the only tonometer which can be used by opticians, and over 200 cases of incipient glaucoma are said to have been detected and referred to ophthalmic surgeons through its use. Its routine use may well enable many patients to avoid the consequence of established glaucoma.

The principle of this instrument is the same as that of the guard-ring electromanometer developed in this hospital for obstetric work and described in the *Journal of Physiology*¹ and the *Journal of Obstetrics and Gynaecology*,² and it is made by Biotronics, Inc., Oakland 12, California, by agreement with the National Research Development Corporation.

It would be interesting to learn whether opticians in this country should be encouraged to screen patients for abnormal intraocular pressures with this type of device.—I am, etc.,

Surgical Unit, C. N. SMYTH.
University College Hospital, Medical School,
London W.C.1.

REFERENCES

- ¹ Smyth, C. N., *J. Physiol.*, 1957, **137**, 3P.
² ——— *J. Obstet. Gynaec. Brit. Emp.*, 1957, **64**, 59.

Lead-poisoning

SIR,—It was with something approaching consternation that I read the article on the treatment of lead-poisoning with oral penicillamine by Dr. A. Goldberg *et al.* (May 11, p. 1270). While not quarrelling with their results, I must take exception to certain statements they make.

First, any worker who "finds it impossible to wear a mask constantly" can only be likened to the deep-sea diver who needs to take his helmet off occasionally—they are both in the wrong job. Secondly, the general standard of hygienic equipment should be of sufficiently high standard to allow the ignoring of drug prophylaxis. If drug prophylaxis is used there is no incentive to raise hygienic standards. I regard the use of drug prophylaxis as a frank admission of failure. Once it has been instituted it is not possible to ascertain the effectiveness of any new hygienic measures.

During the past eight years we have had no cases of lead-poisoning or intoxication in this factory, and it is five years since I have had to move a man off lead work. During this eight-year period some thousands of tons of soluble lead products have been manufactured. This record had been attained only by constant surveillance and high standards of hygiene.—I am, etc.,

I.C.I. Dyestuffs Division, G. I. BENSON.
Derby.

Smallpox Vaccination

SIR,—Dr. J. A. Dudgeon's reference to Dr. Charles West and vaccination at the Hospital for Sick Children, Great Ormond Street, in his paper on the development of smallpox vaccination (May 25, p. 1367) prompts me to make two observations. First, Dr. West learned his paediatrics at what is now known as the Royal Waterloo Hospital, founded in 1816 as the Universal Dispensary for Children. The extermination of "that most infectious and fatal of all diseases, the smallpox" and the promotion of vaccination were high on the list of objects drawn up by the founder, the enlightened and far-seeing physician, John Bunnell Davis.

Second, at the Foundling Hospital in November, 1800, "Dr. Mayo and Dr. Stanger were asked to report on the expediency of introducing the practice of

inoculating with the Cow Pox." In February, 1801, they recommended the vaccine disease as effective and a much milder and safer disease than smallpox. That the matter was not beyond dispute is shown by the suggestion in May, 1819, by the doctors at the hospital that they should return to inoculation with smallpox instead of vaccination. The committee found against the proposal.—I am, etc.,

London W.1.

ALFRED WHITE FRANKLIN.

Persistent Foreign Body

SIR,—It is generally realized that a foreign body can exist in various parts of the body for a considerable time without causing any symptoms, but the possibility of such a diagnosis is often apt to be overlooked, as it would seem to be improbable.

I should therefore like to report the case of a woman patient of mine, aged 62, who recently came to see me for a small ulcerating skin-lesion of the dorsum of the right foot in the region of the head of the third metatarsal. It had a hard base and slight serous discharge and was causing some pain, these symptoms having existed for only two or three weeks. Thirty-one days later she came to see me, thinking there was a piece of bone in the ulcer. There certainly was something hard to be felt, and I removed a splinter of glass over $\frac{1}{4}$ in. long (20 mm.), dagger-sharp, with a base of 4×2 mm. and weighing just over $\frac{1}{4}$ g.

There was no history of recent trauma, but I found that 12 years and 10 months previously I had attended her for a splinter of glass in the same foot between the heads of the third and fourth metatarsals, and had referred her to hospital after having failed to extract it. Whether or not a portion of glass was removed by the casualty officer I do not know. The patient told me she did have penicillin injections (and presumably the routine A.T.S.), but the fact remains that a splinter of glass remained for nearly 13 years in a restricted region subjected to continual heavy pressure, and yet it caused no symptoms whatsoever until very recently.

—I am, etc.,

Kirkby-in-Ashfield,
Nottinghamshire.

J. D. DURANCE.

Foreign Bodies and Operations

SIR,—The medico-legal memorandum printed in your edition of January 23 (p. 270), "Foreign Bodies Left in Patients at Operations," is a most timely and necessary summary of the present position as commonly understood, and no doubt the procedure is already carried out to the letter in most modern hospitals. But rigid adherence to these rules by no means guarantees freedom from conviction in the courts. A recent decision has cost a hospital and a surgeon in Kenya £2,500 damages and very considerable costs although all your criteria were religiously observed.

The story is as follows:

A woman had an operation for blocked Fallopian tubes at hospital "A." Twelve months later she was admitted moribund to hospital "B," where a desperate emergency operation was performed on her in her bed as she was too ill to be moved even on to the theatre table; at this operation a uterine ectopic pregnancy which had ruptured was found together with the polythene tubes from the previous operation. The surgeon removed all swabs of which he was aware and the swab count was reported correct by a very efficient senior theatre sister. Surprisingly enough the patient survived and left hospital very content.

Nine months later, however, she had a third operation for intestinal obstruction and at this operation a pack made of Turkish towelling was discovered in mid-abdomen and

removed. She sued hospital "B" and the surgeon who had performed the emergency life-saving operation.

Most unfortunately the incriminating swab removed at the third operation had been thrown away, but the opinion of the theatre staff involved was that it was a slightly different type to that used in hospital "B" and evidence was given that packs of that type were sometimes used at hospital "A," though no firm conclusion as to the ownership could be reached owing to its absence.

Varying expert opinion was given as to the behaviour of indwelling swabs, and one brave surgeon gave evidence that he had once removed exactly such a pack from a patient on whom he had operated 12 years previously.

The judge in the Supreme Court found that "the pack had probably been left in at the second operation" and that "the whole circumstances of this operation are more consistent with negligence on the part of the surgeon than the absence of it." Damages in the sum of £2,500 were awarded against the surgeon and the hospital jointly. This judgment seemed unnatural and unfair to all concerned (except the happy patient). The Court of Appeal held that the hospital had been negligent by its servants, reduced the damages to £750 and declared the surgeon to have done all he could and therefore not negligent. The Privy Council reinstated the original judgment.

Several questions therefore remain unanswered.

(1) Did the pack belong to the first or the second operation; is there in law any good reason to show that it could not belong to the first and therefore must to the second? And the corollary—if it did belong to the first what a miscarriage of blind justice this has been.

(2) Are there never any circumstances, however hazardous for the patient, which will allow such a pack to remain without it being held as "negligent" by the surgeon—a word which sounds very sinister to a skilled and honourable professional person?

(3) Must hospitals and surgeons always be held as insurers in all their acts in addition to the anxiety of their so often difficult tasks?—I am, etc.,

Kenya European Hospital
Association,
Nairobi, Kenya.

C. V. BRAIMBRIDGE.

"Slipped Disk"

SIR,—It now emerges from Mr. J. R. Armstrong's recent discursive letter (June 1, p. 1478) that his criticism of the terminology used in the television programme "Slipped Disks and Sciatica" is not confined to "slipped disks," but includes any and all of the technical medical terms in current use. Thus the words "protruded" (used frequently in the programme), "prolapsed," "herniated," "retropulsed," and "displaced" are utterly rejected on the grounds that they are "both incorrect and misleading, being inaccurate descriptions of a transient phase in one stage of a prolonged pathological cycle." By these same criteria it seems that his criticism should apply equally to his own slang expression "burst disk." The term Mr. Armstrong apparently favours is that of "lumbar disk lesion," but to the unbiased observer it would seem that whereas the phrase "protruded disk" does succeed in describing one, the most important, of the pathological results of disk degeneration, "lumbar disk lesion" is successful in describing none.

I am in full agreement with the view expressed by "A Consultant Physician" (April 20, p. 1090) that a television programme is not the place to introduce new technical terms, nor is it the place to exploit whims and prejudices about them. This is particularly true of a

nomenclature which, as defined by Mr. Armstrong, has not been accepted nor even generally recognized by the medical profession.—I am, etc.,

London W.1.

"SPECIALIST SURGEON."

Use of Bromides

SIR,—In his review of *Practical Therapeutics* by Dr. H.-J. B. Galbraith Dr. A. G. MacGregor states (May 25, p. 1406) that "there is surely no justification for the continued inclusion of bromides among the hypnotics."

I must categorically and emphatically disagree with this statement. I have both dispensed and prescribed many gallons of bromide solution to patients of all ages for over 20 years in general practice with satisfactory results both for patients and myself. Complications have been few and reversible. I am sure that many of my G.P. colleagues will agree with me in this. There are numerous cases in which the intelligent use of bromides works very favourably where the barbiturates and tranquillizers just do not.

Personally I hope bromides remain available for therapy for a long time to come, and my thanks are due to Dr. Galbraith for including a description of their use in his book.—I am, etc.,

Mansfield Woodhouse,
Nottinghamshire.

KEVIN MCCANN.

Capricious Capitals

SIR,—May I endorse Dr. H. de Glanville's plea (May 25, p. 1417) for consistent, and modern, typography?

Among this "plethora of capitals," however, one notices a particularly capricious point of medical usage. The proprietary names of drugs are always denied a capital, being granted only a somewhat supercilious pair of quotation marks: strange treatment for what is, after all, a proper name. You, sir, would find it not only incorrect usage but also discourteous, I think, if you found yourself addressed or referred to as the "editor" of the "british medical journal."—I am, etc.,

Abbott Laboratories Ltd.,

M. L. MORGAN.

Myelofibrosis

SIR,—It is a pity that your leading article on myelofibrosis (April 6, p. 900) revived the theory of the compensatory function of the liver and spleen in this disease. "As the increasing fibrous tissue interferes with the production of blood cells in the bone marrow, haemopoiesis recurs in the sites which are important in foetal life . . . consequently the spleen enlarges." It would be interesting to know the evidence on which this statement is based. Experience would rather show that splenic enlargement parallels the development of the marrow fibrosis, and many cases are on record in which myeloid metaplasia of the spleen was discovered in the company of a hyperplastic marrow and well before fibrosis set in. The spleen may also become fibrotic at the same time as the marrow. Were splenic myelopoiesis compensatory in nature, one would expect splenectomy in myelofibrosis to have dire results; the opposite is often the case. It seems in fact doubtful if either liver or spleen can ever "compensate" for marrow failure—they certainly do not when there is marrow aplasia. By now the evidence is extremely strong that both myelofibrosis and splenic myeloid metaplasia are part of the same syndrome of myelo-proliferation; and since the authors of at least one of the two recent reviews quoted