cultured in Eagle's medium plus 10% pooled human serum. 1 p.p.m. sodium fluoride was incorporated in the culture medium of the fluoride bottles (the same concentration that is recommended for drinking-water). The experiments were performed over five successive weekly periods with an inoculum of 50,000 cells in each one of the pairs of bottles. The total cell numbers in the bottles were determined at the end of seven days (see Table). It will be seen that the difference between the mean cell numbers of all the control and fluoride cultures is not significant ($P=0.20$).—I am, etc.,

A. H. W. NIAS.

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REFERENCE

- Berry, R. J., and Trillwood, W., *Brit. med. J.*, 1963, 2, 1064.

Monocytic Leukaemia and Phenylbutazone

SIR,—Cases of leukaemia occurring in patients treated with phenylbutazone have recently been reported. We record here very briefly a further case of acute monocytic leukaemia, with an accompanying family history of leukaemia.

In June 1955 a 57-year-old woman developed rheumatoid arthritis, which progressed in spite of treatment. By 1959 she was quite severely crippled and was treated with phenylbutazone in the dose of 300 mg. daily. The drug was maintained at 300 mg. daily for one year, and thereafter was continued at 200 mg. daily until September 1964. There was no doubt that the phenylbutazone enabled her to remain independent.

In September 1964 one of us (H. E. M.) noted that the patient had suddenly developed fever, pallor, and buccal ulcers; she was admitted as an emergency to the Harrogate Royal Bath Hospital. Examination showed a grossly anaemic, ill-looking woman, but the liver and spleen were not palpable and her lymph nodes were not significantly enlarged. A blood count showed Hb 45%, leucocytes 5,000/c.mm. The differential count showed: polymorphs—neutrophils 20%, eosinophils 1%, lymphocytes 77%, monocytes 2%.

The latex screen test was positive. A sternal bone-marrow aspiration was performed, which showed a hyperplastic marrow, in which 70% of the cells were large blasts, consistent with monoblasts. A month after admission to hospital leucocytes were 6,000/c.mm., but by then unclassified cells had appeared in the peripheral blood, varying between 50 and 80% of the total count.

Large doses of steroids produced some clinical improvement, but the patient died two months after admission. At necropsy the relevant findings were confined to the lungs, spleen, and bone-marrow. In the lungs there were many small areas of necrosis scattered throughout both lower lobes. Many small areas of necrosis contained clumps of bacteria. Around such areas there was an infiltrate of lymphocytes and macrophages; polymorphs were strikingly absent. The bronchi contained red cells and degenerating inflammatory cells. The sections of the spleen showed a marked reduction in the size of the follicles and many immature cells off the haemopoietic system in the pulp. Paraffin sections of a rib showed a very cellular marrow with little fat remaining; occasionally normal blasts and megakaryocytes were seen, but the majority of the cells were large and immature. The cause of death was necrotizing, bronchial pneumonia and acute monoblastic leukaemia.

One outstanding feature of interest in this case is that the patient's sister in 1961, at the age of

61, had died of a chronic myeloid leukaemia. The sister had never received phenylbutazone.

—We are, etc.,

J. R. GOLDING.
MARGARET G. HAMILTON.
H. E. MOODY.

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Availability of Enteric-coated Aspirin

SIR,—We agree with the view expressed by Mr. W. J. Clancy (5 June, p. 1495) that enteric-coated aspirin tablets are preferable to ordinary tablets as they cause less gastrointestinal irritation. He is, however, misinformed about the availability to the public of enteric-coated aspirins. The contents of a tablet, and not its coating, determine whether a drug can be obtained without a prescription. Enteric-coated aspirins (325 and 650 mg.) are available to the public without medical authorization. The basic N.H.S. cost of 325-mg. tablets (Nu-seals Aspirin, Lilly) is 3s. 4d. per 100. Although this is rather more than the cost of ordinary aspirins, the price is not prohibitive.—We are, etc.,

ALAN BENNETT.

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London N.W.8.

SEYMOUR LAZARUS.

Non-injury by Thermometer

SIR,—The experiences described by Dr. S. K. Dikshit (22 May, p. 1377) and Dr. A. Melinek (5 June, p. 1496) must be balanced, on behalf of this useful instrument, by the following tale.

I was called to another hospital to see a neonate, because the nurse, on removing the rectal thermometer, found the bulb to be broken. It was considered that the thermometer had broken in the rectum, as no pieces were visible on the floor or on emptying the jar-container. Furthermore, the jagged end of the instrument was so sharp that the nurse could hardly have inserted it without causing some trauma. I found no injuries of the anus and no bleeding occurred subsequently. The broken end of the thermometer I found hidden within the cotton-wool pad used in the bottom of the thermometer jar.

Perhaps this indicates how safe the procedure is in experienced hands, even with a damaged instrument.—I am, etc.,

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London S.E.1.

Hypsarrhythmic Children and Infantile Spasm

SIR,—Congratulations to Drs. B. D. Bower and P. M. Jeavons for drawing attention to the misuse of an electroencephalographic term, hypsarrhythmia, by its application "to a clinical entity with which it is not synonymous" (29 May, p. 1436). It is, however, unfortunate that they have spoiled the presentation of a justifiable complaint by observing that "in as many as a third of cases the E.E.G. is epileptic but not hypsarrhythmic." There is surely no such thing as an "epileptic E.E.G."—I am, etc.,

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Infectious Disease

SIR,—I endorse the welcome (29 May, p. 1435) which Miss Gladys M. Sandes gave to the department for venereal and sexually transmitted diseases which was recently opened at the Middlesex Hospital. This seems a suitable time to remind the profession and its teachers that the provision for the medical care of infectious diseases in general is being neglected in a dangerous way by decreasing instruction, bed accommodation, and trained staff. At present, there is too little ambition to prevent the large amount and wide range of infections which arise in the community generally and sometimes in hospital, and to which the public press draws frequent attention. Now that the Middlesex Hospital has taken up-to-date measures to deal with one form of infection, will other leading hospitals please follow in other areas of the general field of infectious diseases?—I am, etc.,

London W.1.

J. M. ALSTON.

Test for Palatal Paresis

SIR,—May I draw attention to a simple bedside test for palatal paresis? The test consists of placing a small mirror (a vanity mirror such as is carried by the ladies in their handbags suffices well) immediately beneath the nostrils and immediately above the upper lip; it is held in the horizontal plane, the reflecting surface uppermost and with one edge applied against the skin of the face between the upper lip and the nose. The patient is instructed to repeat the word "pop" several times, two or three times per second. If the test is positive, there will appear a misting on the surface of the mirror beneath one or both nostril orifices. The validity of the manoeuvre may be checked by the examiner performing it upon himself. It is important that the patient enunciates the word "pop" as clearly and sharply as is possible, and it is preferable that the mirror be cooled before it is used.

The rationale of the test is that when positive it indicates that the soft palate is insufficiently strong to close off completely the posterior part of the nasopharynx from the posterior part of the oropharynx, primarily during the formation of the explosive consonant "p." The test is limited by the patient's ability to co-operate. False-negative results occur in the presence of marked paranasal sinusitis, nasal congestion, and in the associated presence of a facial weakness sufficient to impede the labial component of the formation of the consonant.

It is possible that this manoeuvre has been described before. Nevertheless I would still draw the attention of your readers to it, for it has a value in certain circumstances. Thus it may help to clarify the differential diagnosis between motor-neurone disease and cervical spondylosis; it may influence the classification of myopathic changes found elsewhere during the clinical examination; it may be of value in such conditions as poliomyelitis, the Lândry-Guillain-Barré-Strohl polyneuritis, and diphtheritic polyneuritis, when in the early stages it may alert the examiner to the possibility of impending bulbar involvement, and in the later stages assist in the assessment of recovery of a palatal weakness.