—a possibility unfortunately abundantly refuted by experience. The statement that the changes of icterus gravis are due to agglutinative thrombi in the vessels of liver, bone marrow, and brain is only an attractive speculation which is, unfortunately, divorced from reality and is in direct conflict with all the morbid anatomy of the disease. The post-mortem appearances provide unmistakable evidence of long-continued pre-natal haemolysis, and the extra-medullary haemopoiesis which is so conspicuous a feature of many cases cannot conceivably have developed only after birth.

In conclusion I can only agree with the last sentence of your annotation, but this is just what the American writers cited have failed to do; instead they have promulgated a theory based on pure speculation without a shred of clinical or pathological evidence to support it.—I am, etc.,

The University, Glasgow.

D. F. CAPPELL.

REFERENCES

- Cappell, D. F. (1947). *Brain*, 70, 486.
Potter, E. L. (1947). *Rh.* H. K. Lewis, London.

Iridocyclitis Treated with Benadryl

SIR,—I found the letters of Dr. Barbara Shaw (Feb. 7, p. 277) and Dr. J. Moss (Feb. 21, p. 367) on this subject interesting. A patient of mine here, an ex-naval officer, has had recurrent attacks of iridocyclitis for many years and has seen several specialists in addition to many general practitioners.

As the condition always occurred in the right eye only, and dated from his service in submarines during the Kaiser's war, he always referred to it as "periscope eye." I usually relied on atropine and heat, but the various specialists have advised a very varied range of treatment, from arsenicals and pot. iod. to colonic irrigation, prostatic massage, and injections of milk! Last year he had an attack which I treated for a short time with sulphapyridine, but as there was no obvious response I put him on to injections of "acetylarsan" and emetine. This attack lasted for 12 days and was the shortest he had had then.

This month he surprised us all by a fresh attack, but in the left eye for the first time on record, which rather upset the periscope aetiology. I was afraid that occurring in a new eye it might be more severe than before, but I treated it with atropine and hot spoon bathing as before, emetine and acetylarsan, and "benadryl" in addition. This attack is the shortest he has had, and he was clear in nine days this time. I cannot say for certain whether the benadryl actually shortened the time, but its soothing and soporific effect was a great help and the patient appreciated it very much.

The rationale of emetine is that he has suffered in the past from dysentery, and in this colony a great percentage of people sooner or later suffer from chronic amoebiasis and require emetine periodically.—I am, etc.,

Nanyuki, Kenya Colony.

G. DUNDERDALE.

Barium Enema and Acute Intussusception

SIR,—Drs. Brenda Morrison and Donald Court are to be congratulated on their excellent account of "Acute Intussusception in Childhood" (April 24, p. 776), but as stated in the annotation (p. 794) "some may differ from them" on their attitude to barium enemata as an aid to diagnosis and as a method of treatment.

As quoted by Morrison and Court, the papers by Nordentoft,¹ Nyborg,² and Hipsley³ show that the barium enema can be of great value both in diagnosis and treatment of early acute intussusception.

In two such cases which I saw as surgical registrar at the King George Hospital, Ilford, barium enemata were found to be of value.

Case 1. A well-nourished baby boy, aged 7 months, was admitted 14 to 15 hours after the onset of what seemed to be spasmodic abdominal pain. There was no vomiting, nor was there any blood detected on rectal examination; while the abdomen, though carefully palpated, held no definite lump.

An enema was slowly administered, under anaesthesia, using a very thin mixture of barium; the progress of the barium was followed by viewing with a screen, and the invaginated loop of ileum was clearly seen to "unfold" itself as far as the ileocaecal junction, when the ileum seemed to "jerk" itself back to its normal position. Two days later the child was home, fully recovered.

Case 2. This child was also suspected of having an early (18 hours) acute intussusception, but again the signs were not sufficient to warrant operation. A barium enema confirmed the diagnosis,

and also appeared to reduce the intussusception, though no "jerk" was seen. In this case, however, pain and vomiting recurred after a short interval, and at laparotomy an early ileo-caecal intussusception was found. Reduction in the usual way was followed by uneventful recovery.

These cases illustrate how a barium enema can be of value in diagnosis in the early stages of intussusception, and when the classic picture is not presented. In Case 1 it was of obvious value as a mode of treatment. Though a failure as treatment in Case 2, the diagnosis was confirmed and no harm resulted.

In this way early cases can be diagnosed, instead of being allowed to become late cases by the "wait and watch" method of observation; whilst in addition to the diagnosis being made the condition may be cured at the same time—thus making operation unnecessary. According to Babcock⁴ 60% of intussusceptions are reducible in the first 24 hours by hydrostatic pressure.—I am, etc.,

London. N.W.6.

PHILIP HOPKINS.

REFERENCES

- ¹ *Acta radiol., Stockh.*, 1943, 24, 484.
² *Acta chir. scand.*, Supp. 80, 1943, 89, 1.
³ *Surgery*, 1937, 1, 825.
⁴ *Text Book of Surgery*, 1935. W. B. Saunders: Philadelphia and London.

Late News

SIR,—Being a weekly issue, the *Journal* is at times necessarily a week and more behindhand with medical news of importance to members. This delay is added to when the *B.M.J.* is not delivered by post till Monday or even later. And so the daily lay press gets in first with some selected snippet of news which reaches client or patient casually before the doctor to whom in these anxious days it may be of the first importance. What has taken place at Council or R.B. meetings, or at local meetings, or what emanates from a Government department, he gets late, perhaps when already stale.

Members, being widely scattered, depend upon the *Journal* for ungarbled facts for which they have to wait impatiently. In these days, when things move so fast, could not a column or part of one be given in the *Supplement*, whose news looms greater in importance than ever before, in the form of a "Latest News Summary" framed by the publicity department of the Association under the watchful eye of the Editor; this to publish happenings from local as well as Headquarters sources? —I am, etc.,

Bournemouth.

S. WATSON SMITH.

Association of Medical Records Officers

SIR,—The need to improve the techniques of medical record keeping has frequently been a subject of discussion, but until comparatively recently little organized action has been taken. Whilst it is recognized that the standard of clinical records is and must remain a medical responsibility, it is thought that this responsibility could be lightened, and medical time and expense saved, by the provision of trained lay assistants. With this end in view an Association of Medical Records Officers has now been inaugurated and it is felt that the medical profession will give their co-operation and guidance whenever it is sought, as they have always done in such matters in the past. Two of the Association's aims are:

(1) To promote the development of techniques in medical record keeping, to diffuse among the members and others all information and technical and general knowledge from time to time available regarding the keeping of medical records or of use in connexion therewith.

(2) To provide opportunities by means of lectures, discussions, or other intercourse among the members for the exchange of information and opinions regarding the method, processes, and technique of medical record keeping.

Training courses for lay personnel already responsible for medical records are being organized in several of the Regions as an interim measure preparatory to a more comprehensive scheme of training. Records officers interested in these training courses and in membership of the Association are invited to get in touch with the honorary secretary.—We are, etc.,

B. BENJAMIN,

Statistician, Public Health Department,
London County Council (Chairman of Council).

ELSIE ROYLE,

Records Officer, Christie Hospital and Holt
Radium Institute, Wilmslow Road,
Manchester, 20 (Hon. Secretary).