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.,

Lewisham Hospital,
London S.E.13.*

S. J. S. LAM.

* Present address: Department of Orthopaedic Surgery, Guy's Hospital, London S.E.1.

REFERENCES

- Moore, W. R., *Harper Hosp. Bull.*, 1957, **15**, 242.
- Dreishpoon, I. H., and Klempner, E., *N.Y. State J. Med.*, 1959, **59**, 847.
- Bornstein, F. P., *Amer. J. Obstet. Gynec.*, 1957, **73**, 1109.
- Jimenez, M., *Ann. Surg.*, 1960, **151**, 903.
- Niswander, K. R., *Amer. J. Obstet. Gynec.*, 1958, **75**, 279.
- Dormandy, T. L., *Lancet*, 1956, **1**, 832.

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.

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.,

Royal Infirmary,
Bristol 1.

R. G. MITCHELL.

REFERENCES

- Baird-Parker, A. C., *J. gen. Microbiol.*, 1963, **30**, 409.
- Pereira, A. T., *J. clin. Path.*, 1962, **15**, 252.

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

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 Bruusgaard² 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,³ 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

assumes neurotropic qualities and in others dermatropic qualities is not clear.

FIG. 3

The five recorded cases where the two conditions appeared concurrently are:

- (1) A case of ophthalmic herpes followed three days later by varicella.³
- (2) A case of intercostal herpes followed four days later by varicella.⁴
- (3) A case of herpes affecting the distribution of the second and third sacral nerve roots with concurrent generalized varicella.⁵
- (4) A case of herpes ophthalmicus followed four days later by generalized varicella.⁶
- (5) A case of herpes zoster ophthalmicus followed three days later by generalized varicella.⁷

—We are, etc.,

Dept. of Paediatrics,
University of Ceylon,
Colombo, Ceylon.

B. K. MULLER.
W. J. GOMES.

REFERENCES

- ¹ Rake, G., Blank, H., Coriell, L. J., Nagler, F. P. O., and Scott, T. F. M., *J. Bact.*, 1948, **56**, 293.
- ² Bruusgaard, E., *Brit. J. Derm.*, 1932, **44**, 1.
- ³ Garrett, F. E., *Amer. J. Ophthalm.*, 1958, **46**, 741.
- ⁴ Melnotte, P. A., and Foliguet, J. M., *Rev. méd. Nancy*, 1960, **85**, 38.
- ⁵ McShane, C. B., *E. Afr. med. J.*, 1961, **38**, 466.
- ⁶ Behara, U. C., and Misra, M. C., *J. Indian med. Ass.*, 1962, **38**, 345.
- ⁷ Fry, A., *Practitioner*, 1964, **192**, 673.

Foster Parentship

SIR,—Recent reports in the daily papers once again attract attention to the controversial subject of foster parentship. It is the duty of public authorities to provide quasi-homes for children who for one reason or another, temporarily or permanently, cannot or must not be accommodated in the homes of their parents. In this duty the authorities find themselves under the influence of public opinion, which, towards the end of last century, swung against the placing of children in cold and impersonal orphanages. Encouraged by the success of adoptions, any system which might provide emotional links seemed preferable; the fundamental difference to adoption is of course that foster parenthood is essentially a salaried service

which the authorities evoke to facilitate their task.

On the face of it, the system seems fool-proof. Periodic visits by trained personnel keep the authorities in contact with the child. Shortcomings in foster-parental behaviour can quickly be brought to the attention of those in charge and the necessary redress machinery is readily set in motion. However, in spite of a skilled visiting service which I do not wish to criticize, a great deal of unhappiness and ill-treatment seems to escape the eye of the visitor until some incident brings it to light.

Over more than 25 years I have seen large numbers of London children, accompanied by their attendants. Over the years I have learnt to spot foster children (or foster parents?) with unexpected accuracy. If it is successful, the "integration" of the homeless child into a family is a system which cannot be improved upon. But the system is beset with dangers and it must not be judged by the happiness of its many successes but by the misery of its failures. I have come to the conclusion that the relationship between foster children and foster parents is unsatisfactory in so significant a minority of cases as to raise doubts whether the system is worth continuing. If a child does not like its foster parents a chain of psychological and physical suffering ensues which is not easily discovered on the basis of quarterly inspections. The child feels imprisoned within a cell of hatred. It does not really matter much whether or not this dislike is mutual, or whether it is justified. Sometimes it is; foster parents can behave very differently in the presence of an outsider and it can be very difficult to unmask their real attitude.

I doubt very much whether the old prejudice against committing children to an institution is still valid. These homes have changed out of all recognition. Mutual dislike for and by a matron may of course face the child in an institution as well; but, and this is their great redeeming feature, the danger of unwanted isolation does not exist. There is always the chance to fasten the "emotional link" to one kindred soul, be it cook or cleaner, and there is no risk of undiscovered misery.—I am, etc.,

St. James's Hospital,
London S.W.12.

A. B. ALEXANDER.

Oral Contraception and Thrombosis

SIR,—Because of the innumerable patterns of coronary disease the attempt to determine the danger or otherwise of "the pill" by statistical methods will be both slow and unsatisfactory.

A thrombus of any sort is only present in about 40% of fatal cases of coronary disease, thrombosis is a major event in only about 10%. Thrombi in the coronary arteries do not occur in the absence of a trigger mechanism. Venous thrombi are typically stasis in type, as are thrombi in the auricles. Thrombi in the ventricles may be either trigger or stasis in type, but are frequently both. It is quite uncommon to find a major thrombus in more than one of the main coronary trunks.

I have attempted to reconstruct the events in coronary arteries by taking a series of

blocks along the main coronary trunks until they appear normal to the naked eye. The 503rd case so studied was a woman aged 34 years. She was found to have major thrombi occluding the lumen of the right, left descending, and left circumflex coronary arteries. She is such a misfit with the series as a whole that I wrote to her doctor to discover if she had been taking "the pill." Because she already had four children it had been prescribed for her nearly a year previously. It is hoped to report this case in detail soon.

The possible danger of "the pill" to coronary arteries could soon be established by adequate microscopic examination of the hearts of women of child-bearing age who die from coronary disease. I would welcome the opportunity to examine the hearts from these cases for pathologists who do not have the facilities to do it for themselves. For this purpose the coronary arteries must be fixed before they are touched at all; they must not be damaged while opening the heart. Should they be calcified they must be fully fixed and then adequately decalcified before selecting successive transverse blocks for processing. Splitting with scissors and injection techniques must not be used under any circumstances.

The uterus should also be examined from these women for evidence of the endometrial pattern characteristic of action by "the pill." Because the endometrium is so easily damaged in necropsy material careful technique is essential. I find it best to make a longitudinal incision with a sharp scalpel, holding the edges apart with the points of dissecting forceps; downward pressure must be avoided. The final opening is best done with sharp scissors, cutting from the external os upwards. For the uterus I prefer fixation in Bouin's fluid, for the heart 10% formalin in 0.6% saline—hypertonic saline mixtures must be avoided.—I am, etc.,

Royal Infirmary,
Derby

G. R. OSBORN.

Hazard with a Gordh Needle

SIR,—In view of recent correspondence about plastic intravenous cannulas breaking *in situ* I thought the following might be of interest.

On 15 February of this year, in the Dandenong and District Hospital, I anaesthetized a healthy 19-year-old married woman for elective tonsillectomy. A previously unused new Gordh needle was inserted into one of the superficial veins of the dorsum of the right hand and held in place in the usual manner with a strip of adhesive tape. After the intravenous injections of sodium thiopentone 0.35 g. and suxamethonium hydrochloride 80 mg., no further injections were made through the needle, and the right arm was placed on an arm board throughout the operation, which was uneventful and lasted 25 minutes. At the end of the operation while the patient was still anaesthetized and lying on the trolley, having been moved gently across from the operating table by means of rollers, the Gordh needle was removed. This manoeuvre was not performed in a forceful manner and the tape was removed before traction was put on the head of the needle. It was then noticed that the body of the needle had become detached at the neck and was still embedded in the vein. An attendant immediately applied manual pressure at the wrist, and, although no part of the body of the needle could be seen, it was palpated, the distal end of it being about one half-inch from the puncture site. An incision was immediately