SIR,—I was interested in Dr. K. M. Tomlinson's letter (Feb. 7, p. 276) concerning "benadryl" and hay fever. Last August I, too, treated my hay fever with benadryl and had complete relief from the symptoms; in September I developed a form of eczema of the beard area which persisted for some weeks and was eventually proved to be due to sensitivity to a brushless shaving cream which I had been using for about twelve months.

Having never had any skin condition like this before, I assume that benadryl may have been in some way responsible. Is it possible that the absence of histamine action in a tissue renders it more liable to become sensitized by a foreign protein?

It would be interesting to hear of any cases of asthma developing after the use of benadryl.—I am, etc.,

Bristol.

A. R. WEAR.

Iridocyclitis Treated with Benadryl

SIR,—I was interested to see Dr. Barbara Shaw's letter (Feb. 7, p. 277) under the above heading. I have been subject to attacks of iridocyclitis since 1944. My last attack started on Dec. 11, 1947, and lasted approximately seven weeks. I performed all the usual investigations, but was unable to find any cause. I was, I found, also liable to sensitivity reactions from various drops which I instilled—namely, hyoscine, hyoscyamine, and atropine—and on this account I used homatropine for a short time. This, however, was not strong enough and I developed approximately 12 posterior synechiae. I was then obliged to revert to atropine and at the same time I began to take "benadryl" 50 mg. t.d.s. This entirely alleviated the sensitivity reaction and I continued to take it for three weeks. It was then discontinued and atropine was exhibited for a further fortnight. In this case, therefore, I do not think that benadryl had the slightest effect on the course of the iridocyclitis.—I am, etc.,

Ednington, Birmingham.

J. MOSS.

Test of Death

SIR,—In my letter on this subject (Feb. 14, p. 315) I should have worded one observation as follows:—In one case at least my ophthalmic examination was made some time after death, but whilst the cornea was still not sufficiently clouded to prevent the fundus being seen, and I found *no segmentation present*. Apparently, therefore, the segmentation sign of death had never occurred or had passed off again.—I am, etc.,

London, W.1.

F. PARKES WEBER.

Trichlorethylene in General Anaesthesia

SIR,—I have read with great interest the article by Dr. Gordon Ostlere (Jan. 31, p. 195) on the above subject. Although I cannot claim to have employed "trilene" in quite such a number of cases as the Hill End Hospital series, nevertheless I have used this drug on many hundreds of occasions with no untoward sequelae whatsoever. Cardiac arrhythmias have been noted occasionally clinically, but are usually transient and appear to be eliminated by the addition of a higher oxygen percentage. Tachypnoea, I agree, is common, but this again can frequently be controlled by increased oxygen and less trichlorethylene, although in certain cases a change over to some other agent may be necessary to combat this condition. I employ the "pentothal," gas-oxygen, minimal trichlorethylene sequence almost as a routine for radical mastectomy, and no surgeon has complained of increased bleeding.

In my view trichlorethylene is quite the most useful adjuvant to gas-oxygen anaesthesia in that it obviously permits of the use of a much higher oxygen percentage than if N_2O were the sole agent. Trichlorethylene is practically non-irritant, so that induction is smooth; also it seems to pave the way for the addition of ether vapour. It very rarely causes post-operative nausea, let alone vomiting.

The main disadvantage of trichlorethylene is that it does not give satisfactory muscular relaxation, with the exception, for some reason, of the muscles of the jaw. This latter exception is of particular value in that a pharyngeal airway can be inserted in a light plane of anaesthesia, whereas this manoeuvre cannot be accomplished with gas-oxygen alone. It is well known that although the jaw is fully relaxed with pentothal the insertion of an airway will often produce laryngeal spasm.

I also have found gas-oxygen and minimal trichlorethylene excellent for maintenance anaesthesia with curare. Similarly it is most useful, again in minimal quantities with gas-oxygen, for the purpose of keeping a patient asleep during spinal anaesthesia. In the latter circumstances it need only be used intermittently and permits therefore of a high percentage of oxygen being employed.

The non-inflammability of trichlorethylene is particularly valuable as it can be used when a cautery is a part of the operative technique. It is of course now well known that trichlorethylene is contraindicated in a closed circuit owing to the toxic products produced by its interaction with soda lime.—I am, etc.,

Penn Street, Bucks.

BERYL L. HARRISON.

Drug Addiction

SIR,—Dr. Eric Coplans (Feb. 14, p. 320) describes a cured case of morphine addiction by slow withdrawal of the drug, but both he and Dr. F. R. Ellis (Jan. 24, p. 175) fail to make clear that there are two types of addicts. The first and more easily cured variety becomes an addict accidentally as the result of pain requiring relief over a prolonged period of time; the second type is the unfortunate possessor of a psychopathic make-up who has neither the desire nor the strength of will to desist from taking the drug and thus frequently reverts to his former ways after a so-called cure.

It does not appear to be generally known that auto-serotherapy—as mentioned by Dr. Margaret Vivian (Feb. 7, p. 277)—will enable both types to get off the drug, with the minimum amount of distress and discomfort, in about two or three weeks.—I am, etc.,

Amesbury, Wilts.

G. LOWELL WEBB.

SIR,—The prognosis of drug addiction is quite serious enough without the absurd statement of Dr. F. R. Ellis (Jan. 24, p. 175) that the condition is incurable. Among the ne'er-do-wells and misfits of society morphine addiction is possibly never cured, but there are many doctors in this country who have been cured and remain cured indefinitely. Dr. Ellis does a grave disservice to those others who in the future, as the result of unbearable stress or intolerable pain, may fall victims to the morphine habit.

I do not, of course, know on what tremendous personal experience Dr. Ellis founds his dictum, "notwithstanding all evidence to the contrary," but I hardly think that his proposal to produce "an arrested development stage" of morphinism (whatever that means) will do much to solve the problem. What he calls the "dreadful agony produced by the conventional form of treatment" is really the agony of deprivation which all treatments, with varying success, endeavour to mitigate. It follows that Dr. Ellis has nothing better to offer than a succession of such periods of agony to be inflicted at intervals when the addict, with developing tolerance, loses the enjoyment of his rationed dose. It would be interesting to discover from any practical experience gained by Dr. Ellis in this sort of procedure what sort of doses of "hyoscine or a barbiturate" are recommended when the patient starts breaking the furniture.—I am, etc.,

London, W.1.

G. LAUGHTON SCOTT.

The Danger of Warming Transfusion Fluids

SIR,—It was common practice a few years ago to warm transfusion fluids by immersing the container in water at approximately 42° C. Under war-time conditions many medical officers discontinued this practice chiefly on account of the time involved in warming fluids. It was generally found to be satisfactory to allow the temperature of blood taken from the refrigerator to rise to that of the surrounding atmosphere. The rapid administration of even large volumes of fluid at atmospheric temperature did not result in an increased incidence of pyrexial or other reactions.

Apart from the time factor, however, there is another very good reason for discontinuing the practice of warming transfusion fluids—namely, the danger of overheating blood and plasma. That such a danger is not fully realized is illustrated by two recent cases in this Region. In each case the blood had been coagulated by immersion in very hot water. The loss of

fluidity prevented any attempt at administration in those cases, but the real danger is in cases where the warming is not sufficient to produce coagulation, but yet great enough to cause haemolysis. The transfusion of such haemolysed blood may have consequences as serious as the transfusion of blood of the wrong group.

Probably the only condition in which it is advisable to warm the transfusion fluids is in patients with a high titre of cold agglutinins, but even in these cases it is probably more important to keep the patient warm than to warm the blood. If, however, it is felt advisable to warm the blood and plasma as a routine before administration then the dangers of overheating must be impressed on those responsible for warming the fluids.—I am, etc.,

Glasgow and West of Scotland Blood
Transfusion Service, Glasgow.

JOHN WALLACE.

Vaginal Temperature

SIR,—Although only a medical student I should like to confirm Dr. G. I. M. Swyer's comments (Dec. 6, 1947, p. 931) regarding the adequacy of oral temperature records for the detection of ovulation. In the course of some investigations at the Melbourne University into body temperature it was found that such records showed the monthly biphasic fluctuations satisfactorily—provided due care was taken in obtaining the readings. It was certainly very much easier to persuade fellow students to co-operate by taking their temperatures orally than per rectum or vaginam.

As a matter of interest, for some time I kept a concurrent record of rectal and oral temperature. From this record it can be seen that the curve for oral temperature is reasonably consistently 0.5° F. (0.27° C.) below that for rectal, and shows parallel changes. Even the rise appearing after a restless night is similarly shown in each record.

Records will be most accurate if the temperature is taken immediately on waking, as oral temperature appears to alter more rapidly than rectal or vaginal. Needless to say the most easily interpreted charts are kept by those who wake at a regular time each morning. If the subject is a mouth-breather while asleep the mouth should be closed for five minutes before taking a reading.—I am, etc.,

Melbourne, Australia.

JOY L. JAMES.

Radiological Evidence of Age

SIR,—With 25 years' radiological experience, which includes nine years as radiologist to a children's hospital, I would agree with Dr. Bernard Sandler's view (Jan. 31, p. 226) that few experienced radiologists would care to be exact, even within a year, as to age judged by shadows of epiphyses, particularly since persistent non-union of epiphyses is not uncommon.

In forensic medicine lectures as a student I was taught determination of age by epiphyses, but had entirely to change my views with practical radiological experience. In a standard forensic medicine textbook before me it states the cartilages of the first ribs ossify at 20 years and "at the middle of life all the cartilages are ossified." Excluding cases of rheumatoid arthritic conditions, where rib ossifications can occur at quite an early age, I suggest that inspection of thoracic films will not generally show cartilage ossifications of a widespread type until 45 years or even later. If the more delicate radiological demonstration is not possible earlier I fail to see how gross macroscopic section of cartilages can show calcification.

Unfortunately the legal mind requires definite statements rather than true statements involving latitude. In a legal case, in chambers before going into Court, I told a K.C. exactly how far I was prepared to go in my evidence. He therefore had little interest in my evidence and pressed a doctor who had attended the plaintiff to extend his evidence, with the result that under cross-examination this was shown to be false, and the doctor was committed for perjury. I was pleased to hear this doctor had been found not guilty, as his evidence had been given in good but foolish faith and the K.C. was more responsible than the witness. My own experience is that medico-legal witnesses tend to acquire this legal attitude for definite statements only and in consequence give dogmatic statements as to

age, height, etc., based on fragments of tissues such as bones. These statements in a very large number of cases must be quite incorrect, but are often undisputed.—I am, etc.,

London, E.7.

BERNARD J. LEGGETT.

The Lazy Eye

SIR,—Dr. Margaret L. Foxwell's letter (Jan. 31, p. 228), defending Devon County Council from my allegation that the school ophthalmic service is curative and not preventive, implies that in other parts of the country the position is unsatisfactory, and I am glad to have the support of Dr. Foxwell for my case.

Devon County Council appears to take its ophthalmic service very seriously, and the system seems comprehensive with one important exception. Dr. Foxwell states that in Devon every child has a yearly visual acuity test, and any child not attaining the standard of 6/6 in each eye is referred for ophthalmic examination. This is satisfactory as far as it goes, but it is well known that a child may have 6/6 vision in each eye and yet have fairly high errors of refraction, likely to lead to a squint developing. The Board of Education's 1931 report emphasized the need for a *refractive* yearly examination of each child, and only when this requirement is met will the school ophthalmic service become truly preventive.—I am, etc.,

Henley-on-Thames.

S. BLACK.

Child Guidance and Youth Organizations

SIR,—Within recent times much publicity has been given to the increase in juvenile delinquency, while psychological and related features of its treatment and prevention have received frequent mention in the medical press. Does it not seem strange that this increase in juvenile crime should be contemporaneous with greatly enhanced social services and should mark the epoch of child-guidance clinics, of rise in the school-leaving age, and of considerable sums spent by Education Authorities on Youth Centres and other means of, as it has been said, "keeping children off the street"? In seeking some other factor to explain this anomaly one cannot but wonder how far it is related to another of the tendencies of our modern civilization. I refer to the breakaway from religious tenets.

In past times it was the faith of our fathers which underlay the moral standards for which our nation has long been renowned. As the discipline of religion is relaxed and forgotten so do these standards decay. This wide theme deserves much fuller recognition from our medical psychologists than most of them are wont to accord it. What I am here concerned with is a subsidiary of the main topic. Although the medical literature which deals with youthful delinquency and the psychological problems of youth abounds in references to all manner of agencies, preventive, educational, disciplinary, and punitive, mention of the standard youth organizations is all too conspicuous by its absence. The writer's personal association is with the Boy's Brigade, and this organization along with the Boy Scouts, the Church Lads' Brigade, and those groups which come within the sphere of influence of the National Association of Boys' Clubs together comprise a force undoubtedly to be reckoned with. Equally among girls the Girl Guides, the Girls' Guildry, the Girls' Life Brigade, and numerous excellent clubs are playing their part—and it is a big one—in the shaping of the national character.

In a number of instances probation officers and other disciplinary authorities are making use of the facilities our youth organizations offer. There is a real need for liaison between psychiatric workers on the one hand and the youth movements on the other. The latter are handicapped in that they enjoy a smaller financial backing than do the official and statutory bodies, while the standard of academic and technical knowledge possessed by their leaders is often less; and it is in this latter respect that I suggest the psychiatrist and psychologist could offer them genuine service. The morale of the youth organizations, *per contra*, is very high, while the relative hardships they suffer and the competition to which they each are subject are productive of a youthful vitality which is very invigorating. I am certain that were the psychiatrist and the social worker to endeavour to avail themselves of the facilities which the voluntary organizations offer they would find them at their service. It is equally certain that reciprocity of this kind will be mutually stimulating to the workers as well as beneficial to the young people concerned.

One point more—the addresses of the secretaries of the youth movements can readily be obtained from the youth secretary of the municipal or county education department.—I am, etc.,

Leicester.

D. T. MACLAY.