramphenicol, erythromycin, or lincomycin to deal with these penicillin-resistant bacteria.⁶—We are, etc.,

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Tracheostomy

SIR,—This letter is prompted by your leading article (22 March, p. 734) on tracheostomy and by our very real anxiety over the best management of these patients.

The Batten Unit at the National Hospital for Nervous Diseases, Queen Square, has over some twenty years treated hundreds of patients requiring respiratory assistance, a high proportion with tracheostomy. In the first fifteen years the incidence of perforation or stenosis at the site of the tip or cuff of the tube was remarkably low, not exceeding 2%.

The last five years have shown an alarming rise in the incidence of these tracheal complications and the only change in technique has been the use of presterilized Portex tubes in place of the Morant Baker rubber tubes with latex cuffs. Portex is a hard material without elasticity, and one cannot help feeling some suspicions about its use. These suspicions are supported by a small recent series without complications since we have returned to the rubber tubes.

This is not conclusive evidence but at least we should have the opportunity to collect further evidence. Instead we find that rubber tubes seem to be no longer available, and the two largest manufacturers have so

far been unable to produce any. We hope that this letter will encourage manufacturers to continue making rubber tubes so that the relative merits of different tubes can be properly assessed.—We are, etc.,

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SIR,—Your leading article on tracheostomy (22 March, p. 734) was very timely, but, having managed several hundred such cases, we cannot agree with many of the opinions expressed. In a note of this length it is not possible to itemize each point of difference, but we feel some of the outstanding statements cannot pass without comment.

Most of the complications of tracheostomy are caused either by emergency surgery or inadequate postoperative management, and with modern pre- and postoperative care should be largely preventable. A true emergency tracheostomy, with the surgeon operating through blackened engorged tissue on a struggling hypoxic patient, should not be necessary. In virtually every case an airway can be obtained either by passing an endotracheal tube or a bronchoscope, through which oxygenation, and if necessary anaesthesia, may be maintained. This then removes many of the hazards inherent in emergency surgery. We routinely use cuffed polyvinyl chloride tracheostomy tubes except for neonates and small children, for whom cuffed tubes are not available. The largest tube which closely fits the trachea is inserted, and the cuff is inflated incrementally until an air-tight fit is just obtained. A note is made of the total volume of air injected, and if it is necessary to reinflate the cuff or replace the tube the same volume of air is injected into the cuff. The cuff is never deflated because of the dangers of inhalation of oral secretions or regurgitation of gastric contents. All surviving patients have tracheal tomography carried out when the stoma is healed, or if death ensues a necropsy is performed. No case of tracheomalacia or stenosis has occurred in this hospital since this regimen was adopted, and this includes patients who have had a tracheostomy for periods of up to seven weeks.

The postoperative management of these patients is very important. Scrupulous attention must be paid to aseptic wound and tracheo-bronchial toilet, and this, together with humidification of inspired air, eliminates most of the other complications listed in your leader.

We believe that, provided careful attention is paid to the details described above, tracheostomy is a valuable routine contribution to medical care.—We are, etc.,

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Swimming in Cold Water

SIR,—The letter by Dr. M. J. Wooldridge (15 March, p. 711) makes the valid point that regular cold swimmers often enter cold water without respiratory distress. The

implication that this can be achieved by will-power could, however, be a dangerous one. Temperament may indeed play a part, but I think it is important to stress that respiratory distress often prevented determined and competent warm-water swimmers from covering as much as 100–200 yards (91–182 m.) in water at near 0° C. While will-power failed to suppress the respiratory response to cold, habituation by repeated cold immersion can do so.^{1,2} Such habituation, which is in effect a negative conditioned reflex, seems to account for regular cold swimmers' customary freedom from respiratory distress in cold water.

I know of no evidence that a thick layer of subcutaneous fat affects the reflex. The buoyancy that fat confers does, however, help people to keep afloat in spite of respiratory distress. Fat is also, of course, of great importance in reducing heat loss during longer immersions, when general hypothermia becomes the main hazard to life.—I am, etc.,

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Abbreviation of Journal Titles

SIR,—A junior contemporary would like to congratulate you on your decision to name journals in full. On the initiative of its editor, Sir Reginald Watson-Jones, the British section of the *Journal of Bone and Joint Surgery* has done so since its inception 21 years ago, and it has had no regrets.—I am, etc.,

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Chairman, British Editorial Board,
Journal of Bone and Joint Surgery.

London W.1.

SIR,—You are to be congratulated on your decision to print the titles of journals without abbreviation in your lists of references. However, most editors still insist that authors of scientific papers should abbreviate the titles of journals cited. Many claim that this saves paper and thus reduces the cost of production of the journal. Since most references do not finish at the end of a line, and most articles do not fill the space of their final page, an attempt has been made to assess the saving of space achieved by abbreviating titles. The saving is small, and is insignificant when compared with the burden presently placed upon authors, referees, and proof-readers in assuring that the abbreviations accord with editorial requirements.

Four groups of 250 consecutive references were taken from the journal *Cancer Research* and it was determined, firstly, how many of these would have required a new line of print if the journal names were to have been printed in full and, secondly, the number of new pages which would have had to have been used (Table). *Cancer Research* lists its references in double columns with the titles of the papers cited. Some journals (for example, the *Biochemical Journal*) print their lists of references in double columns omitting the titles of papers, others (for example, the *European Journal of*