To establish more maternity beds at Roehampton is excellent. More beds, hospitals, and nurses will always be required for this expanding population, but wouldn't it be wiser to establish the new beds, and, at the same time, allow St. Teresa's to carry on for a period of, say, three years to see whether both units can't usefully be maintained, rather than close one before the other is established ?

I hope that all those consultants who feel that it is important that general practitioners have access to obstetric units, and all those who feel that this is once again an example of muddled thinking, will lend whatever support they can to our campaign.—I am, etc.,

London S.W.20. R. I. L. SMALLWOOD.

Foreign Body in Rectum

SIR,—I thought perhaps the following case record of the successful removal of a large foreign body from the rectum, and of the method employed, might prove of interest and help to others confronted with a like problem.

A 36-year-old man was admitted to hospital late in the evening of 20 February 1967, with the history that he had attempted to return his prolapsed piles to the rectum with the aid of a bubble-bath glass bottle 24 hours previously. He reduced his piles successfully, but, having done so, the bottle, being slippery, escaped from his grasp and slid into his rectum. Frequent attempts on his part to pass this bottle by defaecation all that night and the next day were unsuccessful. On clinical examination one was able to palpate the neck of the bottle just below the level of the umbilicus. The patient complained of some abdominal discomfort and of rectal tenesmus, and, per rectum, one was just able to palpate the base of the bottle.

An x-ray of the pelvis revealed a large bottle with the base in the hollow of the sacrum, and the neck lying in front of the sacral promontory. When the patient was anaesthetized and placed in the lithotomy position the anal sphincter was stretched to four fingers. A considerable amount of mucus escaped at this stage owing to the presence of proctitis. The bottle was then readily palpable, but one was quite unable to get one's fingers behind the bottle, as the base was lying so much in the hollow of the sacrum. It was removed by a remarkably simple manœuvre: a large Sargent's intestinal depressor was passed into the rectum and the concave surface of the end of the instrument guided beneath the base of the bottle. By pushing the other end of the depressor backwards, the bottle was then levered forwards and therefore brought into line with the anal canal. An assistant then pushed downwards on to the bottle neck from the abdomen and the bottle slid along the gutter of the instrument and was then readily delivered.

The bottle was found to measure 16¾ cm. long by 5 cm. broad at the base. Postoperatively the patient was put on a course of benzylpenicillin and streptomycin sulphate injections and was discharged from hospital four days later.—I am, etc.,

KEIR MACKESSACK-LEITCH.

Horton General Hospital,
Banbury, Oxon.

Side-effects of Phenothiazines

SIR,—On reading Dr. D. A. Heath and Dr. J. M. McGarry's letter (11 February, p. 363) I was reminded of three similar experiences with phenothiazine derivatives over the past two years in our practice.

A 21-year-old multipara, three months pregnant, had hyperemesis for six weeks. She was given perphenazine (Fentazin) 5 mg. intramuscularly and developed facial dyskinesia but no opisthotonos or carpo-pedal spasm. She was admitted to Bristol Royal Infirmary as a possible case of tetany. She was having spasmodic contractions of the facial muscles with arching of the neck and turning up of the eyes. Twenty-four hours later she made a complete recovery.

A 44-year-old woman developed a paranoid psychotic illness over a period of three weeks. She had a depressive illness five years previously. She was given trifluoperazine (Stelazine) 5 mg. b.d., and shortly after the second dose developed facial dyskinesia and inability to speak. Her symptoms subsided within 24 hours with complete recovery. She was thought to have tetany due to overbreathing

A 22-year-old man complained of feeling "muddled" and bewildered and was failing to cope with life. He was solitary in his habits and day-dreamed. He was thought to have simple schizophrenia, and fluphenazine (Moditen) 1 mg. t.d.s. was begun. Within 48 hours he developed facial muscle hemispasm without any other effects. He similarly recovered on stopping the drug.

Most of the cases reported have been irreversible dyskinesias of the face, mouth, tongue, and jaw where patients have been on long-term therapy without anti-Parkinsonian drugs.[1-3] These three patients have all had unilateral oral dyskinesia after a small initial dose of phenothiazine without pedal spasm at the onset. A negative Chvostek's sign may distinguish this effect from tetany. —I am, etc.,

Bristol. P. M. TERRY.

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"Flip Flop" Sandals

SIR,—The "flip flop" sandal is becoming more and more popular in Britain today. Its cheapness and durability make it a very useful form of summer footwear, especially for children. The sandal had its origin in the Far East and has been a familiar sight to Servicemen overseas for many years.

Service doctors have long been aware of its inherent dangers, and I thought that the following observation would be of value to members of the profession in the United Kingdom. The sole of the sandal is made of ½ in. (1.25 cm.) Sorbo rubber and is easily penetrated by sharp objects such as broken glass, upturned nails, etc.

The patient presents with a small penetrating wound of the sole of the foot. Examination of the damaged "flip flop" reveals a small slit in the Sorbo sole. The wound in the foot may give the impression of being clean and free from any foreign body, but this type of wound warrants careful exploration. When the depths of the wound are explored a small piece of compressed Sorbo rubber is invariably found. This has been punched out of the sole of the sandal and driven deep into the wound. While in situ the piece of rubber may appear small, but when it is removed and allowed to expand its true size becomes apparent. The dangers attendant of leaving such a foreign body in situ are obvious.

Chronic infected wounds of this nature have yielded pieces of Sorbo rubber when they have been eventually explored. The removal of the offending foreign body has been followed by rapid healing.—I am, etc.,

A. J. JOHNSON.

Royal Air Force Changi,
G.P.O. Singapore.

Chloramphenicol in General Practice

SIR,—I have read this under-the-microscope investigation of the prescribing habits of 182 of my fellow general practitioners with an ever-deepening bewilderment (18 March, p. 671). One part of my bewilderment lies in the fact that we were not allowed to know how many cases of aplastic anaemia developed during his study. This omission was really quite startling, was it not ?

Another part of the bewilderment lies in the implied assumption that there *ought* to to be a pattern at various levels in general-practice work. This only shows a supreme ignorance of what work is like in general practice. Very few practices are like the ones carried on next door. Indeed, this is not a situation confined to general practitioners. General consultants vary so much in their treatments of, say, a coronary attack that a general practitioner who had the time could write an interesting analysis of the habits of this other grade in medicine.

This investigation on chloramphenicol should be of value in indicating that general practitioners are very varied people. Anyone who has listened-in to the after-lunch chats during a postgraduate course of the general practitioners attending will soon discover that group A may never have heard of the treatment given by groups C, D, and E for similar conditions, but all get roughly the same results—even group B, which is usually a devil for placebos. Perhaps I exaggerate a little, but I trust that someone will get the point.

Many years ago when I plastered my practice with chloramphenicol—particularly for whooping-cough—I never had a case of aplastic anaemia, so that I would often wonder if the fault lay in the soil and not in the seed (chloramphenicol), and I thought perhaps the antibiotic simply brought to light what would have shown itself in most cases later on. However, I have never been able to do anything but speculate on these matters, and it would be of great help to me to learn from the erudite whether any investigation has been done to this end. I have the honour to be, Sir, a general practitioner.—I am, etc.,

Taffs Well,
Nr. Cardiff. DAVID MONGER.

Assessing the Doctor

SIR,—Dr. T. W. Meade's interesting paper (18 March, p. 671) described indices of performance of general practitioners which should offer much more subtle criteria for the distribution of merit awards to them than those proposed in the working party report (*Supplement*, 11 February, p. 39).

That even so painstaking a classification of general practitioners was found to bear no relation to their standard of clinical performance will surprise few who knew general practice, and finally discredits the conception of merit awards.—I am, etc.,

London S.W.1. BENJAMIN LEE.