that the country can afford any larger sum for the Health Service? Is it not more likely that any increase of the allotment for the above purposes would have to come by readjustment of the present rate of remuneration? Ought we not to have a co-ordinated policy, with priorities?

We deplore the gap between general practice on the one hand and hospital and specialist practice on the other, but any attempt at, or suggestion for, bridging the gap is effectively opposed not by the administrative side of the Service but by one side or other of the profession.

It is said, too, that the hospitals cannot function without their present number of registrars. But do they function any more efficiently than they used to do with smaller numbers? In spite of a medical and clerical staff greater than ever before it would appear to be usual for at least a week to elapse after the discharge of a patient from hospital before a letter is sent to his or her doctor. Investigations are necessarily more searching than they used to be, but much time and money are being wasted by blunderbuss investigations and by patients proceeding from one specialist to another. (Is it necessary for a physician to refer an asthmatic to an allergist for skin tests?) There seems to be a tendency for consultants to hold appointments at as many hospitals as possible, with the natural result that they are unable adequately to supervise the work at any of them. How rare, too, it would appear to be in some clinics for an out-patient to get beyond the registrar, and yet it is often for the consultant's experience and opinion that the patient is sent by the general practitioner. Is not the term specialist becoming more appropriate than that of consultant?—I am, etc.,

K. C.

B.C.G. and Sarcoidosis

SIR,—I was interested in Dr. F. E. Crawley's report (December 16, p. 1362) of three cases of erythema nodosum as a manifestation of Boeck's sarcoidosis.

The recent availability of B.C.G. gives the physician additional help in proving a diagnosis of sarcoidosis. Sulzberger and his co-workers (*J. invest. Derm.*, 1949, 13, 249) have shown the differences in local response to B.C.G. in cases of congenital and acquired tuberculin anergy. Secondly, B.C.G. vaccination will not convert the positive anergy of sarcoidosis to normal tuberculin sensitivity (normergy).—I am, etc.,

Edgware, Middlesex.

C. D. CALNAN.

Erythema Nodosum

SIR,—Dr. F. E. Crawley's interesting paper (December 16, p. 1362) once more raises the question of the aetiology of this disease. Perhaps my experience may throw some light on this. Since 1945 I have been treating erythema nodosum with vitamin K, with the result that the condition has cleared up in from one to three days. The dose of the vitamin appears to have little influence: 10 mg. of the synthetic vitamin twice daily appears to be as effective as larger doses. Those cases seen in the first few days cleared up within 24 hours. Those who had been ill for weeks or months took up to three days. Unfortunately I have only had eleven of these cases in five years, and up to a few months ago was not in a position to obtain accurate prothrombin estimations.—I am, etc.,

Belfast.

T. A. KEAN.

Waiting-lists for Tonsillectomy

SIR,—It is a matter of concern how the many children waiting to have their tonsils and adenoids removed are to be treated in view of the lack of hospital beds in which to put them. In many localities the waiting-list runs into thousands, and children have been waiting so many years that we may expect to see their offspring appearing in the E.N.T. clinics soon. Some I have seen grow out of their disability, and doubtless many children could be better treated by convalescent treatment in the country with proper diet and

environment, but this seems to be unobtainable. New Zealand, I read, has arranged these facilities, and I think if we had them we could save a lot of hospitalization, with its greater cost. I would like to put in a plea for a consideration and development of this type of treatment for patients before they become in-patients.—I am, etc.,

London, W.1.

C. HAMBLÉN-THOMAS.

Introducer in Blood Transfusion

SIR,—Since we have used polythene tubing for blood transfusion or other intravenous work it has been found that the introduction of a needle into a vein and threading polythene tubing through it is a thoroughly clumsy procedure. I have therefore designed an introducer, which is illustrated here.

The handle of the introducer is about the size of a 5-ml. hypodermic syringe and has the same feeling when handled. It gives complete control of the needle. The male end of the introducer is a Record size to fit the ordinary

M.R.C. donor needle, through which either size 1 or 2 polythene tubing can be inserted. The handle of the introducer is grooved (which is not seen in the photograph), and the tubing lies in it. When the handle is gripped the tubing is therefore prevented from slipping backwards and forwards in the needle. When the needle has been inserted into the vein the introducer is disconnected, and the polythene tubing introduced as far as necessary through the needle. The needle is then removed, leaving the polythene tubing in the vein, and is taken off the other end of the tubing so that the tubing can then be connected to the giving apparatus. This polythene introducer was made for me by Allen and Hanburys, and has been thoroughly tested and found to be extremely satisfactory.—I am, etc.,

Colchester.

ALEC E. BLAXILL,
Blood Transfusion Officer.

Death from Exsanguino-transfusion

SIR,—From a study of the literature of exsanguino-transfusion in adults, and from correspondence with its chief exponent, Dr. M. Bessis, it would appear that the manoeuvre is almost entirely free from risk. We consider, therefore, that a fatality arising from this operation should be reported.

In a woman of 44 suffering from acute monocytic leukaemia an exsanguino-transfusion calculated to replace 95% of the patient's blood was planned. Careful physical and radiological examination prior to the operation failed to reveal any concurrent disease.

Thirty-five pints (19.6 litres) of blood were exchanged at a single session over the course of six hours, the patient being heparinized and the blood given into both arms, while withdrawal was effected by a wide-bore polythene cannula in the left femoral vein. Prior to the operation the patient had received six pints (3.4 litres) of packed cells, which had raised her haemoglobin to 13 g. %. During the course of the transfusion the patient developed symptoms of tetany, which were promptly relieved by intravenous injections of calcium gluconate. These symptoms recurred on three occasions, and each time required a larger dose of calcium gluconate intravenously to effect relief. At the end of the exsanguino-transfusion symptoms of tetany again became manifest, and, although they slowly subsided after administering a total of 120 ml. 10% calcium gluconate, the patient died.

Post-mortem examination confirmed the diagnosis of acute monocytic leukaemia, but also revealed tuberculous infiltration at the apex of the right lung, with very early milary tubercles in the kidneys and spleen. No other notable changes were found.