between imipramine and placebo in their effects on depressed mood—and depressed mood is, I suppose, the most important single manifestation of a depressive illness.—I am, etc.,

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E. H. HARE.

Services for the Elderly

SIR,—Dr. R. L. Meyrick (3 April, p. 925) continues to press his argument that geriatric units are unnecessary. True enough, on the figures presented in the King Edward's Hospital Fund report the comments of Dr. R. E. Irvine (20 February, p. 524) are reasonable. It is striking, however, that nearly all those working with the elderly in Lewisham with whom I have discussed the relevant hospital services express the opinions that such services leave much to be desired, and that the report gives an incorrect representation.

How has this contradiction happened? Firstly, the sample taken could hardly give an accurate assessment of the number of people at home who should be in hospital. Taking the figures for the Deptford area, only four or five people would have been expected to have been found in the sample; that they were not does not necessarily mean that in the rest of the population there were none who should be in hospital. (This is quite a different order of significance from that of, say, the home help service where 9% of the whole sample was involved.)

Secondly, the investigation relied upon the voluntary reporting of cases by general practitioners. This is a notoriously unreliable method, and a negative result is of no value.

Thirdly, the committee contained no consultant physician in geriatrics, and this is surely a grave omission when reporting on hospital services for the elderly. It is inconceivable that a paediatric survey would be conducted without a paediatrician, as only he is adequately qualified to judge in his special field. This is no idle quibble, as a committee will only get the right answers if it asks the right questions, and specialized knowledge is needed for these. For example, a high incidence of incontinence and bedfastness was discovered, but no attempt was made to ascertain how many cases were treatable, or could have been prevented in the first place.

Finally, the majority of the committee has direct connexions with the Lewisham Hospital Group. Is this a good way to obtain an impartial report?

I pose these criticisms because they may give clues as to how the committee returned a report at such variance with many people's opinions on the Lewisham hospital services for the elderly. Contrary to Dr. Meyrick's suggestion that no further inquiry is necessary, I feel it is urgently indicated.—I am, etc.,

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R. V. BOYD.

Anaesthesia and Monoamine-oxidase Inhibitors

SIR,—One welcomes the intention behind Dr. H. C. Churchill-Davidson's letter (20 February, p. 520). During the intervening weeks I have been hoping that a more authoritative pen than mine would comment

on it because, although the meaning is clear to those acquainted with the subject, it could lead the less erudite into error.

An unexpected response to a drug is nowadays often described as a "sensitivity reaction." It is usually tacitly accepted that this means no more than that the occurrence of the response is unpredictable and inexplicable in the current state of knowledge, and does not necessarily imply sensitization as normally understood. It is thus unfortunate that the recommended procedure, which he described as a sensitivity test, superficially resembles some type of desensitization. When he goes on to assert that if a certain dose of analgesic causes no abnormal response these drugs can be used freely, he gives the impression that it is known that the response is idiosyncratic and independent of the relative doses of the interacting drugs. This may not be true. A patient who reacted normally to pethidine on one occasion, reacted abnormally on a second occasion when the dose of monoamine-oxidase inhibitors had been increased.¹ The patient he describes who responded abnormally to 5 mg. of pethidine might have reacted catastrophically to 100 mg., and it is because of this likelihood that a very small initial dose is advised.

Of more practical importance, however, is the impression he gives that analgesics are interchangeable in this context. All the

reports of this complication that I have been able to trace seem to have followed the use of pethidine. One patient who died after pethidine had had no ill-effects after a previous dose of morphine.² The establishment of a normal response to one analgesic does not, therefore, preclude a potentially fatal result with a different one. One would, therefore, like to qualify Dr. Churchill-Davidson's advice. One should investigate the response to the analgesic that it is intended to use, and then use no other. If time is short morphine is preferable to pethidine. The procedure is an attempt to establish whether or not a therapeutically adequate dose of the drug can be given without disastrous side-effects and does not modify the patient's "sensitivity."

It is perhaps worth noting that the demonstration of a normal response to pethidine does not eliminate the possibility of a dangerous or fatal response to vasopressors, and this likelihood constitutes a valid reason to stop the monoamine-oxidase inhibitors as soon as possible during a time of potentially acute illness.—I am, etc.,

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Pelvic Endometriosis with Irreducible Femoral Hernia

SIR,—Inguinal endometriosis, and endometriosis occurring in the walls of hernial sacs, have been described on rare occasions. Moore¹ described a case of extensive pelvic endometriosis associated with bilateral inguinal herniae. Dreishpoon² described two cases of endometrial deposits in the walls of hernial sacs—one inguinal and the other femoral—but in neither case was laparotomy done. Bornstein³ reports one case of endometriosis occurring in an umbilical hernia sac, but unassociated with any uterine pathology. Jimenez⁴, Niswander,⁵ and Dormandy⁶ have all reported cases of inguinal endometriosis.

The following case illustrates an unusual finding during the course of femoral herniorrhaphy, in which the contents of the sac led to the discovery of extensive pelvic endometriosis which had hitherto remained undetected.

Mrs. A. B., aged 42 years, was referred to hospital because of a painful, tender swelling in the right groin of one day's duration. There was no previous history of hernia, or of

abdominal or gynaecological disease. Examination showed that she had an irreducible, tender right femoral hernia, but there was no clinical evidence of intestinal obstruction. She had one child following a normal delivery twenty years previously.

Femoral herniorrhaphy was undertaken later that day. Through a Lotheissen approach a large tense femoral hernia sac was found and opened. The sac was filled with altered blood but no bowel was evident. As many loops of bowel as could be delivered through the neck of the sac were examined and found to be normal. It was thought that the amount and nature of the sac content must indicate that a loop of bowel had strangulated, but that it may have returned to the abdominal cavity during manipulation of the hernia sac. The sac was excised and herniorrhaphy was performed. After closure of this incision the abdomen was opened through a right paramedian incision. The whole peritoneal cavity was extensively studded with altered blood, and a detailed examination of the intestine showed no abnormality or evidence of strangulation or incarceration. There was gross haemorrhagic staining over the uterus with "chocolate" cysts over both ovaries. The left

ovary and uterus were adherent to the rectum, and a considerable amount of altered blood was present in the pelvis. All other intra-abdominal viscera were normal. Total hysterectomy and bilateral salpingo-oophorectomy were done.

The patient made an uneventful recovery and was discharged three weeks after operation. On subsequent questioning she stated that she had experienced vague abdominal pains from time to time, but that these were unrelated to her periods.

Histological examination of the hernial sac did not reveal any definite endometrial infiltration, and it therefore seems evident that the large amount of altered blood present in the sac at operation was due to direct extension from the extensive pelvic endometriosis, which had otherwise remained "silent." The Figure shows the appearance of the specimens removed at operation.

—I am, etc.,

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Staphylococci and Urinary Infection

SIR,—I was very interested in the recent article by Dr. D. J. A. Gallagher and colleagues (6 March, p. 622), who found that coagulase-negative staphylococci were the second commonest cause of uncomplicated urinary tract infections in general practice. As they point out, the nomenclature of this group of organism is not uniform.

At the Royal Infirmary, Bristol, we have recently undertaken a study of urinary tract infections caused by "*Staphylococcus albus*." Urine specimens were received from hospital in-patient and out-patient departments and from domiciliary cases. All strains likely to have caused infection were classified by Baird-Parker's¹ scheme as subgroups of the genera staphylococcus and micrococcus. Micrococcus subgroup 3 strains (M 3) were isolated from the urines of 38 patients, 32 females and 6 males, accounting for about a quarter of the cases. Examination of the case-records showed that 36 patients in this group had acquired the organism outside of hospital, and one other had probably done so. Only one patient had acquired an M 3 strain after admission to hospital, and this followed an operation on the genital tract with subsequent urethral catheterization. Most of these patients had urinary symptoms of sufficient severity to require chemotherapy. Investigations usually showed no underlying abnormality of the urinary tract, although a few patients had renal calculi.

All M 3 strains isolated were novobiocin-resistant as judged by a simple disk-agar diffusion method using a Mast 5 µg. novobiocin disk. The importance of novobiocin-resistant strains of coagulase-negative staphylococci in causing urinary tract infections in females was first shown by Pereira.² Two of these strains kindly provided by Dr. Pereira also belong to this same subgroup. Novobiocin-resistance would thus appear to

be a simple diagnostic feature of M 3 strains. The majority of urinary infections due to "*Staphylococcus albus*" recognized in this laboratory occurred in hospital patients after instrumentation of the urinary tract. These were most commonly due to *Staphylococcus* subgroup II strains, and occasionally to those of *Staphylococcus* subgroups IV, V, and VI. We have come to look upon these strains as feeble "secondary" pathogens which require a nidus of damaged tissue for multiplication.

Concurrent Herpes Zoster and Varicella

SIR,—Herpes zoster and varicella are both caused by a filterable virus. Though there is evidence that both conditions are produced by the same virus¹ in herpes zoster the eruption follows the distribution of the cutaneous nerves and the virus is said to be neurotropic, whereas in varicella there is no such distribution and it is said to be dermatropic. Strangely enough the two conditions rarely occur in the same individual, and only five cases have been reported in the literature. The following case seen by us is therefore worthy of note.

A.B., a healthy male of 48 years of age, was first seen on 2 July 1964. He complained that on 28 June he had pain and discomfort on the inner side of the right arm. This had begun on the inner side of the right upper arm and spread to the inner side of the forearm and hand. The pain was of a tingling nature and the palm felt sore. On 1 July he noticed a crop of blisters along the affected area and also on the back of the right shoulder. When he was seen on 2 July he had a crop of vesicles starting on the back of the right shoulder extending up to the midline, and coursing down the inner aspect of the right upper arm, forearm, and middle and inner area of the palm in the distribution of the first thoracic nerve root (Figs. 1 and 2). When

By contrast, M 3 strains appear on clinical grounds to be primary pathogens capable of causing moderately severe infections in otherwise healthy patients, typically young married women. Full details of this work will appear in due course.—I am, etc.,

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he was seen on 4 July a few more vesicles had erupted on his body. They were on the front of the chest and abdomen and were typical of chicken-pox (Fig. 3). There was no pain preceding this latter eruption, and there was no soreness over this area.

The herpetic lesions and varicella lesions erupted on the fifth and seventh day after the appearance of their respective vesicles and they eventually healed by the end of the fifth week, the zoster lesions producing more scarring than the varicella lesions.

Although it was as early as in 1888 that Von Bokay suggested that varicella and herpes may both be caused by the same aetiological agent, it was not until 1932 that Bruusgaard¹ confirmed this when he inoculated vesicular fluid from a patient suffering from herpes zoster into volunteers and produced in some of these herpes, and in others varicella. Rake,² while studying the vesicular fluid from both conditions, found the fluid to be identical, and even with the use of the electron microscope he could not differentiate the elementary bodies in the two conditions.

In view of the fact that both conditions are probably produced by the same virus, the reason why on some occasions the virus

FIG. 1

FIG. 2