catheter and the connecting tube had then been strapped to the abdominal wall with Elastoplast strapping.

Two weeks later the patient made a complete recovery from renal failure with no significant abdominal symptoms, and at laparotomy the catheter was found to be lying free in the peritoneum very close to its initial point of insertion. It had excited no peritoneal reaction at all.

We had thought that our method of fixing the catheter (with purse-string suture and two separate pieces of plaster) was perfectly safe, but this is clearly not the case. Now we fit a small cuff of rubber pressure tubing (3 mm. $\times$ 5 mm.—Franklins Ltd.) over the catheter once the latter has been inserted and fixed with a purse-string suture. This cuff fits very firmly and can be pushed down until it is close to the abdominal wall, and the catheter can then be strapped in the usual way. We consider that this provides an adequate safeguard against a similar occurrence.

A further precaution would be the inclusion of a radio-opaque marker in the catheter, which is at present completely radio-transparent. In this patient's case we could not be absolutely certain before operation that the catheter was in the abdomen.—We are, etc.,

E. K. M. SMITH.

M. J. CHAMBERLAIN.

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Postgraduate Medical School,
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Purpura Associated with Ovarian Tumour

SIR,—Dr. G. M. McAndrew's memorandum on haemolytic anaemia associated with ovarian teratoma (21 November, p. 1307) prompts me to report a case of purpura associated with an ovarian tumour, which was cured by its removal.

Mrs. A. at the age of 41 developed menorrhagia and epistaxis, the latter being considered to be a menopausal phenomenon. Normal curettings being found, she was treated with intrauterine radium. A few months later after further bleeding she had deep x-ray treatment, which effected a menopause. Seven years later further vaginal bleeding was attributed to vaginitis associated with uterine prolapse, and she had colporrhaphies. She came under my care at the age of 51, taking Preludin (phenmetrazine) for her obesity and to give her energy. She was noted to have bruising of her arms and legs. She stated that she had had this for many years; it was painless and antedated her phenmetrazine medication. Nevertheless phenmetrazine was stopped for several months and blood tests were done. These showed no abnormality, quantitative or qualitative, in the formed elements, nor were the various "times" abnormal. She was regarded as a case of purpura simplex, ? cause as the purpura persisted. Six years later she presented with dyspepsia which proved to be due to a large benign pseudomucinous cystadenoma of the right ovary. Post-operatively she drew attention to the fact that the bruising had disappeared—and it had not recurred after a year.

Purpura simplex is classified as an anaphylactoid purpura by Whitby and Britton¹ and an autoimmune basis has been proved in some cases (thrombocytopenic or not).^{2,3} W. David⁴ was given eponymous recognition by Whitby and Britton up to the 1950 edition⁵ for his description of a haemorrhagic condition in women characterized by submucous and subcutaneous haemorrhages, with a normal platelet count, and which he believed

was due to ovarian deficiency, and is still quoted in Wintrobe.⁶

Whatever the mechanism I think it is worth adding unexplained purpura to unexplained recurrent pleural effusion (Meig's syndrome) and unexplained haemolytic anaemia as conditions where an ovarian tumour should be sought.—I am, etc.,

Leeds 17.

M. DALES.

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Tuberculous Immigrants

SIR,—The leading article on this subject (19 December, p. 1547) deplores the Ministry's decision that it is impracticable to x-ray immigrants at the port of entry. It has long been evident that to the Ministry anything is impracticable that is not politically desirable, and everything is practicable if it is politically desirable.

During the war I was in charge of an R.A.M.C. mass x-ray unit. On one occasion it was considered practicable (politically desirable) to x-ray all German prisoners of war. One thousand two hundred and ninety-one P.O.W.s were x-rayed by my unit in three days. It would be interesting to know why the Minister of Health should consider it is impracticable to x-ray immigrants. Surely the Minister does not believe that immigrants would think it vindictive to protect them from or cure them of disease? If it is a matter of expense and priorities, would not a scheme for x-raying immigrants be more rewarding than the present lung-cancer x-ray surveys which, according to U.S.A. findings, rarely reveal a case early enough for curative treatment and costs \$26,890 for each case of cancer detected.

Does not the Minister's attitude make a wasteful farce of the whole programme for the eradication of tuberculosis?—I am, etc.,

Rochester, Kent.

H. J. ROBINSON.

Dangerous Spectacle Frames

SIR,—The need for a wide visual field from the driver's seat of a car has often been emphasized in the technical press. Many years ago arbitrary standards of forward visibility were laid down by the motor industry of Great Britain covering such details as the height of a "standard" driver's eyes and the permissible obstruction by the bonnet and the windscreen pillars. More recent research has led to improvements in all around driver visibility, and now, in so far as vehicle design is concerned, driver visibility is very good indeed.

Considering the number of car drivers who wear spectacles, I do not know of any frame that does not to some degree constrict the wearers' visual fields. Dr. G. F. Taylor (19 December, p. 1597) cites the worst possible

frame design. Here, surely, is a field for profitable research—a spectacle frame and lens without any obstruction to the driver's vision.—I am, etc.,

WILLIAM GISSANE.

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SIR,—I read with interest Dr. G. F. Taylor's letter (19 December, p. 1597), having myself just reached an age when hypermetropia makes me more comfortable driving in glasses. The lenses of my glasses are supported only by fine nylon slings from a light tortoiseshell crossbar above. In spite of this I was immediately aware of a gross impairment of peripheral vision when wearing the glasses for driving. It was obvious to me that with my eyes focused for clear vision ahead through lenses, they were not focused for clear vision outside the field of the lenses.

Happily I am still able to focus clearly without glasses if necessary, and no doubt do benefit from the inconspicuous frame and high-set ear-pieces, but it strikes me the poorer one's vision without glasses the less use it would be trying to peer round the edges of them whether or not the view were obstructed by the frames. I suggest motorists should be advised to choose glasses designed to give a maximum field of corrected vision for driving. I would be most interested to know whether it is possible to construct a "wrap round" lens, giving a full field of corrected vision.—I am, etc.,

Mitcham, Surrey.

W. J. FERRABY.

"Epidemic Collapse"

SIR,—I was interested to read the fascinating account of the mysterious outbreak of "Epidemic Collapse" in Three Coventry Schools" (26 December, p. 1625). I wonder if the authors considered the possibility that these attacks they have described might have represented the "voluntary" syncope that can follow the performance of modified Valsalva manœuvres.

This, I submit, is not so unlikely as it sounds. Many children, particularly in the age-group 12–14 which was principally affected in the discussed outbreak, acquire the knowledge and technique of "making themselves faint," and I have heard of this practice assuming epidemic proportions in some schools in the past. I myself remember practising it when I was a schoolboy (not so long ago). With a group of friends, one by one, we used to stand erect in a clear space, overbreathe for about twenty respiratory cycles, then attempt forced expiration against a closed glottis until loss of consciousness occurred or until we were interrupted by one of our teachers, whose great alarm at the spectacle used to cause us great amusement. However, I also vividly remember how ill these manœuvres made us feel, and any of the symptoms described in the paper could have been applicable to our "post-syncope state." I must add, though, that our symptoms rarely lasted more than a few hours, but then we were not exposed to the vigilant interest of the public health authorities.

In support of my suggestion I would like to point out that practically all the cases reported appear to have had their onset on

school-days. Furthermore, according to the illustration, there seems to have been a remarkable drop in incidence at the week-ends. A very obliging "virus," this! I must admit that it is not so easy to explain, on the basis of my suggestion, the adult and pre-school home-contacts which are said to have occurred. But since this strange phenomenon excited much interest in the public health department and in the local press it may also have communicated itself too vividly to the imaginations of the patients, their associates and relatives, and even their family doctors. Consequently many cases, in reality unconnected with the epidemic, but which presented with the characteristic symptoms admitted by the authors as being "relatively common psychogenic manifestations," may have erroneously been included in the epidemic contact group. Similarly the concentration of attention which must have been focused on the affected children by those around them may well have prolonged the duration of their symptoms.

While I would be the first to admit the presumption inherent in any hypothesis postulated by someone not in possession of first-hand knowledge of the problem, I submit that my ideas on the aetiology of the "epidemic collapse" in Coventry, on the basis of the presented evidence, can be no less valid than this "ash-bucket" concept of "virus infection."—I am, etc.,

Edinburgh 5.

ALEXANDER FRAME.

Forceps Delivery

SIR,—As a general-practitioner obstetrician I would like to make a few observations on your leader "Forceps Delivery" (26 December, p. 1610). The majority of forceps deliveries occur in consultant units, but quite a few low-forceps deliveries are performed by general practitioners in cottage hospitals, and it is from this standpoint that I write. You quote an article,¹ which summarized says: (1) between one-third and one-quarter of infants born in the U.S.A. are forceps deliveries, the majority being low forceps; (2) the incidence of forceps deliveries from hospital to hospital varies from 10% to 60%; (3) comparing hospitals of high forceps rate with the low forceps rate there is no statistically significant difference regarding perinatal mortality or maternal and neonatal morbidity. It would appear, therefore, that a great many unnecessary low-forceps deliveries are effected. Yet, should not a procedure which does not increase maternal and neonatal risk but terminates quickly the second stage of labour be welcomed? Your leader partly answers this question when it says "the benign nature of the forceps operation can be accepted only with considerable reservation." The major reservation you seem to favour is that the operator should not suffer through lack of practice. Now, I have always felt that for a low-forceps delivery repetitive practice is not necessary in order to effect a competent delivery when the need arises: what is more important for the general practitioner is to be able to appreciate this need as dictated by the history and/or the physical signs referable to the mother and/or foetus. This he should be able to do within his present allowable obstetric categories for domiciliary confinement, provided (a) he has a basic obstetric training, and

(b) he personally attends a minimum of approximately 20 confinements per year. His forceps rate will not be high, but I do not see that his lack of practice is going to tarnish any obstetric survey. I would qualify this point by referring to your definition of ideal conditions for a low-forceps delivery—namely, "head on the perineum, with the anus dilating with each pain, with the sagittal suture in the antero-posterior diameter of the pelvic outlet." To this I would add that the occiput should be anterior. The technique of forceps delivery is much the same whether, under the above conditions, the occiput is anterior or posterior, but the latter demands a larger episiotomy. The important point is that the practitioner appreciates (a) the position of the occiput is important, and (b) he is able to identify that position. Whether he has done six or only one forceps delivery in the past three months is not going to affect his acquired technique.

My remarks are confined to low-cavity forceps because they constitute the majority of all forceps deliveries, and are likely to be the only ones a general practitioner will and should perform. Further, all low-forceps deliveries lend themselves to local anaesthesia and thereby eliminate a real hazard—the general anaesthetic.—I am, etc.,

T. M. WINSTANLEY.

Ruthin, Denbighshire.

REFERENCE

- ¹ *Amer. J. Obstet. Gynec.*, 1964, **89**, 568.

Chlorhexidine

SIR,—In your issue of 12 December we have read with interest the review of antiseptics under "To-day's Drugs" (p. 1513), but we would like to draw your attention to some minor inaccuracies which appear in the section describing chlorhexidine (Hibitane).

Both the acetate and the gluconate are soluble in water and also in alcohol.

The forms of chlorhexidine are: chlorhexidine acetate, chlorhexidine gluconate (20%) B.P., and chlorhexidine hydrochloride B.P.

The formulated preparations are the antiseptic and obstetric creams (1%), a liquid concentrate for all general purposes, and an aerosol tincture.

No powder containing 0.1% chlorhexidine is available, but chlorhexidine hydrochloride is used at 1% strength in dusting powders extemporaneously prepared for wound application.

This information could usefully supplement that provided by your reviewer, and if you can find space for a suitable insertion we feel that our comment would be helpful to readers.—I am, etc.,

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Alderley Park,
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Education in First Aid

SIR,—With reference to Mr. Norman Capener's letter (19 December, p. 1596), I should like to urge the widest possible spread of simple first-aid teaching to persons aged 12 and over. I am confident this would reduce significantly the average figure of

approximately 60 accident deaths per day in this country at present.

The two most useful points to teach would seem to be: (1) stopping severe external bleeding by direct pressure over the wound¹; (2) artificial respiration, by mouth-to-mouth method. Since 1962 about 700 people have attended a two-hour course here, which was confined to these points, and was suitably illustrated with film, as well as a demonstration of artificial respiration on a model.

In order to assess memory retention, 114 attenders were selected at random three to six months after the course, and asked: (1) to stop bleeding from a simulated wrist laceration; (2) perform artificial respiration on a model. No assistance was given to those being questioned, and opportunity for last-minute revision was prevented. Results showed that 45% were able to perform both measures and 15% could do neither. The remainder performed one or other satisfactorily. Comments suggested better figures would have resulted if the course permitted individuals to operate the manikin.²

These results are encouraging and would probably not have suffered if the instruction had lasted one hour instead of two. Therefore I think it justifiable for all schools, large industrial concerns, and local authorities to sponsor such instruction. Television certainly could give invaluable help.—I am, etc.,

R. G. ORR.

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Atomic Energy Research
Establishment,
Didcot, Berks.

REFERENCES

- ¹ *First Aid in the Factory*, Lord Taylor, 1962, 2nd ed., p. 34.
- ² *Ibid.*, p. 93.

Is Collagen Inert?

SIR,—In your leading article, "Is Atherosclerosis Reversible" (12 December, p. 1477), it is stated that "fibrosis or sclerosis of the intima would be expected to be irreversible because collagen is metabolically inert." May I point out that this observation needs some qualification.

Although collagen throughout the animal kingdom shows remarkable uniformity from creatures at the level of marine sponges up to that of the human being (both in biochemical and electron-microscopic features) and although there is little, if any, antigenic reaction produced by the collagen of one species transplanted into another, the collagen is not one solitary substance. There are various forms within any individual, and the collagen laid down as a consequence of inflammatory process and repair is not identical with that present in the parent tissue.

Lord Anson, writing of his experiences during his voyage round the world in the *Centurion*, remarked that scurvy caused the breakdown of previously healed wounds. It can be shown experimentally that scurvy will cause collagen resorption. It is therefore not impossible that this process could occur with scar tissue produced in arterial degeneration. It is, after all, a common experience to find that adhesions in the peritoneal cavity disappear after an interval of several months—only the densest persisting once the exciting cause has been removed. The labile nature