

necessary examinations of the body had been made. Having regard to the fact that Form E would sometimes be issued before a formal verdict had been returned the cause of death was omitted from the revised Form E to avoid any difficulties which might otherwise arise."

"We have no doubt that the intention of the Regulations was to enable the referee to rely on the coroner's enquiry and it would seem that they have normally been interpreted that way. It seems to us open to a medical referee to satisfy himself that the cause of death has been ascertained if the death has been reported to the coroner and the latter has issued Form E. On this interpretation of the Regulations it is not the cause of death established by a coroner in a particular case but the fact that the coroner has issued Form E on which the medical referee relies in satisfying himself that the cause of death has been adequately ascertained . . ."

Furthermore, the letter from the Home Office made it clear that a revision of the Regulations may be required if my request to know the cause of death is to be met, and such revision may have to await the report of the Brodrick committee. I hope that the members of the Brodrick committee will appreciate that though the coroner's accurate assessment of a case is in no way challenged, surely the referee should have the right before signing Form F, to be aware of the cause of death. It seems to me that common courtesy as well as common sense demands this.—I am, etc.,

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Periodic Haemorrhages in Haemophilia A

SIR,—Spontaneous haemorrhages in patients with haemophilia A are known to be frequently cyclic.¹ Still, periodic haemorrhages are not mentioned in published retrospective²⁻⁴ or prospective⁵ studies of patients with this disorder. I have attempted to detect a possible seasonal recurrence of bleeding

bouts by a retrospective examination of hospital admissions and of individual case histories of patients with haemophilia A.

The survey of 45 patients with haemophilia A diagnosed between 1950 and 1970 in Tel-Hashomer and Hadassah hospitals in Israel showed an increased incidence of hospital admissions during July-August and December-January (Fig.). This finding did not support the impression reported by most patients and some clinicians, that patients with haemophilia bleed mainly during the transitional seasons (March-April, September-October). However, the data were compatible with a somewhat higher incidence of haemorrhages during summer and winter, and therefore several individual case histories were further studied.

The haematology service of the Hadassah University Hospital serves 14 patients with haemophilia A, of whom five have been followed for 13 to 28 years. Pertinent data on these five patients are given in the Table. In four of them more than 70% of the bleeding events, which had required hospital admission and/or replacement therapy, were confined to less than six of the months of the year: in patients A, D, and E the haemorrhages recurred mainly in winter, winter and summer, and summer respectively; in patient C they occurred mainly during the transitional seasons. The bleeding bouts in patient B as well as those in six other patients who had been followed for shorter periods did not appear to conform to any seasonal or other rhythmic pattern.

The bleeding episodes in some adult patients with haemophilia seem, therefore, to show an unexplained tendency to seasonal recurrence, even though there are considerable variations in the pattern of this periodicity among individual cases. It should be noted that the observations presented here are based on recorded bleeding episodes only, and probably exclude a considerable number of minor haemorrhagic events. If confirmed by prospective studies on a larger number of patients this periodicity may suggest that in some patients with haemo-

philia preventive therapy could be feasible at a reasonable cost by its confinement to the "high risk" months.—I am, etc.,

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- 1 Wintrobe, M. M., *Clinical Haematology*, 6th edn., Lea and Febiger, Philadelphia, 1967.
- 2 Ramgren, O., *Acta Medica Scandinavica*, 1962, 171, Suppl. 379, p. 111.
- 3 Wilkinson, J. F., Nour-Eldin, F., Israëla, M. C. G., and Barret, K. E., *Lancet*, 1961, 2, 947.
- 4 Ikkala, E., *Scandinavian Journal of Laboratory and Clinical Investigation*, 1960, 12, Suppl. 46.
- 5 Stuart, J., Davies, S. H., Cumming, R. A., Girwood, R. H., and Darg, A., *British Medical Journal*, 1966, 2, 1624.

Name Badges for Technical and Ancillary Staff

SIR,—For some time now it has been the practice in many hospitals for medical staff, particularly junior medical staff, to wear name badges, which also indicate the department in which the doctor is working. I personally support this as being helpful to patients and making for better communications, particularly with regard to the rapid turnover of doctors between different posts at more junior levels. There has been some discussion as to whether the system should be extended to include technical staff and eventually, presumably, all ancillary staff.

Might I venture to suggest that before the Department of Health and Social Security makes any recommendation or policy on this the views of the patients and others concerned should be sought? After all, it is primarily for the benefit of patients, who may be confused by the multiplicity of white-coated figures attending them, that the system is in use.—I am, etc.,

A. PLATTEN

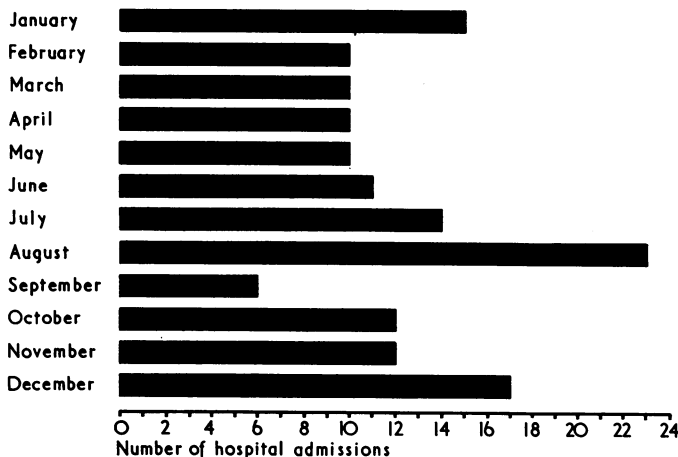
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Air Embolism during Haemodialysis

SIR,—Dr. M. K. Ward and others (10 July, p. 74) report the occurrence of clinically important air embolism in about 1 in 2,000 haemodialyses. They do not state the number of dialyses in which an arteriovenous fistula, as opposed to an arteriovenous shunt, was being used. This method of access to the blood stream, with its great advantages to the patient, is becoming common, but its use introduces another possible portal of entry for air embolism which they have not encountered.

In a long experience, dating back to 1959, of pumped and pumpless dialysis circuits, we have never encountered clinical air embolism from any of the sites of air entry described by Dr. Ward and his colleagues. However, we have had one non-fatal episode of air embolism severe enough to cause cyanosis, hypotension, and transient loss of consciousness similar to their Case 5. This occurred when the arterial needle came out of the fistula and the pump pumped air instead of blood into the circuit. This occurred during the momentary absence of the dialysis nurse towards the end of our first 500 fistula haemodialyses.

This experience underlined for us the need



Patient	AHG (%)	Year of birth	Years follow-up	Recorded bleeding episodes/year	"High risk" months
A	6-23	1930	28	0.8	November-March
B	<1	1953	18	0.9	?
C	<1	1949	13	1.2	October-December March-April
D	<1	1936	19	1.5	December-January
E	<1	1944	19	1.0	July-September May-August