again between the "scientific" method of doing nothing, thereby condemning the patient to lifelong incarceration, and the "empirical" method of leucotomy with its reasonable prospect of success.

Surely Dr. Winnicott cannot defend many of his statements as being either "accurate" or "scientific"—e.g., "convulsion therapy inevitably leads away from the psychological approach to a biochemical and a neurological one." This I submit is a highly controversial statement. My own experience is that all these physical methods require for their *correct* use accurate case histories, precise observation of their effects, and a sound psychological insight into the patient's mentality both before and after treatment. To delegate these treatments to junior medical officers in a sort of hit-or-miss fashion is of course *bad* psychiatry, which no reputable psychiatrist would defend.

Dr. Winnicott's greatest objection, however, appears to result from the implied threat such treatments have to his apparently beloved "analytical" psychology. This is too big a subject to dilate upon here, but I would ask Dr. Winnicott to consider whether he is not himself "unscientific" in assuming that the many amazing concepts of Freud (which, by the way, are outside the realm of scientific proof or disproof) are the only ones of value in the psychological approach? For example, modern child guidance, with its right insistence upon the emotional development of the early years and the importance of "security and affection," appears to derive nothing from Freudian theories but to be based upon the work of Adler (who rejected Freud's teachings) and of Cameron and others in England.

Lastly, I am of the opinion that such misconceptions as are evident in Dr. Winnicott's paper must to a great extent be placed at the door of psychiatrists themselves. When we as individuals become less "aloof" and "mysterious," and when we cordially invite all neighbouring practitioners and specialists to visit our hospitals at any time and to see their own or other patients undergoing such treatments, we shall hear very little of the "unconscious hate . . . that notoriously coloured the management of the insane up to recent times."—I am, etc.,

Armagh, N. Ireland.

ROBERT THOMPSON.

Allergic Reaction to Penicillin

SIR,—I wish to report the following case history showing a marked allergic reaction to penicillin therapy which occurred in the maternity department of Dorking County Hospital.

CASE REPORT

A primipara aged 40 was admitted as an emergency with the history of early rupture of membranes 76 hours previously, uterine inertia, and commencing foetal distress, as evidenced by passage of meconium, though heart sounds were regular and of fairly good quality. Rectal examination showed the cervix half dilated, head in brim not fixed.

Lower segment caesarean section was performed under general anaesthesia shortly after admission. Much meconium in uterus. Baby shocked but responded well.

In view of the history and expected stormy convalescence penicillin therapy was instituted immediately after delivery. The preparation used was penicillin in oil, given intramuscularly with a preliminary dosage of 400,000 units followed by 200,000 units 12-hourly. On the second day after delivery paralytic ileus developed. Treatment consisted of morphine, half-hourly duodenal aspiration through a Ryle's tube, acetylcholine, intravenous drip, radiant heat to abdomen, and turpentine enemata. Response to treatment occurred within 48 hours. On account of a sustained low-grade pyrexia during the puerperium due to a mild genital-tract infection, penicillin in oil in the above dosage was continued for 16 days, the total dosage being 6,400,000 units.

On the day following cessation of penicillin therapy a severe urticarial reaction occurred. It affected the face and limbs and later involved the trunk also. It was unaccompanied by fever or tachycardia, but caused such severe pruritus as to keep the patient in the next bed awake by the vigour of the scratching. Adrenaline, calcium gluconate, and local sedatives gave some relief, but fresh patches kept appearing for a total duration of 6 days, and then cleared up completely. Mother and baby were sent to the hospital convalescent home and discharged well and thriving 5 weeks following delivery.

I would add that this patient had not previously had any penicillin therapy.—I am, etc.,

Dorking, Surrey.

J. C. CUTHBERT.

"Benadryl" Treatment of Penicillin Allergy

SIR,—Accounts of the allergic response to penicillin have appeared recently in the journals. These reactions have been both to intramuscular and local applications of the drug. The commonest reaction is urticaria alone, but occasionally a full anaphylactoid response is seen, with fever, hydrarthrosis, enlargement of the lymph glands, and bronchial spasm. This often occurs 10 to 14 days after the commencement of penicillin treatment and resembles serum sickness. The intense pruritus which accompanies the urticaria is usually the most troublesome feature, causing scratching and inevitable insomnia.

A patient of mine (G. A.), a girl aged 19 years, developed a paronychia, and I first saw her with pus under the left thumb-nail and slight lymphangitis. The nail was removed, penicillin in oil, 125,000 units in 1 ml., was given daily for three days, and the thumb healed uneventfully.

Ten days after the commencement of penicillin she developed an urticarial rash on the back and shoulders; this was associated with intense itching. She had no family or personal history of allergy, and as far as could be ascertained she had not been exposed to any other allergen. The following day, after a sleepless night, she had a temperature of 100° F. (37.8° C.), there was generalized urticaria, which was most marked about the face, and she was also dyspnoeic. On examination the axillary and inguinal glands were enlarged; on auscultation of the chest there was a marked expiratory wheeze; there was no evidence of hydrarthrosis. Calcium lactate 30 gr. (2 g.) and phenobarbitone 1 gr. (65 mg.) were given six-hourly, but the following day the symptoms had increased.

Having used "benadryl" (dimethyl aminoethyl benzhydrol ether hydrochloride) successfully in angioneurotic oedema, I commenced treatment with 100 mg. (two capsules) at once and a further 50 mg. six-hourly. The response was most dramatic; within an hour all urticaria had disappeared, the itching and dyspnoea ceased, and the patient was symptom-free. There has been no relapse.

While further cases will have to be described, "benadryl" appears to be the drug of choice in the long-term treatment of anaphylactoid phenomena; "benadryl" being perhaps to adrenaline what trinitrin is to amyl nitrite.—I am, etc.,

Liverpool.

GEOFFREY DEAN.

Pruritus Ani as an Allergic Condition

SIR,—The association of pruritus ani with allergy is hardly investigated. The unsatisfactory results of treatment in many cases, however, make it desirable to get better information on aetiological factors in these conditions. A case of a man who came into my observation first on July 8, 1946, illustrates this well.

The patient was 66 years old. There was a family history of allergy; the son suffered from asthma, a daughter had attacks of urticaria. The patient has had sinus and antrum operations for "sinus infections" from 1898 on, the last time in 1929. In 1943 piles were operated and "proctocaine" injected. The skin proved to be allergic to skin disinfectants. All these years the patient suffered from severe irritation of the anal region which "made life miserable" to him. Three weeks before he saw me first he again had piles removed by operation. A slight attack of pruritus had occurred 40 years earlier. He has also suffered from urticaria and eczema on his head; otherwise he has been a healthy man all his life.

On examination I found a scar on his right forehead due to the operation on his right frontal sinus. The anal region was in an irritated state, excoriation, thickening, and oedema of the skin were marked, and there were cracks and slight fissures in the perianal region. The middle lobe of the prostate gland was moderately enlarged. A differential blood count showed a hyper-eosinophilia of 6%; basophils, 4%; polymorphs, 67%; lymphocytes, 23%. Skin tests gave positive results to moulds, cheese, and other food proteins. His condition was worse when constipated.

From his faeces *Bact. coli* and *Staph. aureus* were cultured and used for an autogenous vaccine together with a desensitizing mixture of the positive allergens. Apart from that the patient was given vitamin E and testosterone tablets. Local treatment was discontinued. His condition started to improve after three weeks, and the anal findings showed a normal picture and normal skin conditions with no irritation from about six weeks after the treatment. The patient was last re-examined on May 8 and was found absolutely well and the anal region normal. As repetition

of his blood count elsewhere had given no signs of hyper-eosinophilia, I had it re-examined in October, when a "hyper-eosinophil phase" of 11% was found.

F. R. Rugeley published a paper on allergic causes of pruritus ani recently (*Annals of Allergy*, 1946, 4, 374 and 396) and reported about 14 cases of pruritus ani in which a connexion with allergic causes was revealed and rapid improvement achieved by treatment on these lines, whereas the conventional treatment, tried before, had proved to be unsuccessful. He holds the opinion that excoriations, oedema of the skin, thickening, or exudation vary in intensity, and that papillitis, fissures, and other changes thought to be causative factors are often secondary and not primary changes. He recommends strongly that allergic causes of pruritus ani should be investigated before radical procedures are suggested, such as surgical interference, x-ray treatment, local injections, divisions of nerves, or tattooing of the anal margins with anaesthetics.—I am, etc.,

London, W.1.

E. M. FRAENKEL.

Congenital Hepatic-duct Malformation

SIR,—Length of survival may warrant recording the following case. A female child 10 months old had been jaundiced since her normal birth. Weight records were: 7 lb. (3.1 kg.) at birth, 9 lb. (4 kg.) at 6 months, 12 lb. (5.4 kg.) at 10 months. Absence of breast milk had resulted in cows' milk feedings. Three older children were healthy.

The child was lively and profoundly jaundiced. Her spleen extended three fingerbreadths below the ribs, and the nodular liver extended below the umbilicus. The urine was dark, contained bile, and the stools were light. Her haemoglobin was 65%, red blood count 3,000,000, white blood count 5,100, and the Wassermann was negative in mother and child.

On Dec. 12, 1946, the abdomen was opened in the hope of finding a gall-bladder for anastomosis. A small amount of bile-stained fluid appeared. The enlarged liver was hobnailed and had rounded borders. No gall-bladder and no extra-hepatic ducts were present. The spleen surface was granular. Prof. J. H. Fisher examined a biopsy specimen and reported "obstructive biliary cirrhosis." Post-operative condition was good until Dec. 18, when hepatic failure developed. On Dec. 23 the wound disrupted, with bowel prolapse. The child was unconscious, and the wound was closed with through-and-through silkworm sutures without anaesthesia. The child died eight hours later, having lived ten months and eight days.—I am, etc.,

Arkansas, U.S.A.

FRANK RIGGALL.

De Morgan's Spots

SIR,—I was much interested to read the paper by Capt. A. R. Murison, Lieut. J. W. Sutherland, and Flying Officer A. M. Williamson on De Morgan's spots (May 10, p. 634). Their observations on a very large number of patients are a valuable addition to the literature on the subject and incidentally a confirmation of earlier findings by other authors. I would however like to point out that the literature on the "ruby spots" is by no means "extremely meagre" and the erroneous impression that "there is an entire absence of precise information on their significance" is obviously due to some confusion in the terminology.

"De Morgan's spots" is an obsolete term almost wholly unknown outside this country and rarely met with even in the British literature. The more or less generally accepted name for this type of telangiectatic skin lesion is angioma senile. This term is generally used in the international literature, but also by English authors (e.g., Colcott Fox, *Brit. J. Derm.*, 1908, 20, 145) and in English textbooks of dermatology (McLeod, Sequeira). Less common synonyms are angioma eruptivum, angioma tuberosum, angioma nodulare cutis, senile ectasia, *perles sanguines*. The pathology of angioma senile, including its relationship to malignant disease, has been the subject of comprehensive investigations, mainly by French and German authors. In my monograph on "Haemangiomata and Telangiectasias of the Skin" (Jadassohn, J., *Handbuch der Haut- und Geschlechtskrankheiten*, Vol. 12, Pt. 2, Berlin, Julius Springer, 1932) I dealt exhaustively with angioma senile (pp. 379,

398, 404). May I be allowed to quote just a few passages from what I said then.

"These tiny multiple angiomata are of interest also, because, under the name of Leser-Trélat's symptom, their presence has occasionally been regarded as indicative of internal carcinoma. Trélat, de Boucaud, and subsequently Leser believed that their incidence was higher in patients with internal carcinoma. These authors" (not De Morgan) "suggested therefore that senile angiomata had a certain diagnostic significance, especially when present in early adult life and in great number. This concept has, however, been disproved by Gebele, Raff, Reitzenstein, Rosenbaum, A. Symmers, and Wolff." Summing up I said: "There is little evidence to support the view that they [i.e., senile angiomata] are of pathognomonic significance in the diagnosis of malignant tumours."

As for the histological structure of angioma senile, it seems not quite correct to say that the lesions have the character of simple haemangioma. More aptly they may be described as telangiectasias, because—I am quoting again from the above monograph—"there is no evidence of a formation of new blood vessels. Development and enlargement of the minute tumours are entirely due to dilatation of (pre-existent) capillaries or small veins. In addition, pathological changes of the cutaneous tissue, such as destruction of the elastic fibres and degeneration of the collagen, are often, though not in all specimens, found to be present in the neighbourhood of the dilated vessels."—I am, etc.,

Manchester.

L. WERTHEIM.

Prognosis of Primary Pleural Effusions

SIR,—I read with great interest Dr. Brian C. Thompson's article (April 12, p. 487) on the prognosis of primary pleural effusions. I would like to suggest a fourth factor which seems of equal importance to the three that he describes as being necessary in the correct assessment of the development of tuberculosis over a period of five years. This is the nature and duration of the initial treatment of the pleural effusion. Figures quoted by Coope suggest that a period of several months' treatment under sanatorium regime when the pleural effusion is first manifested greatly reduces the incidence of tuberculosis subsequently. He states that, in cases thus treated, there is less than a 10% incidence of tuberculosis, whereas in untreated cases figures up to 60% are quoted.

It would be very interesting to learn whether Dr. Thompson's cases underwent any sanatorium treatment when the pleurisy with effusion first developed, and, if so, how this group compared with those who had no initial treatment with regard to the development of tuberculosis subsequently.—I am, etc.,

London, N.6.

J. D. L. REINHOLD.

REFERENCE

Coope, Robert (1945). *Diseases of the Chest*, Edinburgh.

Acute Non-specific Diarrhoea and Dysentery

SIR,—I was surprised to read Dr. G. R. Kershaw's article (May 24, p. 717) because I had not heard such views expressed by anyone of the present generation. I can only say that some of us slept for two months in a troopship to the Far East with at most a pair of short pants for cover, with a louvre directed at our naked forms without ill-effect. In India many of my acquaintance slept almost nude under fans through very hot weather and they reputedly were less frequently troubled with epidemic diarrhoea than others who slept in a more temperate way.

Any epidemics of local "tummy rot" could well be ascribed to the lack of hygiene in Indian cooks and cookhouses. In fact one was persuaded that the less covering to which one could accustom one's body, the more resistance one achieved to local minor diseases—a view which received the approval of Army authorities.—I am, etc.,

Bournemouth.

G. DALLEY.

SIR,—I read Dr. G. R. Kershaw's article on acute non-specific diarrhoea (May 24, p. 717) with interest. From my own experience I am convinced that chilling of the abdomen is a common cause not only of acute diarrhoea but of chronic loose motions. During six years in South China I was able to study the effects of chilling on the abdomen, often after violent