

or resigned and I have no access to cervical-smear-testing facilities.

Since 1 January this year I have seen 84 antenatal patients, 37 post-natal patients, 33 patients for family planning, and an uncounted number of gynaecological cases. The latter three groups have all had complete gynaecological examination, including the use of the vaginal speculum. I feel that all the patients for family planning advice should have had a cervical smear test taken at the time of my examination.

I should be grateful if any member can tell me where I can send slides to be read.—I am, etc.,

Dagenham, Essex. YVONNE G. BEECHING.

Wholly or in Part

SIR,—Surely the overwhelming vote taken by the Representative Body in favour of a direct payment by the patient at the time of consultation is by far the most significant step yet towards reducing Government control and restoring some responsibility to the individual patient. In my view these are two of the fundamentals upon which any new National Health Service must be built. But it is unfortunate that the ambiguous phrase "recoverable wholly or in part from the State" is incorporated, because this could mean that all fees paid by all N.H.S. patients are wholly recoverable. (If the Minister of Health, instead of adopting a doctrinaire attitude, were to consider this further alternative method of payment, he would undoubtedly do all he could to fix this interpretation.)

Left like this the idea of payment by the patient at the time of use is robbed of a great deal of its purpose. The doctor would be paid according to the amount of work he did, which in itself is a step in the right direction, but if all fees were wholly recoverable no new money would be brought into the service and there would be no financial bond between the patient and the doctor.

What is needed is an at-the-time payment recoverable only in part (probably a major part) by those who are reasonably placed financially and recoverable wholly by those who are not.—I am, etc.,

Eastbourne. R. HALE-WHITE.

Unusual Urinary Contaminants

SIR,—We wish to report the occurrence of some unusual contaminants in a urine specimen.

A fresh midstream specimen of urine was received in a sterile Universal container from a female animal attendant, aged 22, who was an in-patient of one of the medical wards. The urine was centrifuged and the unstained deposit examined in the usual way. Several unfamiliar objects were seen which were quite different from any of the commonly found extraneous particles. These were of two main types, as follows:

(1) *Ellipsoidal Objects*.—Most of these were fairly uniform in size, being about 50 μ by 35 μ , with a moderately thick wall and a fine irregular periphery. The inner structure appeared to be granular, pale yellow in colour, with no obvious nucleus. The granular material was separated from the wall by a more translucent layer (Fig. 1). A few of the objects were seen to have a blunt protrusion which appeared to be a germination tube, these varying in length from 10–50 μ (Fig. 2).

(2) *"Football" Type Objects*.—These were regular in shape and size, being about 50 μ in diameter (Fig. 3). They were symmetrically segmented, having eight divisions at the periphery and four units in the centre of the surface examined. They were pale yellow in colour. The cell wall was thin, regular, and smooth in appearance. No protrusions were found on any of these objects and no nuclei were seen.

The presence of two distinct types of unusual objects in the urine deposit and the fact that some of the ellipsoidal ones appeared to be germinating suggested the possibility of these being pollen grains. On examination of samples of pollen from the spring flowers in the ward we were able to show that pollen grains identical to the ellipsoidal ones found in the urine could be obtained from the daffodils and narcissi, and the "football" type from the mimosa. We

have not previously seen pollen grains of these types in specimens during the past 18 years' clinical laboratory experience, nor have we seen them described in the literature.

A visit to the ward enabled us to check the process of contamination. Apparently the specimen after collection in a urine flask and prior to transference to the Universal container had been placed for a short time on a bench where some fresh bunches of flowers were being handled, thus exposing it to dispersed pollen grains in the adjacent air.

Further specimens of urine from the same patient taken with due precautions were devoid of pollen grains.

Some authors refer to pollen as an occasional contaminant of urine or faeces⁴⁻⁶ but others do not.¹⁻³

An unwary technician could conceivably have reported the pollen grains of the narcissus species as parasitic ova, especially if they had been very scanty in number. The possibility of pollen grains contaminating faeces or urine in the wards could be a possible source of confusion to the microscopist.

We are indebted to Mr. P. Stinchcombe for the photography.

—We are, etc.,

R. A. HOLMAN.
JILL PEXTON.

Department of Bacteriology,
The Royal Infirmary,
Cardiff, Glamorgan.

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- 5 Gradwohl, R. B. H., *Clinical Laboratory Methods and Diagnosis*, 1943, 3rd ed., vol. 1, p. 92. Kimpton, London.
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Dangers of Radio-translucent Dental Plates

SIR,—During the last twelve months two patients have been admitted to the Royal Cornwall Infirmary having swallowed their dental plates, and in each case a consultant radiologist had reported that no foreign body was seen in the oesophagus.

Mr. A. B., aged 35, attended the casualty department of the West Cornwall Hospital, Penzance, on 25 August 1964, saying that he had swallowed part of his dental plate. There were nine teeth on his denture. A part of the plate with three teeth was missing. A consultant radiologist reported that no foreign body was seen in the oesophagus in straight x-ray films nor during a barium swallow examination. It was assumed that the piece of denture was in his stomach and he was admitted for observation. On 27 August 1964 his temperature rose to 101 and he continued to have discomfort on swallowing radiating through to his back. On further x-ray examination the radiologist thought the plate could be in the lower oesophagus. He was transferred to the Royal Cornwall Infirmary on 28 August 1964. At oesophagoscopy the same day the piece of dental plate was seen in the lower oesophagus and removed. He made a speedy uneventful recovery under antibiotic cover.

Mrs. C. D., aged 47, was seen in the Casualty Department of the Royal Cornwall Infirmary during the afternoon of 23 January 1965. She

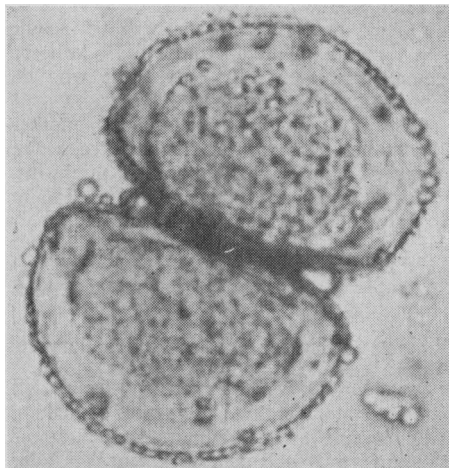


FIG. 1

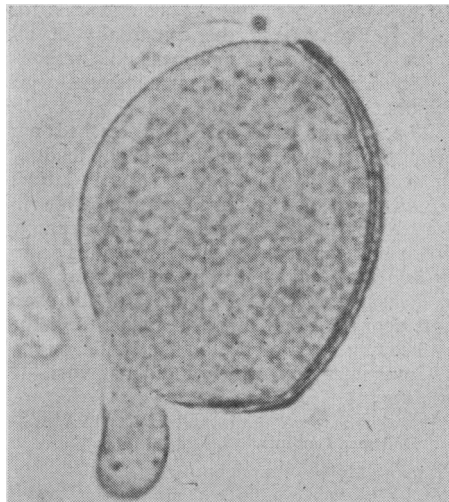


FIG. 2

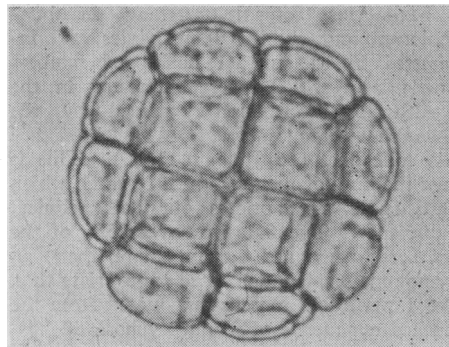
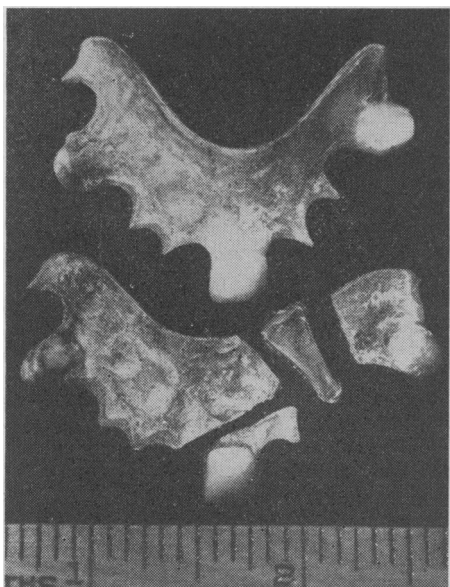


FIG. 3

said that she had swallowed her dental plate at about 2 p.m. the same day. She could feel it in her throat. X-ray pictures were reported by a consultant radiologist "no foreign body is seen." On clinical examination it was obvious that the denture was impacted in the upper oesophagus. At oesophagoscopy at 5 p.m. the dental plate



was seen lying transversely in the oesophagus. It was firmly impacted. It was impossible to rotate the foreign body so that it could be extracted in one piece, as the hooked corners were firmly embedded in the oesophageal wall. With considerable difficulty the plate was broken and removed in four pieces. The photograph shows a duplicate plate and the four pieces of the swallowed denture (see Fig.). During the course of instrumentation the right upper premolar was loosened and was therefore removed. The patient was given antibiotic cover and remained on sterile fluids for 48 hours. She made a rapid but somewhat uncomfortable recovery.

There are two reasons for reporting these cases. Firstly, with the hope that our dental colleagues will be encouraged to manufacture dental plates from radio-opaque material, and, secondly, as a warning for hospitals with x-ray departments open directly to general practitioners. A negative x-ray report is likely, even if a barium swallow is carried out, as these plastics are not only radio-transparent but the nature of their surfaces prevents adherence of barium particles. A clinical examination might not be performed if the patient is referred direct to a radiologist and not from a casualty or ear, nose, and throat department. The negative radiological findings might possibly cause dangerous delay in removal of this foreign body.—I am, etc.,

Royal Cornwall Infirmary, T. M. BANHAM.
Truro, Cornwall.

Large-bowel Obstruction

SIR,—In the 17 April (p. 1040) issue of the *B.M.J.* Dr. M. A. Feldman gave an interesting case report of large-bowel obstruction caused by urinary-bladder distension. I am sure Dr. Feldman would be interested that this phenomenon has been noted before in two patients, and was briefly discussed by the undersigned in a publication entitled "The Practice of Surgery in a Neuro-psychiatric Hospital."¹ In this same paper, while noting that a large distended bladder

can cause large-bowel obstruction, it was further noted that the obverse can occur—namely, that large-bowel distension in patients with megacolon can cause urinary retention.—I am, etc.,

W. E. MARCHAND.

Veterans Administration Hospital,
Fort Meade,
South Dakota, U.S.A.

REFERENCE

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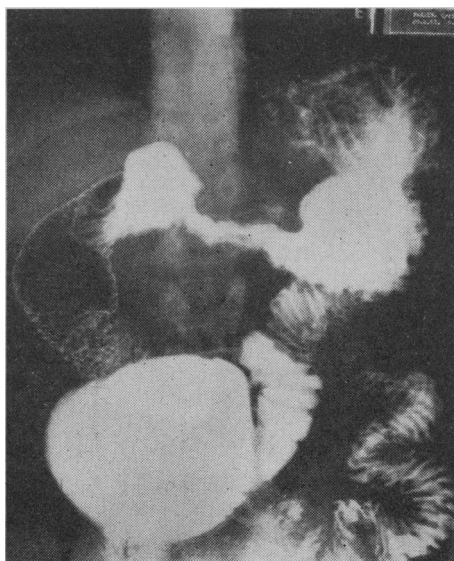
Duodenal Obstruction

SIR,—I think that the lesion in Mr. H. Sheikh's patient (12 June, p. 1539) is more likely to have been a duodenal obstruction, of unknown cause, rather than due to acute pancreatitis, since the serum amylase was normal.

I presented a similar case to the Royal Society of Medicine (Clinical Section) in March 1961.

This was a man of 48 with acute metabolic alkalosis producing tetany due to vomiting from duodenal occlusion. Gastrograffin film showed the obstruction to be in the horizontal duodenum. At operation the duodenum was widely dilated in two sections—one, stomach-width to the base of the mesentery; the other to the attachment to the ligament of Treitz. Biopsy of the duodenal wall was normal (no ischaemia despite the green-black discoloration and more than a week's history) and no intraluminal block was present (duodenum opened). A retrocolic gastro-jejunostomy was performed.

There is much confusion about this type of duodenal obstruction. "Chronic duodenal ileus" is probably the commonest name for it in Britain (it is not always chronic, and hardly ever an ileus). In the United States following Bockus's¹ massive classification of duodenal dilatation and stasis (32 sections of causes), arterio-mesenteric obstruction is the usual term used. Strong² showed that it was due to the narrowing of the lumen of the duodenum by the acute angle formed by the root of the mesentery (with the superior mesenteric artery) pressing against the right anterolateral aspect of the aorta, and to a high tethering of the distal duodenum at the ligament of Treitz. Section of this ligament produces relief.³



The post-operative films of my own case (see Fig.)—and I think that of Mr. Sheikh's patient also—shows the continuance of this vice at the root of the mesentery.

I am indebted to Dr. S. Karani and M. Joffe, consultants at St. Nicholas Hospital, Woolwich, for permission to publish case details.

—I am, etc.,

A. R. F. WILLIAMS

Luton, Beds.

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Biochemical Findings in Suprarenal Adenoma

SIR,—I read with interest the report by Dr. Joyce Warner of the biochemical findings in suprarenal adenoma (26 June, p. 1654).

Whilst I agree that there has been some controversy as to the response of adrenocortical adenomata and carcinomata to corticotrophin,¹ I do not agree that in cases of Cushing's syndrome due to adenomata it is unusual to find an increase in urinary steroids following an infusion of corticotrophin.

When assessing the results of the dexamethasone-suppression and corticotrophin-stimulation tests in cases of hyperglucocorticism, I have been accustomed to regard normal findings as comprising: (a) *bilateral adrenocortical hyperplasia*—positive response to suppression and stimulation; (b) *adenomata*—no response to suppression, with response to stimulation (the latter finding occurring particularly in well-differentiated tumours such as the case described); (c) *carcinomata*—no response to either suppression or stimulation. Using these criteria, which find support in two standard texts,^{2,3} the case described would not be regarded as being unusual.—I am, etc.,

ROBERT W. LOGAN.

Department of Biochemistry,
Royal Infirmary,
Glasgow C.4.

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Persistent Infection by *Trichophyton megninii* in Leeds

SIR,—The only published clinical report of infection in Britain due to *Trichophyton megninii* Blanchard, 1896 (syn. *Trichophyton rosaceum* Sabouraud, 1909), is that published by Sarkany, Clayton, and Beck.¹ They described fingernail infection due to this species in two immigrants, one a native of Sicily, the other from Eastern Germany. Since then *T. megninii* has been isolated from another immigrant, an Italian (Miss G. Midgely, Institute of Dermatology, St. John's Hospital, London, personal communication, 1965). It is therefore perhaps of interest to record now the occurrence of another case of infection by this species, this time in Leeds, in a native of this city.