important duty to educate. Indeed, they may be conditioned into believing that there is something reprehensible and shabby about refusing patients' every whim and fancy.—I am, etc.,

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S. H. F. HOWARD.

Tuberculosis in the Elderly

SIR,—Your leading article of December 29 (p. 1737) rightly stresses the importance of the middle-aged and elderly males with tuberculosis as foci of infection in the community.

The results of sanatorium and domiciliary treatment in India reported by Fox¹ have confirmed the findings in this country² of the comparative insignificance of bed-rest as compared with chemotherapy. Ambulant treatment is quite justifiable where a high proportion of the population is already infected by tuberculosis. In this country, where now a big percentage of young adults are tuberculin-negative, or only positive as a result of B.C.G. vaccination, there is no justification for running the risk of further spread of disease in the population by infectious patients who are undergoing ambulant treatment. As we now have enough beds, admission of bacillary excretors should be the order of the day whenever suitable isolation under good home conditions is not practicable. In the majority of cases infectiousness ceases after a few months of treatment, and though chemotherapy for about two years may then be necessary there is no reason against ambulant treatment of the now non-infectious case.

With tuberculosis epidemiological problems vary with epoch and with environmental circumstances. When there is a high level of tuberculinization present in the community and there are many infectious patients at large, a few extra foci of infection on ambulant chemotherapy do not make much difference. The fact that they are being treated is so much to the good. When, however, the level of tuberculinization from natural infection is low and infectious tuberculous cases at large comparatively few, it is much more important to isolate infectious patients.

At the present time when ambulant treatment seems (and is) so attractive for the individual infectious patient, its dangers for the community need to be stressed in the conditions in this country. It is important that the elderly patient's reluctance to start his antituberculous treatment in hospital should not be reinforced by reference to practices which, though wholly commendable in India, do not have the same force here and now.—I am, etc.,

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Treatment of Macroglobulinaemia

SIR,—The communications by Dr. N. Conway and Dr. J. Miles Walker (November 17, p. 1296) and by Dr. F. Bedo Hobbs (December 15, p. 1618) prompt me to draw attention to the use of alkylating agents in the treatment of Waldenström's macroglobulinaemia.

The disorder is a reticulosis, characterized by the appearance, particularly in the marrow and in lymph nodes, of a pleomorphic infiltrate, in which lymphoid

cells predominate.^{1,2} Certain of these cells produce a macroglobulin,³ which then appears in varying concentrations in the blood. The disease may pursue a relatively benign course for many years,⁴ during which no specific therapy is required. Sooner or later, however, it becomes rapidly progressive. This is manifested by a further rise in the serum macroglobulin level, which may eventually constitute 50% or more of the total serum proteins, and by the development of many of the clinical features associated with the disease; death has been usual within six months of the onset of this change in the rate of progress of the disease.

Destruction of the infiltrate would appear to be a rational form of therapy, and the prolonged remission reported by Ferriman and Anderson,^{5,6} following treatment with nitrogen mustard and cortisone, is of considerable interest. Remissions of some years' standing have also been obtained by long-continued administration of chlorambucil.^{7,8} Response to this drug is slow. Plasmapheresis is especially valuable as an additional short-term measure when rapid clinical improvement is imperative—for instance, in cases in which coma or thrombosis of the central retinal veins is impending.⁹—I am, etc.,

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D'A. KOK.

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Detection of Glaucoma

SIR,—Following the recent correspondence it may interest your readers to hear of our experience in carrying out 477 routine tonometries in individuals 40 years old and over.

We decided to carry out this procedure at our periodic examinations after reading the work of Reed *et al.*¹ and Bendor-Samuel *et al.*,² who found that 2% of persons over the age of 40 have unrecognized glaucoma and that routine tonometry was the best method of detecting it.

We arranged, through the kind help of Mr. E. C. Zorab, consulting ophthalmologist to Southampton Eye Hospital, to have two of our staff trained in the use of the Schiøtz tonometer at the Southampton Eye Hospital. This involved attendance at two tonometry sessions, where they quickly mastered the art.

We bought one Schiøtz tonometer and an ultra-violet tonometer sterilizer which sterilizes the instrument in under two minutes. This proved a valuable time-saver. Our method is as follows: The patient lies on a couch and the eyes are anaesthetized with 1% amethocaine drops. The readings are then taken and "polyfax" ointment is instilled. The patients are told to return on the following day, when the eyes are stained with fluorescein and examined for corneal lesions. In our series no corneal damage has been observed. In each case the total time taken is about eight minutes—five for

tonometry itself and three for the check on the following day.

We started routine tonometry at routine periodic examinations in April, 1961, and to date we have examined 477 patients. Only two patients have declined the test. The majority of patients are co-operative and interested.

Total number of patients examined	477
No. of individuals with raised intraocular tension (above 29 mm./Hg)	9
No. of cases confirmed as glaucoma	3

Our practice is to refer patients with intraocular tension of 29+mm./Hg to their own doctors. The three confirmed cases had not previously been diagnosed as glaucoma, and would presumably not have been found till a later date had we not carried out this procedure.

In summary, we believe that the effort has been worth while.—We are, etc.,

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J. L. J. DE BARY.

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"Ancoloxin" and Foetal Abnormalities

SIR,—We have been investigating the cases of foetal abnormality reported in the letter from the Epidemic Observation Unit of the College of General Practitioners (December 1, p. 1446).

The object of our investigation has been to compare the date of "ancoloxin" administration with the embryological stage at which the deformity must have occurred. The results are as follows:

Case No.	Abnormality	Time of Ancoloxin Administration from L.M.P. (Weeks)	Critical Embryological Date from L.M.P. (Weeks)
1	Meningocele	10	6
2	Meningocele, hydrocephalus, and bilateral talipes	8	6
3	Meningomyelocele, flaccid legs, and patulous anus	8½	6
4	Spina bifida, microcephaly, and hydrocele	7½	6
5	Hypoplasia of lungs, kidneys, and gall-bladder	—	—
6	Imperforate anus	8	8–10
7	Rudimentary thumb	20	8½
8	Vascular naevus on neck	7½	Not applicable
9	Bilateral talipes	9½	" "
10	Pyloric stenosis	6½	" "

Cases 1 to 4 were C.N.S. defects of the spina bifida group. The first stage in this type of malformation is non-closure of the primitive neural tube, which normally closes by the third¹ to the fourth week (sixth week from L.M.P.). In these cases the neural tube was therefore already defective before ancoloxin was given.

Case 6, now 3 years of age, had an anal membrane which was corrected by surgery. The child now has normal function and control. The anal membrane is said to break down at the eighth week, and in this case ancoloxin was given during the material time. We are not aware that the incidence of this type of malformation has increased during the seven years ancoloxin has been used.

In Case 7, which occurred five years ago, an examination of the mother's record card showed the first antenatal visit at the 12th week. Ancoloxin was recorded as having first been given at the 20th week, but the mother thinks it may have been prescribed on her first visit. Even if the mother's recollection is correct after five years the material date for this type of deformity is eight and a half weeks.

Cases 8, 9, and 10 represent conditions for which no material dates in pregnancy are applicable. Case 9 was reported as suffering from mild talipes. No treatment has been given, and now, at 14 months of age, he is regarded as normal. Case 10 is a typical example of hypertrophic pyloric stenosis developing six weeks after birth in a first-born male. This condition was suggested by Cockayne and Penrose in 1934² as being transmitted by a faulty gene. Many such cases have now been recorded in successive generations and in the same family, thus supporting this view.³ We are unable either to associate or to dissociate Case 8, the small vascular naevus, and ancoloxin.

Retrospective investigations of cases scattered all over the country have their difficulties; for example, in Case 5 both the doctor and patient have left the practice and we have so far been unable to trace the records. We should, however, like to thank the general practitioners concerned who have so willingly collaborated with us.

We have personally investigated other cases reported to us, both in this country and in the Commonwealth. No pattern of abnormality such as one would expect from a drug-induced condition has emerged. The occurrence of meclozine administration and foetal abnormality in the same pregnancy is, in our opinion, purely coincidental and an expression of nothing more than the widespread use of a drug which has been taken in early pregnancy by an estimated 10,000,000 women throughout the world.—We are, etc.,

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SIR,—Dr. L. A. Ruben (December 1, p. 1469) is to be congratulated on his timely letter condemning the monstrous press conference called by the Perinatal Mortality Surveyors of the National Birthday Fund.

Recently I read in the public press that the College of General Practitioners had unearthed mounting evidence that "ancoloxin" (meclozine and pyridoxine) was unsafe if given in early pregnancy. As I have used this drug with excellent results for the past six years, I awaited the arrival of my *B.M.J.* (on Monday, December 3!) with considerable anxiety. I noted with relief that the evidence was almost unbelievably flimsy. Ten unrelated cases of congenital abnormalities were quoted. These abnormalities were distinguished by their diversity in contrast to the almost universal pattern of phocomelia which distinguished the thalidomide victims. These abnormalities were all common long before ancoloxin was discovered, and I certainly remember reading no reports, either in your journal or elsewhere, that any of the abnormalities mentioned had shown any increase in the ten years since ancoloxin was first marketed.