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In fact, the bins have now been replaced by wheeled bedside containers, to which a notebook and pencil are attached, with coloured bags for foul linen; these bags are closed and transported to the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

years free from infection. The brother (aged 18 years) was known to have a calcified primary complex in the right lung. This had been present and observed at intervals for a period of three years. He had had a routine x-ray on March 21, 1956 (i.e., within two months before the baby's birth), which confirmed that the complex had remained healed. (In our original paper it was erroneously stated that he had a lung cavity.) The father was a healthy man who had had one previous "contact" x-ray, which was negative. There was no question of his suffering from pulmonary tuberculosis at this time or being a source of infection. The above being all the home contacts, it was considered entirely safe to vaccinate the child at home.

Second Month.—A Mantoux test, 1/1,000 P.P.D., was done on June 26, 1956, with negative result. B.C.G. vaccination (intradermal vaccine) was performed on June 29, and a Mantoux test done on August 22 was positive—induration 9 mm., erythema 12 mm. This result was considered to be in keeping with a normal reaction following B.C.G.

Third to Eighth Months (Inclusive).—The child remained healthy, thriving and increasing in weight normally during this period. The mother had three attendances at the clinic during this period and complete arrest of the lesion was confirmed. The brother had two routine attendances, and it was considered that there was complete arrest of the calcified complex.

Ninth Month (February, 1957).—During this month an independent x-ray of the brother, who had reached military age, was arranged by the national service medical board. This raised doubts of active disease adjacent to his old primary infection. He was investigated immediately, and on suspicion of having an active lesion was admitted to hospital on March 23, 1957. Two weeks later *M. tuberculosis* was isolated from sputum culture taken on February 23. The child was probably infected during the weeks around this period. The use of the term "overwhelming infection" may well be justified, as contact was a daily occurrence. During the ninth month the child's father was examined at the clinic following routine mass radiography which had been done in the previous month. A small lesion of "doubtful activity" was noted. Investigation and subsequent follow-up proved this to be inactive, and at the time of writing it has remained unchanged for almost two years. This incident, in our opinion, is of collateral interest only.

Tenth Month (March, 1957).—The child showed signs of failing health during the latter part of this month, and in the following month (April, 1957) she was admitted to hospital suffering from meningitis. Her brother had been previously admitted to chest hospital (tenth month).

Careful scrutiny of these facts brings us to the conclusion that the child most probably contracted infection around the eighth or ninth month of her life, resulting in tuberculous meningitis in the eleventh month.—We are, etc.,

King's Cross Hospital,
Dundee.

MARY KERR.
J. M. DUNBAR.

Auto-immune Erythrocyte Sensitization

SIR,—Dr. J. Darnborough, under the heading "A Unique Case of Auto-immune Erythrocyte Sensitization," describes the case of an apparently healthy man who had no significant illness and whose red cells gave a true positive direct antiglobulin test (*Journal*, December 13, p. 1451). Such a finding, although uncommon, is not as rare as Dr. Darnborough's title suggests. Stratton, Stone, and Tovey (1958, unpublished, referred to by Stratton and Renton¹) have described eight similar cases of positive direct Coombs tests in blood donors. Two of these

donors had a previous history of virus pneumonia and one of these has since developed rheumatoid arthritis, but the others were, and have remained, apparently healthy. Indeed, some of them declared that they had never had any illness throughout their lives, and exhaustive tests failed to reveal any abnormalities other than the positive direct Coombs test.

The exact frequency of such cases is unknown, but when they do occur they may give rise to difficulties in blood-grouping procedures. Six of the eight cases were detected, like Dr. Darnborough's case, because of apparent incompatibility by the indirect Coombs technique when cross-matching their blood for transfusion. The remaining two were Rh-negative donors whose blood reacted "positively" when tested against an anti-D serum by the indirect Coombs technique. These samples would have been labelled "D^u-positive" had not a direct Coombs test been carried out, and this latter test is desirable on any sample thought to be D^u-positive.—We are, etc.,

National Blood
Transfusion Service,
Manchester.
Bristol.

F. STRATTON.

GEOFFREY H. TOVEY.

REFERENCE

- 1 Stratton, F., and Renton, P. H., *Practical Blood Grouping*, 1958, p. 74. Oxford.

Foreign Body in the Nose

SIR,—A relative recently told me that she had been advised by her doctor to try and remove a bead from her 3-year-old child's nose with a hairpin. In view of this I suggest a simple and, I think, infallible method of removing a rounded foreign body from the nose of a young child. Toddlers are frequently seen at our Mission hospital in Uganda with groundnuts up their nostrils, and this method, for which I claim no originality, can be carried out by any of our untrained nurses.

Take a Higginson syringe and squirt water up the clear nostril, which will cause the child to cry. Quickly close the nostril by pressure with the finger and the crying of the child will force the water down the other nostril under pressure, pushing the foreign body before it.—I am, etc.,

Church Missionary Society, Ngora,
Uganda.

P. B. SPARKE.

Antibiotic Therapy for Bronchitis

SIR,—No one will deny the advantages of any drug that will cut short the duration of illness, but Dr. W. J. Keating seems on insecure ground when he supports antibiotic therapy for bronchitis by reason of the saving of costs of a hospital bed (*Journal*, December 13, p. 1475). Surely "sickness diagnosed as bronchitis" is at the very foundations of family practice and will in most cases be treated at home whatever drugs are used. The argument that prophylactic tetracyclines reduce the cost to the nation of sickness insurance benefit is tempered by the fact that true bronchitis is usually most severe at the extremes of life, and neither the very young nor the elderly draw this monetary benefit.

There are two articles in common domestic use to-day which in the writer's opinion may contribute to respiratory lesions of irritant or infective origin. These are oil convector heaters when used in bedrooms or when faulty, and, secondly, paper handkerchiefs