

from the casualty department those patients whose self-poisoning episode was trivial in the poisoning sense. It is realized that to put the burden of psychiatric assessment in such cases on a busy casualty officer, often with little psychiatric training, is grossly unfair on the doctor and possibly lethal for the patient, whose initial attempt at suicide failed from lack of medical knowledge rather than from mental illness, which may be severe.

To have a psychiatric unit in a general hospital must be very useful. Unfortunately this is not the case in Sunderland.—I am, etc.,

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Vitamin B₁₂, Serum Folate, and Hypochromic Anaemia

SIR,—The letters from Mr. P. H. Johnson and others (8 March, p. 643) and from Dr. D. W. Dawson and Dr. A. L. Buckley (19 April, p. 187) illustrate the difficulties in the interpretation of evidence of folate deficiency in the presence of iron deficiency. We have previously described a high incidence of sub-normal serum folate levels, neutrophil multilobing, and marrow giant metamyelocytes in a series of patients with apparently uncomplicated iron deficiency anaemia.¹ In severe folate or B₁₂ deficiency coexisting iron deficiency almost certainly partially masks the degree of megaloblastic change. However, without bone marrow studies and a complete reassessment of the patients after iron repletion, it is not possible to interpret the data of Mr. Johnson and his colleagues as evidence for hypochromic anaemia masking folate or B₁₂ deficiency in the patients they describe.

We agree with the findings of Dr. Dawson and Dr. Buckley that the giant metamyelocytes and multilobed neutrophils tend to disappear with iron therapy alone, but this cannot be interpreted as correction of the vitamin defect. In our series of patients, together with the improvement in these morphological changes, iron therapy produced a significant fall in both red cell and serum folate levels. Our findings will be published in detail elsewhere.—We are, etc.,

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REFERENCE

- ¹ Roberts, P. D., St. John, J., Stewart, J. S., Coghill, N. F., Baird, I. M., and Sinha, R., *XII International Congress of Hematology, Abstracts*, 1968, p. 88. New York, International Society of Hematology.

Malabsorption Induced by P.A.S.

SIR,—We read with interest Dr. D. J. Coltart's report of malabsorption during treatment with para-amino-salicylate (P.A.S.) (29 March, p. 825). He states that "the only reports of increased faecal fat excretion appear to have been by Tygstrup *et al.*¹

and Levine,² who demonstrated this effect in normal subjects given test doses of P.A.S."

We recently reported increased faecal fat excretion occurring during treatment with P.A.S.³ In one patient the daily faecal fat excretion was 17.3 g. but returned to normal after P.A.S. was stopped. Unlike Dr. Coltart's case a jejunal biopsy showed incomplete villous atrophy. We agree that P.A.S. should be added to the list of drugs which may induce reversible malabsorption.—We are, etc.,

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REFERENCES

- ¹ Tygstrup, N., Winkler, K., and Jørgensen, K., *Ugeskrift for Læger*, 1961, **123**, 255.
² Levine, R. A., *Annals of Internal Medicine*, 1968, **68**, 1265.
³ Akhtar, A. J., Crompton, G. K., and Schonell, M. E., *Tubercle*, 1968, **49**, 328.

Granules of Electrolytes for Infants

SIR,—I was interested to read the letter of Mr. T. M. French (26 April, p. 248) describing the elegant preparation for the replacement of electrolyte losses in babies suffering from diarrhoea and vomiting, and agree that there is a real need for such a preparation, particularly for domiciliary use.

In conjunction with a commercial pharmaceutical company an electrolyte solution tablet was prepared, and has been in use in this department in the management of several hundred cases of infantile gastroenteritis during the last year with perfectly satisfactory results. The tablet contains:

Sodium chloride	...	...	200 mg.
Potassium chloride	...	...	160 mg.
Sodium bicarbonate	...	...	200 mg.

It has been designed to dissolve in 120 ml. (4 oz.) water and then produces an electrolyte solution of the following approximate concentrations:

Sodium	...	...	48 mEq/litre
Potassium	...	...	18 mEq/litre
Chloride	...	...	46 mEq/litre
Bicarbonate	...	...	20 mEq/litre

The compressed tablet contains a trace of tartaric acid which combines with a trace of bicarbonate to produce a satisfactory effervescent breakdown, and is mildly flavoured with either orange or lemon. No dextrose has been incorporated, since it is our experience that, even in modest concentrations, dextrose is apt to aggravate diarrhoea. Although the tablet was primarily designed for water and electrolyte maintenance in infancy, it has also proved useful as an electrolyte supplement in acute or chronic diarrhoeal diseases in adults, when it has simply been given dissolved in a cupful of water six to eight times daily.—I am, etc.,

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SIR,—Mr. T. M. French (26 April, p. 248) points out the usefulness of granules containing electrolyte and dextrose, which can be dispensed for dissolving in water to provide an electrolyte-sugar solution for treating gastroenteritis in infants and others. To the same end, I arranged¹ for a simple tablet containing sodium chloride 0.28 g. and potassium chloride 0.21 g. to be produced. When dissolved in 140 ml. (5 oz.) water, sweetened or flavoured as desired, this provided a solution of about one-third the tonicity of normal saline. These tablets were for many years manufactured commercially, but unfortunately have been recently discontinued. A pity, as they had proved extremely convenient and useful, both in Britain and overseas.

Your editorial suggestion² that the *National Formulary* should provide some such tablet is therefore even more pertinent.—I am, etc.,

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- ¹ Gairdner, D. *British Medical Journal*, 1956, **1**, 843.
² *British Medical Journal*, 1968, **1**, 70.

Mesenteric Adenitis

SIR,—In 1965 you commented¹ that mesenteric adenitis was a condition "... based on supposition apart from the fact of the enlarged glands so frequently found in these cases of abdominal pain mimicking appendicitis in childhood." Mr. P. F. Jones (12 April, p. 120) presents a well-reasoned argument against the use of the label of mesenteric adenitis with which I fully agree. It seems unsound to use a term of unproved clinicopathological significance as a diagnosis for those cases about which uncertainty as to treatment exists.

In an unpublished part of my recent study of abdominal pain in adults² (not, of course, statistically comparable to childhood studies) enlarged mesenteric nodes were described in 119 of 1284 abdomens opened for suspected acute appendicitis, and in 66 of these cases a surgical diagnosis of mesenteric adenitis was made. Appendicitis was in fact found on histological examination of 12 of these 66 cases. The frequency of cure of abdominal pain after removal of normal appendices has greatly hindered assessment of the relationship between "normal" appendices, mesenteric adenitis, and abdominal pain, but the use of the prussian-blue reaction as an indication of recent appendicitis in 40 patients operated on with acute symptoms added to recent previous symptoms out of the 66 cases of mesenteric adenitis described above appears to provide interesting results.³

Histological Findings and Clinical Follow-up Results of 40 Patients with Recurring Abdominal Pain Diagnosed at Emergency Operation as Having Mesenteric Adenitis

Prussian-blue Reaction	Recurrent Symptoms within 2 Years of Operation	
	Present	Absent
Appendix—		
iron positive ..	25	1
iron negative ..	15	6
Total ..	40	7
		33

The Table shows two groups of patients: (1) Those with mesenteric adenitis who have evidence of recent appendicitis—that is, are iron-positive—in whom appendicectomy coincides with cure in 24 of 25 cases (96%). This approximates closely to the cure rate of 98% which I have described for removal of acutely inflamed appendices.⁴ (2) Those who have no evidence of recent appendicitis—that is, are iron-negative—in whom appendicectomy coincides with cure in only 9 of 15 cases (60%). This is well below the cure rate of 86% normally associated with emergency removal of a normal appendix.⁴

There thus appear to be two distinct groups of patients with mesenteric adenitis, one in whom the appendix is involved (whether as cause and effect or sharing a common aetiology), and the other in which the appendix is not involved—or at least has not yet become involved. Until the two can be separated clinically the surgeon making the diagnosis of mesenteric adenitis must weigh the risks of unnecessary operation against those of missing appendicitis. The findings described above would appear to make a diagnosis of mesenteric adenitis a less attractive justification for non-operative treatment than it is at present, at least for the adult patient.

Were my findings applicable to the problem of the acute abdomen of childhood, I feel Mr. Jones would have won his point. However, until they are confirmed or refuted for the patients in the younger age groups the criticisms of 1965 must unfortunately remain valid.—I am, etc.,

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- ¹ *British Medical Journal*, 1965, 1, 707.
- ² Howie, J. G. R., M.D. thesis, University of Glasgow, 1967.
- ³ Howie, J. G. R., *Journal of Pathology and Bacteriology*, 1966, 91, 85.
- ⁴ Howie, J. G. R., *Scottish Medical Journal*, 1968, 13, 72.

Holmes-Adie Syndrome

SIR,—As your leading article (1 February, p. 267) shows, the pathological report of Harriman and Garland¹ has confirmed previous hypothetical postulates as regards the site of the pupillary lesion in Adie's syndrome. Your leader does not, however, cover two interesting aspects of this disorder.

The complete Adie's syndrome has been reported in association with other neurovegetative phenomena—for example, delayed gastric emptying. Secondly, and of more interest in explaining the pupillary phenomena, are various reports²⁻⁵ which show that sympathetic (stellate ganglion) block can relieve the pupillary changes. This ties in with the pathological changes.

Six patients with unilateral Adie's syndrome were treated as follows: Two with guanethidine eye-drops 5.0%, and four with thymoxamine 0.5%. The two guanethidine-treated patients had a spontaneous recovery of light reflexes. Three out of four of the thymoxamine-treated patients had a recovery of pupillary reflexes to light and all four had a change in the pupillary response to dark adaptation.

From pupillographic studies, the pathology, previous reports of pharmacological responses, and the changes with sympathetic blockade, surgical and therapeutic, it is reasonable to assume that the pupillary changes arise from incomplete parasympathetic interruption.

Further, that there is an intact peripheral neurone and that the size and shape of the pupil would depend on the volume of sympathetic activity.—I am, etc.,

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- ² Russell, G. F. M., *Journal of Neurology, Neurosurgery, and Psychiatry*, 1956, 19, 289.
- ³ Marré, E., Marré, M., and Richwien, R., *Albrecht von Graefe's Archiv für Ophthalmologie*, 1963, 166, 70.
- ⁴ Masson, R., Boucher, M., Bady, B., *Lyon Médical*, 1964, 211, 3, 121.
- ⁵ Masson, R., Boucher, M., Bady, B., *Revue d'Oto-Neuro-Ophthalmologie*, 1964, 36, 311.

Strokes and the Pill

SIR,—The arrival of the *B.M.J.* on 22 March with your leading article (p. 733) coincided with the admission to this hospital of a 26-year-old Indian woman with benign intracranial hypertension. She complained of headaches and blurred vision for two weeks. There was bilateral papilloedema but no sign of focal neurological disease or other systemic disorder. Carotid angiography was normal.

She had been using an oral contraceptive (5 mg. lynoestrenol and 0.15 mg. mestranol) for two years. This was discontinued on admission to hospital. Thereafter there was steady improvement in her symptoms and the papilloedema had almost completely disappeared in three weeks. No specific treatment was given.

This appears to be a further example of pseudotumor cerebri developing in association with the use of oral contraceptives.—I am, etc.,

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as venereal and non-venereal with the implication, insinuation, and conclusion that can be drawn from them, but as sexually transmissible infections, when the management and treatment of the patients with these infections will be more successful. I await positive proof to the contrary.—I am, etc.,

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W. TSAO.

Doctors and the Practice of Nursing

SIR,—I share the sentiments of Mr. M. C. T. Morrison (19 April, p. 191) that the special relationship which used to exist between doctors and nurses is in danger of disintegrating.

Fortunately this is not the case between doctors and midwives. The Central Midwives Board will only approve hospitals as training schools for midwives if the consultant staff participate, with the midwife teacher, in the instruction and examination of pupil midwives. Hence since the formation of the C.M.B. by Act of Parliament in 1902 a happy relationship has existed between doctors and midwives. Every year eight examinations are held and hundreds of obstetricians each paired with a midwife teacher correct scripts and conduct clinical and oral examinations for about 9,000 pupil midwives. In several centres in Britain doctors of many specialties play an important part in the instruction of future midwife teachers.

The C.M.B. are deeply appreciative of the willing co-operation of the medical profession in the training of midwives, and they believe it is of mutual benefit to both professions and thus to the public we both serve.—I am, etc.,

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Central Midwives Board.
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Cyclator Ventilator

SIR,—I would be grateful if the attention of your readers could be brought to two faults which may occur in the Cyclator ventilator.

On several occasions it has proved impossible to ventilate a patient by hand using the Cyclator circuit although the ventilator has been apparently switched off. On squeezing the reservoir bag gas was vented at low pressure inside the machine, and inflation of the patient did not take place. To restore the situation a separate circuit had to be connected, and the time lapse might have endangered the patient. It was found that two minor faults could give rise to this situation and both happened to be present simultaneously.

Some rotation of the on/off switch while in the "off" position was possible on this particular machine. In certain positions this allowed a small leak through the switch permitting the driving chamber to pressurize, thus activating the bypass valve and preventing manual ventilation. This fault was rectified by replacing the valve seating.

The expiratory pause control on this machine allowed a pause in excess of the theoretical maximum (30 sec.), and, in fact, over the last half-turn of its travel the variable

Trichomoniasis and Gonorrhoea

SIR,—I have read with interest the comments raised by Dr. D. F. Hawkins (12 April, p. 116) and Dr. N. Rosedale (3 May, p. 315) in connexion with my letter (8 March, p. 642).

At present, methods available for the detection of Neisserian infection are far from satisfactory, especially in women and in respect to tests for cure. Frequently, repeated tests are necessary after treatment of trichomoniasis before gonorrhoea is detectable. Trichomoniasis is usually a more acute infection in the females, particularly when associated with gonorrhoea. I have repeatedly seen patients who were almost in tears with distress from being reinfected as their asymptomatic male contacts have not been treated at other clinics because of negative findings. In each case cure has only resulted after proper treatment of the patient and the contact. It is always more difficult to cure the infections than to clear the patients of their symptoms. Unfortunately, the disappearance of symptoms is too often regarded by both patients and doctors as a sign of cure, which is not always the case.

In the present state of affairs, perhaps these infections should now not be regarded