minutes to a routine Trendelenburg operation and is, in my opinion, always worth while doing before embarking on a major operation like lumbar sympathectomy.—I am, etc.,

Coventry.

P. E. ROLAND.

Prevention of Venereal Disease

SIR,—I feel obliged to add my testimony on the subject of prevention of venereal disease to that of your correspondents in the *Journal* of July 31 (p. 268). I am sure that to rely upon methods of prophylaxis to be applied after exposure to infection is to court failure. The attention to detail necessary to make them efficient is rarely available, and the false sense of security given simply encourages risks to be taken. Dr. Earle Moore, with his vast experience, has no doubt that prophylactic treatment if properly carried out can be of value, but he says the average man will not take the necessary trouble; and when one remembers how often the patient was more or less under the influence of alcohol when the risk was taken this is not surprising. If anything is to be done on such lines of prevention, surely the use of a rubber sheath is much simpler and more likely to be carried out; this indeed is what I am in the habit of telling those patients who seem unlikely, in spite of all one can say, to abstain from future risks.

Finally I must add that I am astonished Lord Horder (July 17, p. 171) should take such a pessimistic view of the present situation. Looking back over the 25 years that I have been in charge of a fairly busy clinic I feel that, owing chiefly to the action of the Ministry of Health in making the public "V.D. conscious" and in providing free treatment, we can reasonably anticipate a continuation of the improvement which was so marked before the war and which is now showing itself again. That war conditions should cause a relapse was inevitable and to be expected. Has not this happened in every war since syphilis was first brought to Europe by soldiers in the sixteenth century?—I am, etc.,

East Croydon, Surrey.

P. W. HAMOND.

SIR,—The sexual requirements of the individual vary immensely, and each is entitled to judge for himself or herself whether extramarital relations are right or wrong. There can never be a standard sexual morality. The problem is therefore a moral one for the individual only. To regard V.D. as a moral problem, as does Dr. G. L. Russell (July 31, p. 268) is to be prejudiced. It would appear from what Miss K. B. Hardwick writes (p. 269) that the Association for Moral and Social Hygiene, having found chastity as an ideal unsuccessful, is now preaching chastity as an anti-V.D. device.

The first essential in any campaign against V.D. is to stop looking upon extramarital relations as a disease in itself. The lack of a marriage certificate does not transform sexual experience from something beautiful into something ugly and shameful, but the present official outlook of Church and State, by driving sex into back streets and sordid lodgings, does precisely that, and at the same time favours the spread of V.D. The inevitability of extramarital sex relations must be accepted, and every effort made to keep such relations, if not on a spiritual, at least on a healthy physical level.

All anti-V.D. appliances should be banned until some really efficient method is discovered, and V.D. propaganda stopped. Would not anti-T.B. propaganda be of more value in its own field? Surely the early symptoms of pulmonary tuberculosis are more insidious than those of any of the venereal diseases, and early treatment more important.

Until some super prophylactic drug which can be taken by mouth comes along, legalized and controlled prostitution, as was carried on until recently in France, is the only sure method of V.D. control. The termination of this system in France has led to an increase in V.D. The relaxation of official harshness manifested in the adoption of such a system would also do much to establish a healthier outlook on sexual matters, and a more sensible attitude to V.D. A quotation from *Sex, Life, and Faith* by Rom Landau is appropriate, "The number of divorces for sexual misdemeanour is much smaller in France than in Great Britain . . . they have suffered far less from neuroses or sexual aberrations. Evidently their more frank and natural approach to the problem of sex is to some extent responsible."—I am, etc.,

Edinburgh.

W. B. LAING.

Confidential V.D. Treatment

SIR,—By her complaint against the Minister of Health for removing the statutory requirement of secrecy about V.D. Miss Katharine B. Hardwick (Aug. 7, p. 313) fails to see the wood for the statutory trees and betrays signs of a legalistic mind out of touch with realities.

When in 1916 the V.D. service was started the Government accepted the recommendations of the Royal Commission on Venereal Diseases that attendance should be voluntary and free, but added a statutory requirement of secrecy which was not one of the Commission's recommendations. No doubt this addition was made for propaganda purposes to beguile an unprepared and possibly distrustful public into voluntary attendance at V.D. clinics. No doubt also the provision was inserted in deference to the fears of those who thought that the public would not regard public clinics as sufficiently private and that therefore V.D. would still be treated inefficiently in an underground manner by unqualified persons.

Whatever the reasons for inclusion of the provision of statutory secrecy there is no doubt that after more than thirty years of experience of the V.D. service the public is firmly convinced that the staffs of V.D. clinics do in fact maintain the greatest secrecy, and few members of the public who use the V.D. clinics are as well informed as Miss Hardwick about the legal background or as impressed by its power.

Having worked in V.D. clinics for many years I have no hesitation in emphatically stating that the high standard of secrecy and confidence obtaining in these clinics is due neither to statute (as she asserts) nor to Ministerial hopes (as she agrees), but to the sense of responsibility and loyalty of the medical and lay staffs, who have learned during more than thirty years' experience the great importance of securing the trust and confidence of their patients. Secrecy is now so strongly entrenched by custom in the minds of public and clinic staffs alike that a statute is unnecessary to buttress it. Rather than complain that a Minister of a Socialist Government revokes regulations we should congratulate him and those who advised him for removing unnecessary legal lumber.

Finally, by encouraging ventilation of the Minister's revocation of statutory secrecy Miss Hardwick is tending to obtain the very opposite of what she wants. If she says from the mountain tops that there is now no secrecy about V.D. (because it is not statutory) not only is she publishing error, not only is she casting an unwarranted slur on the devoted staffs of V.D. clinics, but she is herself likely to cause unfounded doubts to arise in the minds of the very public she wishes to protect.—I am, etc.,

London, N.W.5.

F. R. CURTIS.

Thiouracil in Treatment of Thyrotoxicosis

SIR,—We should be grateful to Professor H. P. Himsworth (July 10, p. 61) for his lucid exposition of the status of thiouracil in the treatment of thyrotoxicosis. For more than a year I have taught that white counts are not a routine necessity in thiouracil therapy, but that they should be done in the three following circumstances: (1) In the first few weeks of treatment they are valuable in order to detect the occasional case in which granulopenia reaches a dangerous level. It is helpful to know the usual white cell level of each patient, for this varies greatly in different individuals (my own white count is usually between 4,000 and 5,500 with about 50% to 60% of polymorphs), and it is correspondingly difficult to generalize regarding the level of granulopenia. (2) A white count should be done whenever the minor toxic effects of thiouracil appear. By themselves these manifestations do not call for cessation of the drug; it is the level of the white count that matters. (3) Agranulocytosis: I fully agree with Professor Himsworth that routine white cell counts are no safeguard in preventing or detecting this dangerous complication.

I believe that the quickest way of dealing with a suspected case of agranulocytosis is to make a thick film of peripheral blood, as is done in the diagnosis of malaria, and stain it with Field's stain—a few seconds' gentle agitation in solution A, then in distilled water, then in solution B, and finally in water again. Anyone can make a good thick film if they trouble to practise, and most people should be able to distinguish a polymorph in a thick smear. Given a microscope and the necessary stain (which

can be carried in screw-capped bottles wide enough to admit a microscope slide) the method should be within the scope of any competent practitioner.—I am, etc.,

Liverpool.

F. J. ZACHARIAS.

REFERENCE

¹ Field, J. W., *Bull. Inst. med. Res., Federated Malay States*, 1941, No. 2.

Dietetic Treatment of Hepatic Cirrhosis

SIR,—In the leading article under the above heading (June 5, p. 1089) you suggest among other considerations the use and clinical test of antithyroid drugs in the treatment of human hepatic cirrhosis. It is a pleasure for us to let you know briefly about our work in this subject since 1946. We used thiouracil in 11 cases of human cirrhosis based on the works of György and Goldblatt (*Science*, 1945, 102, 450). These authors demonstrated that the addition of thiouracil in the cirrhosis diet for rats plays a powerfully preventive role. In our group of patients the drug was used in amounts of 0.6 g. per day with a total dosage which fluctuated between 3.6 g. and 20.4 g.

In order to estimate the effects of this treatment three groups of cirrhotic patients of the same condition were studied—one group (the control) with hydrocarbonate diet, glucose, serum, and paracetamol; a second with a hyperprotein diet and vitamin B complex; and a third with hyperprotein diet, B complex, and thiouracil. The results of these different systems of therapy are summarized in the following table.

Group	No. of Cases	Better	Results Same	Worse
I	9	1 (11%)	4 (44.5%)	4 (44.5%)
II	17	7 (41%)	4 (24%)	6 (35%)
III	11	7 (63.6%)	1 (9%)	3 (27%)

Those requiring further information may like to refer to our paper in *Jornadas Clinicas de Verana, Chile* (1947, 2, 291).—We are, etc.,

Viña del Mar, Chile.

C. SILVA LAFRENTZ.
D. VERDUGO BINIMELIS.

Liquid Paraffin in Baking

SIR,—In the leading article entitled "Liquid Paraffin Risks" (June 12, p. 1141) mention is made of the potential dangers inherent in the use of medicinal paraffin and other less refined mineral oils in baking. The work of Frazer and his colleagues indicating the possibility of liver and other damage due to mineral-oil absorption when ingested as finely dispersed emulsions of particle size less than 0.5μ is reported, and comment is made on the lack of information regarding mineral oil distribution when dispersed in flour products, such as cakes and pastry, baked with liquid paraffin as a replacement for vegetable fat.

We have recently examined some emulsions containing mineral oil before and after heating, the unheated emulsions containing particles ranging in size from less than 0.5μ to 10μ or greater. On heating, the individual oil particles coalesce, forming larger aggregates, until ultimately the emulsion is completely broken into two layers. It might be anticipated therefore that, after incorporation of liquid paraffin in a cake batter, on baking the emulsified material would break down and no particles would remain in the final product less than 0.5μ in size. This supposition is not, however, in accord with the observations herein reported. Examination, using a Reichert optical system, of sponge-batter smears containing liquid paraffin, baked in a micro-oven (to be described elsewhere) and under continuous observation on a glass screen, indicated that although some aggregation of the initially finely dispersed liquid paraffin did occur there still remained in the final product some particles approximately 0.5μ in size. The smears under examination were taken from a bulk batter composed of cake flour 14 g., sugar 10 g., dried egg 3 g., baking powder 1 g., water 10 ml., and liquid paraffin 15 ml. A red, oil-soluble, water-insoluble dye was used to colour the liquid paraffin in order to differentiate it from the other constituents of the batter. Magnification was 600 diameters and the observation screen had a scale etched thereon so that direct observation of particle size could be made.

In the experiment quoted some 30% of the total number of liquid paraffin particles present in the uncooked batter were about 0.5μ in size, and although this percentage was con-

siderably reduced after baking some very small particles were still clearly discernible. It should be noted that the actual weight percentage of the original mineral oil used that would exist in this fine state of subdivision would be extremely small, and it might be claimed that even on continuous ingestion over long periods absorption of sufficient oil likely to cause liver damage might not occur. Nevertheless the very existence of a number of small particles which come within Frazer's classification as potentially liable to cause liver damage suggests the desirability of ascertaining whether there exists a threshold limit to their number before damage becomes real.

The work of Alvarez¹ indicates, however, that the fine emulsification necessary for liver damage can be effected by the bile acids, oleic acid and glyceryl monostearate, which may be found in the bowel. In this connexion it should not be overlooked that glyceryl monostearate is a common emulsification agent and is, in fact, now used in the preparation of certain foods. It would appear therefore that, even though the number of particles of mineral oil of size less than 0.5μ appears to be considerably reduced on baking, this may be immaterial inasmuch as subsequent ingestion may well restore the level of such particles to the original value. Further physiological investigation on these points is clearly desirable, as the problem would appear to be of even wider significance than the editorial previously referred to implies.—We are, etc.,

The British Baking Industries
Research Association,
Chorleywood, Herts.

J. B. M. COPPOCK.
R. C. A. BRADSHAW.

REFERENCE

¹ Alvarez, W. C., *Gastroenterology*, 1947, 9, 315.

Comprehensive Child Health Service

SIR,—Dr. H. R. Youngman's letter (Aug. 7, p. 313) stirs me to comment on the recent correspondence on this subject. A high percentage, I should say the majority, of complaints for which the child is brought to the doctor these days are described as behaviour problems—e.g., feeding problems, sleeplessness, bed-wetting, etc. These are usually the result of home conditions and parental mismanagement. How can a "clinic" doctor appreciate these conditions unless he has an intimate knowledge of the complete home picture and of all its members? To abolish the general practitioner would be to kill the root and main stem of medicine—its specialist branches would then soon wither and die.

What we want are more general practitioners with better undergraduate training in paediatrics, who have time to know and understand the home life of their patients so that with the aid of improved housing conditions and social services behaviour problems can be more easily corrected or even prevented. Then we shall find the paediatric specialist will be superfluous.—I am, etc.,

London, N.W.7.

C. ELAINE FIELD.

Geriatrics

SIR,—The first supplement to the report of the B.M.A. Committee on the Care and Treatment of the Elderly and Infirm (Aug. 7, p. 71) contains several interesting recommendations for the solution of the chronic-sick problem. However, one important point seems to have been overlooked—this is the need to train more doctors in the special techniques which have been evolved by such hospitals as the West Middlesex, Orsett Lodge, and St. John's, Battersea. It is probably true to say that a hemiplegic patient treated by Dr. Marjory Warren's methods has a better chance of complete recovery than one not so rehabilitated. A patient with incontinence of urine is just another bed-wetter in hospitals where Dr. Thomas Wilson's cystometric technique is unknown. A chronic arthritic treated by Mr. Grant Waugh's procaine-lactic acid injections has prospects of improvement undreamt of by those who have not used this method.

In the same way the rehabilitation of elderly patients can reduce the number of bedfast patients considerably, as mentioned in the report.

Why does the Ministry of Health take no steps to make this special knowledge available throughout the country? The discoverer of a new form of treatment for cancer would probably be given every facility for making his techniques known