question his reference to "Bedlam Melancholia"—depressed patients so bad as to be willing to go and sit about for weeks in Bethlem," etc.

There can be few general practitioners, whether depressed or not, who would not welcome the chance to sit about in Bethlem at present, with its individual bedrooms, squash court, heated swimming-bath, lecture theatre-cum-cinema, the canteen in which to entertain one's friends, and the whole set in magnificent grounds, abounding in rhododendrons, woods, lawns, and fields. If in spite of these attractions one did wish just to sit about, pleasant quiet indoor facilities exist for this purpose too in the reading-room well supplied by the library, although the large, light, warm, and well-ventilated occupational unit could well provide a counter-attraction.

I suggest that just as the depressed melancholic of twenty years ago is hardly to be seen now that E.C.T. is used, even more is the term "Bedlam melancholia" an anachronism to be deplored and hastily to be dropped from medical terminology.—I am, etc.,

Beckenham, Kent.

RONALD M. PENNY.

Abortion Law

SIR,—The pressure for reforming the law on abortion continues. In recent months there have been "slanted" television and radio programmes, press articles, resolutions from women's organizations, and a private member's Bill. Now there is this letter (5 June, p. 1497) by a group of consultant psychiatrists appealing to the present Minister of Health for "implementation of the law on abortion as it now stands." They state that they have had their recommendations for abortion turned down by consultant gynaecologists because of the latter's religious scruples. They argue that "whole sections of the community may be denied a service which is recognized as both legal and ethical." They, however, do not state whether refusal to abort in these instances rendered the mothers physical or mental wrecks, yet that is what the law regards as the essential criteria for a therapeutic abortion.

Since you published my paper¹ nearly two years have elapsed, and, though there was no lack of criticism (the correspondence was eventually closed), there has to date been no evidence produced to cast doubt on my findings or conclusions. These gynaecologists were no doubt acting on their knowledge of the psychiatric aspects of abortion and should not be criticized for disregarding advice which was counter to what they know. To say that such abortions are legal because people can still get away with it may be sound law; I don't know. To say they are ethical when all the available medical evidence indicates they may be psychologically harmful and at best can only result in the destruction of the unborn child is a new and perverted meaning of the word "ethics."

Until those who advocate such abortions can support their agitation with careful studies, they have no right whatever to condemn others who are practising a more ethical and better form of medicine. The Minister will, I am sure, not support legislation which is not based on a serious study, and will be extremely wary of doctors who exploit

religious prejudice. The letter from the eleven consultant psychiatrists has no more force than if it were written by eleven enthusiastic and uncritical members of the Abortion Law Reform Association, which they may well be.—I am, etc.,

The Queen Elizabeth Hospital,
Birmingham 15. MYRE SIM.

REFERENCE

- ¹ Sim, M., *Brit. med. J.*, 1963, 2, 145.

SIR,—I have read with great interest the letter by Dr. H. R. Rollin and others (5 June, p. 1497). If these 11 psychiatrists could pool their experience over the last five years and answer the following questions they would put us greatly in their debt. How many pregnant women have consulted them; in how many termination of pregnancy was advised; in how many instances this was (a) done, (b) not done; and the degree of psychiatric deterioration which stemmed from not accepting this advice compared with that which occurred when it was accepted?—I am, etc.,

Obstetric Hospital,
University College Hospital,
London W.C.1.

G. W. THEOBALD.

Indications for Chloramphenicol

SIR,—Your leader "Therapeutic Misadventure" (8 May, p. 1205) once again castigates chloramphenicol as one of the main causes of death from blood dyscrasias due to drugs. That this may be so is not disputed, although idiopathic aplastic anaemia is a relatively common condition and chloramphenicol still a widely used antibiotic. I would, however, contest the statement that the indications for the drug are "very few outside the treatment of typhoid fever." If this were so the indications must be few indeed.

Chloramphenicol, far and away the most potent of the wide-spectrum antibiotics, is often life-saving in the treatment of severe respiratory infections, particularly in the elderly patient. This action may well be due to its effectiveness against the two highly pathogenic bacteria *Staphylococcus pyogenes* and *haemophilus*, and the rarity of primary or induced resistance to the drug of these and other organisms. Very often in the severely ill elderly patient there is no time for antibiotic sensitivity tests on sputum or for trial of a less potent antibiotic. In my opinion there is no doubt that the number of elderly bronchitics saved by chloramphenicol who would otherwise have died exceed many times the twelve aplastic fatalities said to have occurred in 1962.

Whilst I do not wish to advocate the use of the drug in anything but severe infections, the tragedy is that physicians, intimidated by the remarks of coroners and others, feel obliged to veto the use of the drug for all conditions irrespective of their nature and severity.

I fear that if this unqualified propaganda against chloramphenicol persists there is a real danger that perhaps, through Ministry action, the drug will be withdrawn from the market. If this should happen the mortality of chest infections, substantial in this country, would be unjustifiably increased.—I am, etc.,

Hornchurch, Essex.

S. L. O. JACKSON.

Diagnosis of Hysteria

SIR,—Dr. Eliot Slater is to be congratulated on his provocative article (29 May, p. 1395), and it should be standard reading for all psychiatrists and neurologists. Not everyone will agree entirely with him as to his conclusions. Without knowing all the facts, it is difficult to assess the data upon which his conclusions are based. Several facts, however, would appear to emerge:

(1) In three-quarters of the men and two-thirds of the women, a diagnosis of psychiatric illness was made by someone not a specialist in the field of mental health.

(2) A diagnosis of primary hysteria was made in a group, the mean age for men being 42 years and for women 37 years. These people had presumably gone through the milestones of puberty, adolescence, and early adult life without hysterical manifestations. Most psychiatrists would probably agree that primary hysteria occurring for the first time over the age of 30 is a rare occurrence apart from those involved in claims for compensation or those exposed to overwhelming stress.

(3) It seems incredible that a man of 65 (44098) and two elderly men (46411, 42995) were diagnosed as suffering from primary hysteria.

The fact that several cases developed depressive or schizophrenic features does not necessarily invalidate the original diagnosis. There is no reason why a hysteric should not in middle life develop a depressive illness, and the clinical accounts published of the mental state of Rudolph Hess strongly suggest alternating phases of hysteria and schizophrenia in the same individual.

My apologies are due to Dr. Slater if I have misinterpreted any facts in his article, but on the face of it it would seem the fault lies not so much in the diagnoses as in the diagnosticians.—I am, etc.,

Purdysburn Hospital,
Belfast 8.

J. B. NABNEY.

Ultrasonic Dosage

SIR,—The International Electrotechnical Commission, Geneva, which claims to include representatives of the United Kingdom and the U.S.A., published in 1963 its Publication I.E.C. No. 150, "Testing and Calibration of Ultrasonic Therapeutic Equipment." Though a member of the relevant B.S.I. committee, it is astonishing that only this month did I become aware of the existence of these recommendations, ostensibly officially accepted by 16 countries. Though open to criticism in detail these recommendations adopt substantially the system of measurement advocated in *Ultrasound as a Diagnostic and Surgical Tool*¹ which I had the honour to edit.

In recent weeks I have tested four ultrasonic transducers that were being used in research projects though designed for physiotherapy. In all cases the output meter indicated that full power was being delivered. Three showed respectively 75%, 10%, and 0% of the rated power. The fourth showed 21% or 5%, according to whether one calculated from the apparent size of the transducer or from the size of the crystal in the centre.

Both manufacturers concerned were unaware of the recommendations or of the use of radiation pressure measurement. Both are discontinuing the models tested and bringing out improved designs.

As ultrasound is now being used in destroying nerve tissue in Ménière's disease and in neurosurgery, and much more extensively in diagnosis, the importance of an accurate method of measuring dose is obvious. It is not surprising in view of my measurements that ultrasonic equipment is regarded as witchcraft by many specialists in physical medicine. There is, however, good empirical evidence (Professor A. E. Ritchie and Dr. Alan Bass in personal communications) of its value in scar tissue conditions and in accelerating the absorption of haematomata in professional footballers.—I am, etc.,

Richmond, Surrey. DOUGLAS GORDON.

REFERENCE

- ¹ *Ultrasound as a Diagnostic and Surgical Tool*, edited by D. Gordon, 1964. Livingstone, Edinburgh.

Acute Synovitis of Hip

SIR,—Mr. W. J. W. Sharrard's statement (29 May, p. 1421) that there are no radiological changes in acute synovitis of the hip is only true in so far as there are no bone changes. Good quality films will often give useful confirmation of the diagnosis by showing an increase in volume and density of the soft tissues around the hip-joint, compared with those of the opposite side. These changes are attributed by Drey to oedema and swelling of the obturator internus, ileo-psoas, and gluteus minimus.—I am, etc.,

G. F. MAYALL.

Radiodiagnostic Department,
Royal Devon and
Exeter Hospital,
Exeter, Devon.

REFERENCE

- ¹ Drey, L., *Radiology*, 1953, 60, 588.

Urinary Infection in Children

SIR,—The publication of Mr. D. Innes-Williams's article on urinary infection in children (17 April, p. 1043) refers to the use of the "newer drugs" nalidixic acid and colistin as invaluable where the organisms resist the simpler methods, but cautions on the use of the former on account of side-effects.

I have conducted clinical trials with nalidixic acid recently, and of the many cases treated have presented the results of a few of the more difficult ones, including staghorn calculi, in a paper to be published shortly in *Medical Proceedings*, in Johannesburg.

Although the drug was heavily challenged by complications aggravating infection, satisfactory results were obtained, even where the causative organisms had proved resistant to previously repeated courses of treatment with antibiotics and sulphonamides, etc.

The tolerance to the drug throughout the course of treatment was good. In one case some gastric irritability of a transient nature was observed, while jaundice returned to another patient after treatment with nalidixic acid following an appendicectomy, who developed peritonitis and pelvic abscesses with recto-vesical fistulae. The low toxicity of the drug was confirmed by medical co-workers. Very few side-effects were reported

from the extensive clinical trials which have been carried out in Southern Africa, and it is felt that nalidixic acid is a valuable addition to the choice of drugs available for the treatment of Gram-negative urinary-tract infections, be these either chronic or acute.—I am, etc.,

Johannesburg,
South Africa.

C. D. KISNER.

Chromosomal Abnormalities in Lymphoma

SIR,—The preliminary communication by Mr. M. C. Baker and Dr. N. B. Atkin (20 March, p. 770) has added greatly to the little available information about chromosomal abnormalities in lymphosarcoma and Hodgkin's disease. The special value of their observations lies in their having been made on cells from lymph nodes. The previously published results on chromosome studies in lymphosarcoma include only one case in which lymph-node cells were studied.¹ In all the malignant lympho-proliferative disorders chromosome studies on lymph nodes are likely to be of much more value than similar observations on bone marrow and peripheral blood.

We have recently studied material obtained at lymph-node biopsy in eight cases of malignant lymphoma of various histological types and found chromosomal abnormalities in all cases. No specific anomaly has as yet been identified with certainty, nor has any definite pattern of change emerged, but abnormalities involving chromosomes 17–18 and 21–22 have been found in four cases. Our chromosome preparations are made after culture for 16 hours without the addition of phytohaemagglutinin or other mitotic stimulant. These studies are continuing and a first report of our findings is in preparation.

Like Mr. Baker and Dr. Atkin we find that as a rule only very few cells from non-neoplastic lymph nodes divide in cultures without phytohaemagglutinin. The only exception in our experience was in a case of sarcoidosis, which is in accord with the observation² that in sarcoidosis peripheral-blood lymphocytes may enlarge and divide in culture without mitotic stimulants. The possibility therefore remains that normal lymphocytes present in malignant lymph nodes may divide in cultures without phytohaemagglutinin. On the other hand, our results and those of Mr. Baker and Dr. Atkin make it unlikely that in short-term cultures normal lymphocytes, if they are present in the lymph nodes in malignant lymphoma, are capable of completely replacing abnormal cells in the final chromosome preparations. Only if chromosome abnormalities are not found in cultures from malignant lymph nodes has this possibility to be considered. The conditions of culture appear to be appropriate for the division of neoplastic lymphocytes, and both our results and theirs suggest that the addition of phytohaemagglutinin is unnecessary. In one of their cases of Hodgkin's disease phytohaemagglutinin stimulation of normal cells probably accounts for the progressively lower proportion of abnormal cells found on continued culture.

We agree with Mr. Baker and Dr. Atkin that chromosome studies on malignant lymph nodes, as with all neoplastic tissues, would best be performed on direct prepara-

tions without preliminary culture. Like them we have found the number of mitoses in direct preparations from lymph nodes commonly to be too low for satisfactory study. It is surprising that they should refer to direct methods without indicating that they have already been used successfully in the study of lymph-node cells. Several reports^{3,4} have appeared of single cases of malignant lymphoma studied by direct methods. The most important results obtained in this way are those of Jacobs and her colleagues⁵ in Burkitt's lymphoma, yet Mr. Baker and Dr. Atkin make no mention of their work. Had they considered these results in Burkitt's lymphoma they might have found possible similarity with their own results in lymphosarcoma. The karyotype of Mr. Baker and Dr. Atkin's Case 1 shows that at least one chromosome of pair 2 is missing. Loss of a No. 2 chromosome was reported in 4 of the cases of Burkitt's lymphoma (Cases 5, 11, 13, and 15) studied by Jacobs *et al.* In Mr. Baker and Dr. Atkin's first karyotype there is shown a large submetacentric chromosome which closely resembles an abnormal chromosome present in three cell lines in Case 5 of Jacobs *et al.* The same worker⁵ also described a large submetacentric chromosome in three other cases of Burkitt's lymphoma (Cases 10, 15, and 16), an extra chromosome of the pairs 4–5 in one cell line of Case 5, and extra chromosomes of about the size of pairs 4–5 in two other cases (Cases 11 and 13). In Mr. Baker and Dr. Atkin's paper the karyotype of their second case of lymphosarcoma shows an abnormal large submetacentric chromosome. The reproduction of karyotypes in papers reporting the results of chromosome studies may often seem to be extravagant. The extent of the similarities of these findings in Burkitt's lymphoma and lymphosarcoma can be determined only by the publication of more karyotypes or better still by comparison of the actual preparations.—We are, etc.,

A. S. D. SPIERS.
A. G. BAIKIE.

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Melbourne, Australia.

REFERENCES

- ¹ Tjio, J. H., Marsh, J. C., Whang, J., and Frei, E., *Blood*, 1963, 22, 178.
- ² Hirschhorn, K., Schreibman, R. R., Bach, F. H., and Siltzbach, L. E., *Lancet*, 1964, 2, 842.
- ³ Spriggs, A. I., and Boddington, M. M., *ibid.*, 1962, 2, 153.
- ⁴ Ricci, N., Punturieri, E., Bosi, L., and Castoldi, G. L., *ibid.*, 1962, 2, 564.
- ⁵ Jacobs, P. A., Tough, I. M., and Wright, D. H., *ibid.*, 1963, 2, 1144.

Eye Disease in Children

SIR,—I am replying to the criticisms which Mr. H. Jackson (5 June, p. 1495) made of my recent article on "Eye Disease in Children" (22 May, p. 1361) only because he assumed in his final paragraph that I would agree with these. With regard to buphthalmos I agree that its management is essentially surgical. But I mentioned medical treatment simply as a temporary measure, and this is of particular value to the surgeon who favours a goniotomy (by far the most effective and logical operation), because a reduction in the intraocular pressure pre-operatively often relieves the haziness of the cornea—thereby avoiding the