Be careful to do this correctly to avoid further sorting of potentially infected material.

Put all *Foul Wash* in the coloured bins:

White linens and cottons in the white striped bin.

Coloured linens and cottons in the blue striped bin.

White woollens in the uniform white bin.

Coloured woollens in the uniform blue bin.

Enter each article as you put it in.

In fact, the bins have now been replaced by wheeled bedside containers, to which a notebook and pencil are attached, with coloured bags for foul linen; these bags are closed and transported to the laundry, where the contents are tipped straight into disinfectant.

The advantages of this scheme are that no handling of foul laundry takes place, except from the bedside to the bag, until it has been sterilized, and so the staff are saved from an unpleasant task with risk of infection. A theoretical disadvantage is that linen is not so thoroughly checked, but in practice this has not caused excessive losses.—I am, etc.,

The Central Hospital,
Nr. Warwick.

E. S. STERN.

Traumatic Fore-quarter Avulsion

SIR,—Apropos Mr. D. S. Pracy's interesting report of a traumatic fore-quarter avulsion (*Journal*, December 27, p. 1578), an early example of this formidable injury is illustrated by a copperplate* in William Cheselden's *The Anatomy of the Human Body*. The patient was a miller, Samuel Wood, whose arm was caught in a rope attached to the cogs of his mill. He was treated at St. Thomas's Hospital with superficial dressings only, lost little blood, and recovered without severe symptoms. The year was 1737.—I am, etc.,

General Hospital,
Northampton.

H. ELLIS.

* This copperplate was reproduced in our issue of October 16, 1948 (p. 722), where it illustrated a letter by Mr. J. Dudfield Rose drawing attention to the case of the miller.—ED., *B.M.J.*

Afibrinogenaemia after Transfusion

SIR,—Having read the comments of Dr. H. J. Friend and Surgeon Rear-Admiral S. G. Rainsford (*Journal*, December 27, 1958, p. 1592) on my recent article (*Journal*, November 15, p. 1201), I must say that I am in complete sympathy with any attempt to prevent the misuse of such a valuable and potentially dangerous material as donated blood. In my anxiety to avoid confusing the issue regarding the trigger mechanism of the afibrinogenaemia, which I have no doubt was the incompatible transfusion, I may have painted too rosy a picture of the patient's immediate post-operative condition. I can only say that her condition was not in any way unusual for a patient after a major surgical operation, but that in the opinion of those responsible blood transfusion was desirable.

Surgeon Rear-Admiral Rainsford raises a number of points regarding dextran. Although it is obvious that dextran played no part in the onset of the afibrinogenaemia, I feel that administration of any substance known to interfere in any way with the haemostatic processes was inadvisable. I consider that there is enough clinical evidence given in the papers I quoted on dextran to make me reluctant to order it in any condition associated with bleeding. Now that "large pool"

plasma is no longer used and the risk of infective hepatitis from plasma is probably no greater than from blood, it might be debated whether there is still a need for unphysiological substitutes such as dextran in civilian hospital practice.—I am, etc.,

Victoria Infirmary,
Glasgow, S.2.

JAMES M. MOORE.

SIR,—The letters of Dr. H. J. Friend and Surgeon Rear-Admiral S. G. Rainsford (*Journal*, December 27, 1958, p. 1592) regarding the paper by Mr. James M. Moore (*Journal*, November 16, p. 1201) raise the question as to whether the blood given was really necessary. As one who is constantly faced with the problem of supplying blood to clinicians I feel that a clinical pathologist must reiterate the dangers of blood transfusion, but, having done so, the final decision as to whether to transfuse a patient must lie with the physician or surgeon in charge of the case. Doubtless Mr. Moore had his own good reasons for transfusing blood, and in the unfortunate circumstances of the case I think he is to be congratulated on publishing the facts as another warning of the dangers of blood transfusion.

The case described by Mr. Moore illustrates a rare but alarming complication of incompatible transfusion, of massive blood transfusions, and indeed of certain surgical operations. The existence of this haemorrhagic syndrome must be recognized and appropriate treatment undertaken at an early stage. The case also emphasizes the danger of the clerical or administrative error in blood transfusion work. Most transfusion accidents arise from clerical or administrative errors. It is essential, before any transfusion is given, to read the label on the bottle and to ensure that the identity of the patient about to be transfused agrees with the information given on the matching label on the bottle.

Many surgeons and obstetricians will agree with Admiral Rainsford that moderate blood loss can be treated successfully with plasma or with dextran. More use could be made of these products. In any event, however, the danger to life by withholding blood must be weighed against the risks of transfusion. The final decision as to whether to transfuse must surely rest with the clinician who is accepting full clinical responsibility for the patient.—I am, etc.,

Blood Transfusion Service,
West of Scotland Region,
Lanarkshire.

JOHN WALLACE.

Tuberculous Meningitis after B.C.G.

SIR,—In view of the particular interest aroused by our paper reporting the development of tuberculous meningitis in a baby nine months after B.C.G. (*Journal*, October 25, 1958, p. 1019) we feel that it may be worth while to give a more detailed account of the epidemiology, kindly supplied to us by Dr. W. H. Findlay, area chest physician, Perth.

At Birth (May, 1956).—The child was born on May 13, 1956, and the situation in the family as regards tuberculous infection at this time was as follows. The mother, who was the index case, had had an arrested lesion for some years. Four years previously (August to October, 1952) her sputum was positive for *M. tuberculosis* but has been negative since. From the time of her discharge from hospital (April, 1953) the lesion had remained completely inactive and was considered in a state of complete arrest at the time of the baby's birth (subsequent follow-up confirms this). At the time of writing she has completed a period of over six