It was thought that the positive Wassermann reaction was probably a false biological result related to the increased protein in the cerebrospinal fluid, and a further cerebrospinal fluid specimen obtained four weeks later was completely normal with a negative Wassermann reaction.

Of the seven cases reported, apart from Case 5, a burnt-out tabes, and Case 7, a juvenile neurosyphilis, I would hesitate to attribute the symptoms to a syphilitic infection of the central nervous system unless the C.S.F. T.P.I. test was positive, and apparently this test was not performed in all the cases reported. Furthermore, even if the T.P.I. test is positive it is well to remember that syphilis can involve the central nervous system asymptotically. The suggestion that the "Wassermann reaction today is of even greater importance than in the past" deserves some qualification. It is well known that many diseases and conditions other than syphilis can produce positive Wassermann reactions, and if this test is relied on alone to diagnose syphilis many patients will be treated unnecessarily for this disease, and, perhaps more important, the true diagnosis may be delayed.

A 46-year-old married woman, under investigation for bilateral pleural effusion, was referred in October 1967 because serological tests performed on a specimen of her blood showed the following results: venereal disease reference laboratory, positive 1:4; Wassermann reaction, positive; Reiter test, negative. There was no historical or clinical evidence of syphilis, and a negative *Treponema pallidum* immobilization test from a further specimen of blood sent for examination confirmed that the positive Wassermann reaction and V.D.R.L. tests were due to false biological reactions.

Many V.D. clinics nowadays, when investigating difficult diagnostic cases, use the V.D.R.L., W.R., and Reiter tests as a screening procedure, and then confirm or refute the diagnosis of syphilis on the result of the T.P.I. and/or fluorescent treponemal antibody test.—I am, etc.,

Royal Infirmary,
Sunderland.

BASIL LEVY.

Oral Contraceptives and Thromboembolic Disease

SIR,—The articles by Drs. W. H. W. Inman and M. P. Vessey, and M. P. Vessey and Richard Doll (27 April, pp. 193 and 199) concerning the increased incidence of venous thrombosis and embolism in women seem to indicate that oral contraceptives are more dangerous than other forms of contraception and should not be prescribed unless absolutely necessary.

However, it has been my impression that the incidence of carcinoma of the uterine cervix is much less in those women who have been taking an oral contraceptive. I think that it might be of considerable interest to compare statistics of carcinoma of the cervix in these same groups of women to see if their overall incidence of significant disease (vascular and cancer) might actually have been lower than expected, because there was far less cancer in this group.—I am, etc.,

JOHN P. CANBY.

Consulate General of the United
States of America,
Melbourne, Australia.

Smoking, Sputum, and Lung Cancer

SIR,—It has been pointed out to me that a difference in the prevalence of lung cancer between those reporting and those not reporting persistent respiratory symptoms (23 March, p. 732) might be attributable substantially to differences of age distribution. This is because respiratory symptoms might be expected to be reported more frequently by older individuals among whom the prevalence of lung cancer is greater.

In preparing the data for publication the available age range had been divided into those aged 40 to 59 years and those aged 60 years and over, and an examination of this division seems to indicate that the differences in prevalence of lung cancer between those with and those without chronic sputum production were too great to be accounted for by

differences in age. However, the data have been re-examined, using a finer (quinquennial) age distribution, and age-standardized prevalences have been calculated for those with and for those without chronic sputum production within each smoking category.

The Table shows actual and age-standardized prevalences of lung cancer, as well as the ratio between the rate for those with and the rate for those without chronic sputum production, both for the actual prevalence rates and the standardized prevalence rates. It will be seen that, although standardization has reduced the extremely high ratio of the prevalences in those with and those without chronic sputum among the ex-smokers and pipe smokers, the reduction in the ratios among the cigarette smokers is

trivial, and in one consumption category the ratio is in fact increased.

The conclusion, therefore, would seem to be that any differences in prevalences of lung cancer between those with and those without chronic sputum production is substantially due to differences other than age.—I am, etc.,

J. RIMINGTON.

No. 3 Mass Radiography Unit,
St. Thomas's Hospital,
Stockport, Cheshire.

Record Sales of Cigarettes

SIR,—I am encouraged by Dr. E. H. L. Harries (2 March, p. 576) and by the publication of two recent reports to comment further on the subject of smoking.

On 22 February the *Daily Telegraph* reported: "Record sales in Britain last year of 119,100 million cigarettes." A week later came the report: "British fire losses reach new peak—£90,000,000—10% higher than in 1966." (*Times of Malta*, 29 February).

It is apparent from the first report that the findings of top scientists of the Medical Research Council, checked repeatedly and independently, that cigarette-smoking is highly carcinogenic and responsible for a great many other morbid states, have been, for all practical purposes, thrown on the scrap-heap. Can it be doubted, moreover, that the astronomical number of naked lights and smouldering cigarette butts which derive from smoking are mainly responsible for the figure in the second report?

And, unless I am utterly wrong in my basic thinking, we of the medical profession are 100% responsible for this appalling state of affairs, because tobacco-smoking is a disease, a drug addiction, which, like opium smoking, is wholly preventable, and it is our sole function to eliminate disease.—I am, etc.,

Marsascala,
Malta.

LENNOX JOHNSTON.

Recurrent Tetanus

SIR,—The extreme rarity of tetanus recurring or relapsing was stressed by Mr. S. Y. D. C. Wickramasinghe and Dr. Malinie Fernando (2 December 1967, p. 530), and rightly so. This prompts me to report a case from my records.

A 20-year-old male was admitted to the hospital at Calicut, India, in September 1963 with an unmistakable clinical picture of tetanus. A chronic ulcer near the left ankle was thought to be the route of infection. *Clostridium tetani* was demonstrated in a swab taken from the ulcer.

Rates of Lung Cancer per 1,000 Males aged 40 years or more

	Non-smokers		Cigarette Smokers								Ex-smokers		Pipe Smokers		All Subjects	
			1-9		10-19		20 +		All							
	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S
Actual rates ..	0	0	0.73	6.25	0.91	4.96	1.87	5.01	1.30	5.09	0.24	10.13	0.97	13.76	0.84	6.29
Age-standardized rates	0	0	0.64	4.63	0.90	5.81	2.67	4.66	1.73	5.96	0.53	9.26	1.77	12.82	1.31	7.84
Ratio $\frac{(S)}{(NS)}$ actual rates ..			8.333		5.451		2.679		3.915		42.208		14.186		7.488	
Ratio $\frac{(S)}{(NS)}$ standardized rates			7.198		6.418		1.743		3.441		17.468		7.231		5.971	

S denotes volunteers claiming daily sputum for a minimum of 5 years and NS denotes those not claiming this symptom.

Recovery was prompt with the routine regimen followed in the hospital. As the ulcer did not heal, he was re-examined carefully and found to have an enlarged firm spleen, which had been missed earlier on account of the severe abdominal rigidity. On further investigation he was found to have spherocytosis, and the cause of the chronic ulcer became clear. He was advised surgery but was not willing for this and took his discharge.

He was seen again in February 1964 with another full-blown attack of tetanus. The ulcer had not healed and again yielded the organisms. This time recovery followed a stormy course and the patient consented to undergo splenectomy. After surgery the ulcer healed rapidly, and he was free of symptoms when seen in May 1964.

The interval between the two attacks was five months. Any difference in the antigenic properties of the organism isolated on the two occasions was unfortunately not looked for. I am not aware of any reported instance of tetanus in the literature in which the organisms gained entry through a chronic ulcer associated with haemolytic anaemia.

I am grateful for the opportunity to report this case.

—I am, etc.,

M. G. SAHADEVAN.

Armed Forces Medical College,
Poona, India.

Dysentery Organisms and Immigrants

SIR,—In Bradford all newly arrived immigrant children of school age receive a medical examination before they are admitted to school. This preschool examination comprises a full physical examination, a Heaf test, microscopy of a specimen of faeces for helminth ova and culture of a portion of this specimen for intestinal pathogens, and a chest x-ray. In the period mid-1965/mid-1966 1,300 examinations were made and resulted in seven positive isolations of organisms of the "dysentery group." In the period between August 1967 and January 1968 a total of 568 examinations were made. Five of these (0.9%) were positive for pathogens. The results of the five positives are as follows: two cases having *Salmonella typhi*; one case having *Shigella flexneri*; one case having *Shigella sonnei*; and one case having *Salmonella give*.

The *Salmonella give* infection was almost certainly an imported one and occurred in a child of West Indian origin who had recently arrived in this country. *Salmonella give* has not been isolated in Bradford from a human case since 1961, although it was found in pig offal three times and in a swab from the animal lairage of the Bradford abattoir once in the period 1961-5. *Salmonella give* was isolated 11 times from human cases of salmonellosis in the United Kingdom in 1967. Examination of faeces specimens from the rest of the family gave negative results. The child in whom the salmonella was found has been treated and further faeces specimens have been negative. The infection with *Shigella sonnei* was found in a West Indian child of 14 years. No members of the family were infected and there was no history of illness. He was treated by his family doctor and subsequent specimens were negative. The *Shigella flexneri* infection was due to *Shigella flexneri* type 5 and was found in an Asian boy aged 13. He was well and there was no significant history of gastrointestinal illness. No other member of the household of six other persons showed the organism. The child was treated by his family doctor, and subsequent specimens were negative.

The first child showing *Salmonella typhi* infection was an Asian boy of 12 years of age. He had come from Mirpur, Azad Kashmir. There was no significant history of gastrointestinal disease. The typing of the organism showed a phage G Eastern strain of *Salmonella typhi*. The bacteriologist reported that there were few colonies of the organism present. Widal examination was not helpful. It was decided that the boy should be admitted for treatment on production of a further positive specimen. In the last four months a considerable number of specimens have been taken but they have all been negative and the boy has remained well. He is continuing under surveillance. The second boy with *Salmonella typhi* infection was an Asian lad of 15 years. He also had come from Mirpur. When first seen at the school clinic he gave no history of gastrointestinal disease, but later questioning revealed that he had had an illness which was diagnosed as typhoid fever some 13 months previously. The organism was a degraded, untypable *Salmonella typhi*. He was admitted to hospital for treatment and on completion of treatment gave six negative specimens at weekly intervals. He still has a high *Salmonella typhi* Vi antigen titre and may well prove to be still harbouring the organism. Surveillance is continuing. Examination of all household contacts of these two boys has shown no secondary cases of the infection.

It is considered the results of these routine bacteriological examinations indicate them to be an essential part of the examination of all recently arrived immigrant children of school age, prior to their attending school. The wider implications of the results are the advisability of a comprehensive routine medical examination, including such laboratory investigations as are considered necessary, of all immigrants to exclude imported disease. It is realized that a single examination of this type cannot with certainty exclude the presence of imported disease, but it will lead in many cases to earlier diagnosis, and this will be of benefit to the health of the patient and the continuing health of the community.

We are grateful to Dr. H. G. M. Smith, of the Public Health Laboratory, Bradford, for the bacteriological examinations and information regarding the previous isolations of *Salmonella give* in Bradford, and also to the Salmonella Reference Laboratory of the Public Health Laboratory Service, for information in the isolation of *Salmonella give* in the United Kingdom. We are also grateful to Dr. W. Turner, Medical Officer of Health of the City of Bradford, for permission to publish these results.

—We are, etc.,

G. A. BELL.
J. S. DODGE.

Public Health Department,
City of Bradford,
Yorks.

"Bucket" Ulcer

SIR,—We were interested to read the numerous reports that appeared following the description of artifact ulcers produced by elastic bands by Mr. I. D. Kitchin and others (22 April 1967, p. 218). Dr. F. W. Webb (27 January 1968, p. 250) has added to the increasing list another of neck ulcer in a six-month-old girl.

May we add one more case of a mechanical ulcer that illustrates incidentally some of the problems at the other end of the spectrum? With the evolution of progressive patient care and other modified active methods of treatment most of the geriatric units are emerging out of the gloomy era of intractable bed

sores. Nevertheless one not infrequently encounters different sources of pressure sores.

A 72-year-old very obese female patient was admitted with a history of living in squalor and utter self neglect. She complained of sore buttocks. She was an aggressive large woman with compulsive eating habits and poor mobility. Physical and psychiatric examinations showed that she was hypertensive, arthritic, and suffered from a gross degree of dementia and depression.

Circular linear ulceration over the buttocks as shown in the photograph was the outcome of the habit of using a bucket for lavatory purposes and on one occasion she was found having sat 17 hours, unable to move of her own volition. Fortunately she was soon brought in and treated for her physical and mental condition with good results. It is conceivable that had she not been detected early there would have been a much deeper and intractable ulcer.—We are, etc.,

D. B. RAO.

St. Francis's Hospital,
London S.E.22.

M. S. KATARIA

New Corticosteroid

SIR,—In your leading article "Increasing Deaths from Asthma" (10 February, p. 329), the author mentions that some doctors tend to avoid the use of corticosteroids for fear of their side-effects.

I have recently completed a preliminary evaluation of a new corticosteroid which appears to have certain advantages over the older preparations. It has been suggested that prednisolone stearoyl-glycolate (Sintisonone) has a diminished water-retaining tendency¹ and diminished inhibition on the pituitary adrenal axis.² I therefore decided to compare the efficacy and effect upon weight of this new steroid in patients suffering from asthma with that of prednisolone.

Sintisonone is prepared as white scored tablets containing 6.65 mg. of prednisolone stearoyl-glycolate (equivalent to 3.5 mg. of prednisolone), so that in order to give equimolecular doses of the two steroids one would have to give three tablets of Sintisonone in place of two tablets of prednisolone.

Twelve patients, three females and 9 males, between the ages of 28 and 63 years were included. All had asthma of at least 24 months' duration, and all had had previous emergency hospital admissions with status asthmaticus requiring steroids. All were receiving a maintenance dose of prednisolone. I used three parameters for purposes of comparison: rapidity of response to equimolecular doses of the two drugs; weight changes during treatment; and incidence of any other side-effect.

The results showed that rapidity of response was the same with both steroids, and the incidence of side-effects was the