in my experience, can then safely be left to clear up by itself. After all, it is not considered scientific to apply ointment to the anus in a case of pruritus and omit to test the urine for sugar first.

Surely patients with non-specific vaginal discharge should have the cause of their condition correctly diagnosed first; and for this the doctor often needs clinical acumen which is wide in its scope and not limited to a survey of the region that is peculiarly the realm of the gynaecologist—i.e., the umbilicus to the knee.—I am, etc.,

London, W.1.

G. M. SANDES.

SIR,—I agree with Dr. Margaret C. N. Jackson (February 17, p. 357) that many male urethral infestations with trichomonas are transient and hardly need any treatment at all. I should like to add that these cases probably never reach us. I agree also that trichomonas in the prostate or vesicles is more difficult to treat than in the urethra; but this, *mutatis mutandis*, applies in most cases of urethritis with prostatitis.

I quoted the figure of 6 as the incidence of trichomonas in 4,000 consecutive cases of male urethritis to support my suspicion that trichomonas does not like the male urethra and persists there probably only if the infestation is massive or frequently repeated. I thought it unlikely that the few males should be blamed for reinfesting the multitude of women. Dr. Jackson considers this figure too low and suggests that either the flagellate was not detected in men who in fact were harbouring it or that most men were wearing condoms. I can assure her that the figure was reached after most careful searching for trichomonas in each individual case with the dark-ground illumination method by experienced workers. The urethral signs still being acute, it was impracticable to look also in the prostate. I do not know how many of the 4,000 men wore condoms at the time of intercourse. But even if I knew I would not be sure how many of these condoms lasted out. The mere fact of using one is no guarantee of protection. While serving with the R.A.M.C. as venereologist in Singapore I was faced with the second highest V.D. rate in the British Army, in spite of the fact that many patients had worn condoms. An inquiry showed that almost half of them did not know how to use them properly.

I have yet to learn in what way non-specific cervicitis of "the type commonly seen in gynaecological out-patients" differs (pathologically) from non-specific cervicitis in other departments. Surely "non-specific" is but a convenient term meaning that the specific cause or organism cannot be identified by present-day laboratory methods. The group of "non-specific" conditions is decreasing in direct proportion to improved diagnostic methods. For example, pleuro-pneumonia-like forms and organisms were recently reported (by Dr. Durel, a French venereologist of repute, to the Medical Society for the Study of Venereal Disease) to be present in one-sixth of his cases of non-specific cervicitis. It is questionable whether these cases would respond to the routine treatment of cauterium-cum-sulphonamide-cum-penicillin recommended by Dr. Jackson. I still maintain the treatment advised by her is too pragmatic to be generally applicable, and in less experienced hands may lead to abuse and expensive waste.—I am, etc.,

London, W.1.

G. JELINEK.

Dose of Chloromycetin

SIR,—Now that "chloromycetin" is available to general practitioners, it might be useful to some to know that a rapid way of working out the daily dosage is to divide the patient's weight in pounds by ten. This gives the number of 250 mg. capsules needed daily, if a dosage of 55 mg. per kilogram of body weight, which is usually adequate, is desired.

Thus a patient weighing 10 stone would require 14 capsules daily.—I am, etc.,

Newport Pagnell, Bucks.

A. A. CLAY.

Aureomycin in Ophthalmic Herpes Zoster

SIR,—This case may be of interest. A healthy man aged 42 years felt a dull pain in the left occipital region on August 25. Ten days later he noticed a vesicular eruption on the left temporal region, with one single vesicle over the left eyelid, and within three days the eruption spread to the left forehead and the left side of the nose. Fourteen days from the onset of pain he exhibited a fully blown ophthalmic herpes zoster with involvement of the ciliary branch. The left eyelids were considerably swollen and prevented examination of the eyeball; he ran a temperature of 99° F. (37.2° C.), did not complain of any pain, and except for the inconvenience of a closed eye he felt tolerably well.

Aureomycin was started (on the 14th day), the dose being 8 capsules per day spaced at six-hourly intervals, and was continued for six days (total dosage 12 g., weight of patient 140 lb.—64 kg.). Within three days there was considerable improvement: the oedema of the face had completely subsided and the vesicles had dried up. However, there was one small corneal ulcer with some degree of iridocyclitis which yielded quickly to orthodox treatment.

Six weeks from the onset of pain he had recovered completely. The left eye was perfectly normal, and, except for slight pigmentation of the skin, there were no very discernible scars. Up to the present (February, 1951) he has been free from post-herpetic neuralgia.

It may be of interest to remark that in spite of vitamin administration loose motions, soreness, and itching of the anus were present throughout aureomycin therapy and for six weeks after, the anal irritation persisting up to four months.

My thanks are due to Professor J. E. Debono for permission to publish this report.

—I am, etc.,

Malta.

A. LANFRANCO.

Penicillin and Tubercle Bacillus

SIR,—In his recent Kettle lecture (February 3, p. 205) Professor L. P. Garrod made the following comment on our criticism of Ungar and Muggleton's (1946) claim that penicillin stimulated the growth of the tubercle bacillus: "... Iland and Baines (1949) could not confirm this result, but they used higher concentrations of penicillin, and their criticism of Ungar and Muggleton's work ignores some of the controls used by these workers." We would like to point out that this statement is not correct in so far as the published work of Ungar and Muggleton is concerned. Our concentration of penicillin was the same as one of the two used by them, and we consider that our criticism of their work applies to all the controls described in their paper. We do not think that any reliable evidence of the *in vitro* stimulation of the tubercle bacillus by penicillin has been put forward. Apart from ourselves eight other workers have tested the effect of penicillin on this organism, and four have noted inhibition and the others no effect (see Iland, 1946; Iland and Baines, 1949, for references). Dubas and Kirby (1947) have reported some inhibition at a concentration of 1 unit per ml.—this is one of the concentrations at which Ungar and Muggleton claim stimulation.—We are, etc.,

Bristol.

Birmingham.

C. N. ILAND.

S. E. BAINES.

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Modifications of the Gordh Needle

SIR,—The illustrations show three modifications of the Gordh intravenous needle which were made for me by Blease Anaesthetic Equipment Ltd. The difficulty of having to screw back the diaphragm cap when it has been

removed in order to use the needle with a Record syringe has been overcome by mounting the diaphragm on a separate fitting which fits by a taper on to the needle body; when this is removed the nozzle of the syringe will engage directly into the body.

The needles are made in three types: (1) Diaphragm mount with needle and body in one piece. (2) Diaphragm mount

and body with fitting for a detachable needle. In these models a small plate is fixed *above* the body. When held by a strip of adhesive plaster this modification causes the needle to lie flat in the vein and the plaster keeps it securely in position. (3) Diaphragm mount fitted to a round clip which carries in its centre a short needle. This can be clipped on to the tubing of a transfusion apparatus; the needle pierces the tube and lies in its lumen. With this device drugs may be added to the transfusion without repeatedly piercing the tubing.—I am, etc.,

London, W.1.

STANLEY ROWBOTHAM.

SIR,—I am indebted to Dr. D. Blatchley for his description (March 3, p. 470) of my modification of the Gordh needle which he saw demonstrated at Westminster Hospital. There should be no difficulty, however, in obtaining the rubber caps I use for this purpose. They are supplied by the Genito-Urinary Co., Devonshire Street, W.1, and cost but a few pence.

There are two precautions which appear to me worthy of mention in the use of this device. The needle which lies in the vein should always be of larger gauge than the one attached to the syringe, otherwise leakage is liable to occur at the site of injection in the rubber cap; and when an injection of pethidine is to be given the needle in the vein and the rubber cap should be cleared before and afterwards with sterile water, as pethidine forms a heavy precipitate when mixed with thiopentone.—I am, etc.,

London, W.1.

I. W. MAGILL.

Ski-ing Injuries

SIR,—I was interested in your leading article (February 24, p. 401). Having been attached to various Service units where ski-ing was a normal part of the winter training, I saw a fairly considerable number of such injuries. Most common, I found, were tears of the lateral ligaments of the ankle and medial ligaments of the knee-joint, both quite frequently occurring together. The knee injuries seemed to cause the worst disability, and one or two cases had complete tears of the ligament. Other joint injuries included meniscal lesions, which were not infrequent, and minor strains of the cruciate ligaments. These latter did not make ski-ing anything like so painful as they did walking.

Most joint injuries seemed to be a result of badly fitting boots and binding. The boots were not suitable for downhill running, and the bindings, of Kandahar type usually, were often old and worn.

From personal experience I feel certain that with a modern "downhill" boot, and a fairly tight binding, the danger of "edging" the ski, and consequently of falling, is greatly reduced. At high speeds, of course, the results of

a fall are likely to be more serious than where the bindings are looser and the boot less rigid, but a sprained ankle will cut short a ski-ing holiday just as much as will a fractured fibula, and I feel that the ease of control with modern boots and bindings more than outweighs any slight increase in apparent safety given by equipment of an older type.—I am, etc.,

Sheffield.

E. J. CLEGG.

Lumbar Puncture in Miliary Tuberculosis

SIR,—In the report of the Ministry of Health on trials of streptomycin in the treatment of tuberculous meningitis (*British Medical Journal*, 1950, 2, 413) it is mentioned that, "in patients suffering from miliary tuberculosis without meningitis, examination of the C.S.F. at the commencement of, and at intervals during, streptomycin treatment is important." I would differ on this point, for the following three important reasons.

It has been my experience that characteristic symptoms of tuberculous meningitis precede the pathological changes in the C.S.F. sometimes even by one to three weeks. Hence I have learnt to depend more upon symptoms than upon the abnormal findings in the C.S.F. for the early diagnosis of tuberculous meningitis. If reliance is placed on the abnormal C.S.F. findings for the early diagnosis of tuberculous meningitis, many cases will be diagnosed late for the treatment to be successful.

Lumbar puncture in a case of miliary tuberculosis is likely to favour the onset of tuberculous meningitis, perhaps by carrying the infection to the meninges along the needle. I have observed two cases of caecal tuberculosis where anastomosis was carried out under spinal analgesia. On about the twelfth day, when everything seemed to be going on well, the patients complained of severe headache. This later proved to be due to tuberculous infection of the meninges, which ended fatally in a few days. Though the causal relationship of lumbar puncture to tuberculous meningitis is difficult to establish beyond doubt in these cases, the probability appears striking when no such complication was observed in cases done under local or general anaesthesia. Some cases have done well even with spinal analgesia. It is impossible for me to mention these findings only as clinical impressions during practice and not in terms of statistical figures. In miliary tuberculosis, it is still more likely that the meninges will be infected by frequent lumbar punctures in an endeavour to diagnose meningeal involvement early, owing to the presence of blood infection.

There is a tendency at present to avoid lumbar puncture unless it is expected to be of definite help in the diagnosis or treatment of the patient. It has been realized that severe spinal complications may result from lumbar puncture, which can easily be avoided. Hence it would appear unwise to undertake the risk in miliary tuberculosis only to diagnose early meningeal infection. Discomfort caused to the patient thereby is also worth taking into consideration.

Hence I believe that frequent lumbar punctures in miliary tuberculosis are not only unsupportable, but meddlesome and harmful as well.—I am, etc.,

Poona City, India.

P. L. DESHMUKH.

Lung Abscess after Shock Therapy

SIR,—I have been very interested in the correspondence on this subject. In 872 patients treated in St. Luke's hospital till now, over a period of approximately seven years, there has been no suggestion of lung abscess, and in fact no serious complication of any kind, notwithstanding that some of the patients were elderly and frail, upwards of 80 years, and a few were almost moribund from toxic delirium. I agree with Dr. W. L. Milligan (January 6, p. 40) that the patient should be turned on his side, but would suggest at the *very beginning* of the clonic stage and not, as he states, at the end. This, I think, is the key to the whole problem. It is amazing the quantities of fetid saliva that sometimes drool away and which, if this precaution is not taken, stand a very fair chance of being aspirated into the bronchial tree. I cannot agree with Dr. A. A. Robin's suggestion (February 17, p. 354) that in dehydrated cases it is reasonable to delay E.C.T. until the patient has been rehydrated. Prior to the days of E.C.T. one tried to rehydrate these