between the smegma and the cervix may be exerting a beneficial effect in this respect.

It would seem important, therefore, that the authors should again attempt to identify those women whose husbands are circumcised, and if this proves impossible in the present series it could perhaps be evaluated in the future. If indeed the incidence of uncircumcised husbands remains the same in all ethnic groups examined and the statistical difference between diaphragm and steroid methods remains the same, it would seem that the diaphragm acting as a barrier against smegma might possibly be one of the explanations for this difference.—I am, etc.,

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Sudden Death in a Young Asthmatic

SIR,—We should like to reply to some of your correspondents who have commented on our report of the sudden death of a young asthmatic (5 April, p. 29). One of the main reasons which prompted us to publish the case report in detail was that it illustrated a problem in the management of asthma which we believe is a not uncommon one—that of a patient whose symptoms are suppressed by a maintenance dose of corticosteroids but in whom there is evidence of persistent airways obstruction.

We were interested by the letter from Dr. N. Macdonald and others (3 May, p. 312) in which they discuss the place of bronchial lavage. As they point out, the difficulty is to know when this procedure is indicated. In our patient, eight weeks before his fatal attack, a severe episode of asthma had occurred in which he had an epileptiform convulsion, presumably due to hypoxia, and he was taken to another hospital. That episode was unlike typical status asthmaticus, since he recovered and was allowed home within a few hours. When he was seen by us a week later we decided to stop corticosteroids and to substitute prednisone, initially in high dosage. We confidently anticipated that he would respond to a resumption of corticosteroids. Our dilemma arose two weeks later, when it was clear that, despite considerable symptomatic improvement, his peak expiratory flow (P.E.F.) had not risen to the values which had been obtained when he was previously taking betamethasone. While bronchial lavage may have great value in status asthmaticus, as reported by Drs. P. E. Walker and M. Marshall (5 July, p. 31), we wonder whether it would have been of any benefit in our patient so long after an episode of severe asthma.

We have no personal experience in the use of potassium iodide, which was recommended by Dr. H. Herxheimer (26 April, p. 246) and Dr. Erik Ask-Upmark (21 June, p. 762). Dr. Herxheimer appears to have assumed that the mucus which was found in the bronchi at necropsy had been present ever since the previous severe episode of asthma. While this may have been the case, we were careful to point out that Professor Lynne Reid was able to state only that this mucus had probably been present

for several days before death. It seems possible that other factors than mucous plugging contributed to the persistent airways obstruction in our patient. It is also possible that the major cause of his sudden collapse from hypoxia in the terminal episode was intense bronchial muscle constriction.

Dr. Monica K. McAllen (26 April, p. 246) has drawn attention to the possibility that disodium cromoglycate may mask symptoms which might give warning of an impending relapse. It has been shown¹ that disodium cromoglycate is able to give protection against exercise-induced asthma, and this may explain why our patient was able to take strenuous exercise without distress.

We reject Dr. Arend Bouhuys's contention (5 July, p. 53) that peak expiratory flow is an unreliable test for following the progress of asthmatic patients. He himself admits that our measurements of P.E.F. gave evidence of persistent airways obstruction, since he asserts that we did not accord due importance to its presence in our clinical management. He suggests that our patient was inadequately treated, since he should have been admitted for bronchoscopy and "active physiotherapy." We doubt whether either of these measures would have been of benefit. In any case it is clearly impractical to carry out bronchoscopy in every patient in whom tests disclose a suboptimal level of ventilatory capacity, particularly when, as in our patient, he has no symptoms and can play a vigorous game of football without distress. Apart from the much less practical convenience of tests which require a spirometer for their performance, we doubt whether either of the tests which he recommends (F.E.V. 1 second or M.M.E.F.R.) would have given us any more reliable information. In fact, there was a close correspondence between the values of P.E.F. and F.E.V. 1 in our patient. Nevertheless, we should have been interested to learn from Dr. Bouhuys what values of either F.E.V. 1 or M.M.E.F.R. for a boy aged 14 and 64 in. (1 m. 60 cm.) tall would have led him to take such measures as he would regard as being more adequate treatment.

While it is both impractical and probably unnecessary to subject every patient with suboptimal ventilatory capacity to procedures additional to an increase in dosage of steroids, nevertheless it seems clear that special consideration needs to be given to patients aged 10 to 14 years (since it is in this age group that the largest increase in deaths from asthma has occurred²), particularly if serial measurements of ventilatory function disclose persistent airways obstruction after a recent episode of severe asthma or status asthmaticus.—We are, etc.,

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Outpatient Management of Diabetic Children

SIR,—In the article by Dr. G. W. Chance (24 May, p. 493) we read that the prevailing trend at present is to admit every new patient with juvenile diabetes to the hospital, and to keep him there, both for initial treatment of

the disease as well as for an initial educational programme prepared for both the patient and his parents.

In our area diabetes is generally recognized in the early stages, so that we have encountered neither ketoacidosis nor coma as the presenting symptom in juvenile diabetes. Furthermore, a study carried out by us on the rehabilitation of the juvenile diabetic¹ revealed the marked psychological disturbances present in the juvenile diabetic and their families, partly owing to the prolonged hospitalization. We therefore introduced into our clinic a programme of initial treatment and education on an outpatient basis. Before treatment is instituted insulin reserve is measured,² by one or all of the following tests: intravenous arginine infusion; intravenous tolbutamide; and oral glucose tolerance. All of these tests are performed ambulatorily. The patient is taught to test urine for sugar with Benedict's solution, or Clinitest tablets, and to register the results three times a day. Insulin injections are first administered by a nurse, who comes to the home until the patient or one of the patients is able to do it by himself. In the meantime the patient and his family are seen several times a week in our clinic by a team consisting of a doctor, nurse, and dietitian, who direct the medical and dietary management. Psychological and psychiatric counselling is also begun at this stage.

We have found this approach to be very rewarding to the patients and their families, as well as for the treating team.—We are, etc.,

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Hand and Wrist

SIR,—I was pleased to see that Dr. V. Wright in his interesting article (19 July, p. 155) touched on the surgical treatment of rheumatoid arthritis as it affects the hand and wrist. It is not always appreciated that certain simple measures can give pleasing functional as well as cosmetic results—operative relief of compression of the median nerve and of trigger finger phenomenon in particular. It is even less well known that rebalance of the extensor mechanism of the finger can be achieved surgically if done at an early stage in mallet and boutonnière deformities—by division of the central slip in the former, and of the distal attachment of the tendon in the latter. One should also mention, of course, that the intrinsic release procedure gives a satisfactory result in swan neck deformity if performed early on, and before secondary proximal-interphalangeal joint stiffness has occurred.

Surgical synovectomy should certainly be considered, particularly when synovitis is persistent in the metacarpophalangeal joints; in more advanced cases realignment of the extensor tendons is often called for, and in the later stages, as Dr. Wright mentions, excision