Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Leucocyte Agglutinins

SIR,—In your recent annotation on this subject (*Journal* August 29, p. 295) you make the final statement that leucocyte antibodies produced by foetal immunization of the mother do not seem to harm the foetus. This appears to be a broad and rather premature assumption. Our knowledge of the presence and frequency of leucocyte antibodies in the newborn is scanty, but we do know that scattered cases of neonatal neutropenia and agranulocytosis have been reported, and that some of these have proved fatal.^{1,2} We have reported¹ two cases of neonatal neutropenia in siblings, and, while at the time no investigation for leucocyte antibodies was practicable, the work of Payne and Rolfs³ makes it appear possible that such a mechanism may have been involved. Lehndorff² considers that his cases of acute neonatal neutropenia were examples of "allergy of the newborn" and postulated sensitization *in utero* followed by massive release of the antibody into the foetal circulation by rupture of chorionic villi during labour.

The syndromes of infantile familial neutropenia of the more chronic type,^{4,5} and of acute neonatal infection where neutropenia is attributed to marrow depression by toxins, also seem to be worthy of investigation from this aspect before the possession of leucocyte antibodies in the neonatal period is accepted as a harmless condition.—I am, etc.,

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H. E. EMSON.

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Tongue-tie

SIR,—May I congratulate Dr. I. M. Cullum on rediscovering tongue-tie and on his fascinating historical research (*Journal*, September 19, p. 497)? I regret that he did not consult that other repository of ancient knowledge, the textbook of anatomy,¹ from which he would have discovered that fatal tongue-swallowing can only arise from the separation of the genioglossi from the genial tubercles at the back of the mandible, and troublesome haemorrhage from the division of the terminal parts of the lingual arteries as they run to the tip of the tongue on either side of the frenulum. A guard was commonly attached to the old surgical dissectors² to protect these from surgical damage.

I feel the admission of these occasional babies for formal operation is unnecessary, as the frenulum can readily be separated from the back of the gum and jaw by firm pressure with the pulp of the finger. This procedure takes about two seconds and does indeed give immediate relief. Provided too much is not attempted, complications will not arise.—I am, etc.,

Rugby.

S. C. ROGERS.

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Treatment of Pilonidal Sinus

SIR,—I was tempted last week to comment on an omission in the article by Mr. A. J. H. Rains (*Journal*, August 15, p. 171), and this week this became a definite decision when I noted the same omission in the letter written by Mr. D. Lang Stevenson (*Journal*, September 12, p. 430). This error is expressed in his statement that "leaving the resulting wound open to heal by second intention is common practice to-day, *no doubt because of lack of success with primary suture.*" (My italics.) I cannot agree that he is correct in making this assumption.

Our surgical technique is not determined by mere expediency but by our conception of the pathological process involved and a consequent planned attempt to eradicate it. Surely the problems involved in the excision of an ellipse of skin and subcutaneous tissue down to periosteum, and the subsequent closure of the wound, with obliteration of dead space and primary union as its end result, are not peculiar to this area of the body. Twenty years ago I too was puzzled "to find the literature, year after year, implying that a problem exists." I am satisfied that it still exists, but the real problem is not that of securing primary union after excision of the sinus with its secondary abscess tracks, but that which is created by the reappearance of an exactly similar pilonidal sinus three, four, or five years later—after an undoubtedly sound primary union.

If one accepts the congenital theory of aetiology there should never be any late recurrences of this kind. If, on the other hand, one accepts the "hair trauma" theory, then it is clearly undesirable to aim once again at the approximation, in the midline of the natal cleft, of two skin edges which still grow hair sloping in opposing directions. Surgeons who accept this aetiology aim, as a matter of deliberate policy, at the production of a non-hairbearing cicatrix in the sacro-coccygeal midline. With skin grafting this is not an unduly lengthy procedure.—I am, etc.,

Douglas, Isle of Man.

ERIC VERNON.

Diabetes in the Tropics

SIR,—In the Diabetic Clinic for Zulu and Indian patients at the King Edward VIII Hospital in Durban, we are compelled on many occasions by force of circumstance (patient ignorance; through dislike of, or irregularity, of insulin injections) to adopt therapeutic measures which would probably not be regarded as good diabetic practice in non-tropical countries, in respect of the use of oral therapy. As many as 15% fall into this category of patients who would not ordinarily be regarded as suitable candidates for oral therapy, and some cases have features which would absolutely contraindicate the use of these drugs. Our task in changing these unlikely patients from insulin to oral therapy is frequently facilitated by the fact that patients, previously "dependent" upon insulin, will default from the Clinic and arrive back a few months later having had no treatment, though feeling fairly well, but with a heavy glycosuria and having lost a good deal of weight. Most of these patients have been Indians, and a good many of them thin.

The mildness of tropical diabetes is frequently stressed (*Journal*, January 24, p. 219), though previously we have noted (*Journal*, July 18, p. 73) that 7% of all our Zulu diabetics have been admitted in diabetic coma. We should, however, like to mention in detail certain established diabetics, who had previously been ketotic,

or who were or had been pregnant, or who belonged to the so-called "J" type of diabetes^{1,2} whom we have been able to control satisfactorily with oral antidiabetic substances.^{3,4}

In two "J" types, we achieved remarkable results; previously (*Journal*, July 18, p. 73) we had recorded disappointments trying to lower the dose of insulin in "J" types with oral therapy.

(1).—*Indian male, thin, "J" type, aged 39, 16-year diabetic on 160 units lente daily*: was very anxious to have a trial of "tablets" because of painful local reactions to insulin. Was changed to chlorpropamide, 250 mg. twice daily, and warned of risk; he has remained well controlled and almost free of sugar for four months, and feels very well.

(2).—*Indian male, thin, "J" type, aged 17, 3-year diabetic on 240 units lente daily*: suffering from "true" diabetic cataracts. Was put on to 250 mg. chlorpropamide twice daily and insulin dosage reduced to 100 units lente daily; developed five hypoglycaemic reactions in one week; encouraged by this, we dropped the insulin altogether, and he has been very well controlled, free of sugar, and quite well for three months and very grateful for not having to inject himself with large doses of insulin.

Pregnancy in the established diabetic is an absolute contraindication to oral therapy, though we have found it very useful in the "glycosuria of pregnancy."

(3).—*Zulu girl, thin, aged 19, 3-year diabetic on 40 units lente daily*: became pregnant, and at the 24th week became so lackadaisical about her insulin injections that she was put, in desperation, on to tolbutamide, 500 mg. t.d.s., and became perfectly controlled, virtually sugar free. Was delivered of a fine baby by caesarean section at the 36th week, in spite of having developed hypertension and albuminuria at the 32nd week. Four months after she is perfectly controlled on 500 mg. t.d.s.

(4).—*Zulu girl, thin, aged 27, pregnant, 4-year diabetic on 40 units lente daily*: two previous pregnancies under insulin "control" ended with stillbirths. Changed to tolbutamide, 500 mg. t.d.s., at 20th week, and was delivered of a live baby by induction at the 36th week, and at time of default two months later was controlled on oral therapy.

(5).—*Indian girl, thin, aged 26, 5-year diabetic on 20 units lente daily*: two stillbirths on insulin "control," and finally had live baby whilst on insulin. Very anxious to change to oral therapy, and was given a trial of tolbutamide with excellent control, and has been virtually sugar free for six months.

Previous ketosis or diabetic coma are a contraindication to the use of oral therapy.

(6).—*Zulu woman, thin, aged 46, admitted in diabetic coma initially*: made good recovery with energetic treatment and large doses of insulin. Six weeks after discharge was changed to tolbutamide at her own request, and was very well controlled for six months; then developed a severe cold, became ketotic, and had to be put on to insulin again.

In the diabetic nephropathy of the Kimmelstiel-Wilson type, the insulin requirements often fall in the later stages. We decided to try oral therapy in two cases, in spite of unchanging insulin requirements.

(7).—*Indian male, thin, aged 47, 16-year diabetic on 40 units daily*: classical advanced Kimmelstiel-Wilson nephropathy. Changed to tolbutamide 500 mg. daily, and developed hypoglycaemic symptoms, the nature of which he knew well, and which were reversed by sugar. Dose lowered to 250 mg. t.d.s. and he has been well controlled for five months thus far.

(8).—*Zulu male, thin, aged 44, 11-year diabetic on 60 units lente daily*: one of our two Zulus with Kimmelstiel-Wilson nephropathy. Changed to tolbutamide, 500 mg. t.d.s., with very good control for five months so far.

These are a few of the rather unusual results that we have achieved in our Clinic. In the last 400 diabetics that were referred to the Clinic, only 9 were put on to

insulin. The majority of these 400 patients were fat middle-aged and young Indian patients and fat middle-aged Zulu patients, though we have had good results in a number of thin Indians, both female and male, who have been put on to oral therapy *as soon as the glycosuria has been noted*. We have not followed our patients long enough to draw any definite conclusions, but our results bear out the general mildness of the tropical diabetes, though this is by no means invariably so; there does seem to be a place for the use of oral treatment in the tropics for young thin diabetics, for pregnant diabetics, and for some of those patients who have been ketotic.

Our object in reporting these cases briefly is to find out whether other doctors (particularly in Jamaica) in the tropics and subtropics have had similar results with oral therapy.—We are, etc.

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G. D. CAMPBELL.
W. G. McNEILL.

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Sextuplets

SIR,—I believe that the literature relating to multiple births does not contain any well-authenticated record of a set of sextuplets. The accompanying photograph, which was found among the papers of the late Professor Sir Alexander Simpson, may therefore be of interest. The birth took place at Accra in 1903 to a woman called

Ashong, and the photograph was taken by a missionary in the area. The case was later reported to Sir Alexander in the following letter, dated February 3, 1905.

"Dear Dr. Simpson,

"I think this photograph may have some interest for you. A native woman on the Gold Coast had all those children at a birth. They were all living when born, but were allowed to die. When the photograph was taken by our friend Mr. Schultz of the Basil Mission, all were alive except the first on the right."

The event does not appear to have been reported previously in medical literature, although I believe it may have achieved mention in the daily press at the time. In accordance with native custom, which believed multiple births to be unlucky, this unique set were allowed to die, although it seems that five of them were in good condition after delivery.—I am, etc.,

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