jerking patients seen in mental hospitals or neurological units whom a second-year medical student could hardly fail to diagnose. Following Pleydell's[1 2] and Reid's[3] pedigrees, and new pedigrees in this county, we find many more patients out of hospital than in hospitals. It is of course the less obvious cases that transmit the illness. As Huntington's chorea is transmitted as a Mendelian dominant, and is *not* a sex-linked condition, why was the B.M.A. committee only interested in the mother's condition? It is also irrelevant to refer to the risk to "families with a high incidence of the condition." If one generation happens to have well under the 50% expected incidence, the next may be unlucky, with perhaps most or even all of the siblings affected.

Manifestation of symptoms can occur after some or all the children are born. The consequences of the illness (in either parent) on the children can be intensely harmful. In Northamptonshire we now have details on a pedigree spanning six generations in which 10 of the 44 adults have had Huntington's chorea. Of the remaining 34 subjects 10 or more have had (or have) serious neurotic and/or marital troubles, divorce, etc., five have been (or are) alcoholics, five have had psychotic illnesses, and two or more have criminal records. The incidence of abandoned or illegitimate children, or children who have died young, should interest anyone interested in preventive medicine or public health. Finally, among all this illness and distress the relevant medical notes for each affected individual seldom have a remotely accurate family history concerning the other members.

The personal tragedies, morbidities, and mortalities occurring in Huntington's chorea pedigrees point to the need for a country-wide medical linkage system as has been started at Oxford. They also act as a reproach to the leaders of the medical profession for such an enfeebled attitude to the question of birth control, sterilization, and, as a last resort, termination of pregnancy. My experience is the same as that of Pleydell: in general, members of these unfortunate drifting families welcome sympathetic but decisive help in preventing them from having large numbers of children.—I am, etc.,

St. Crispin Hospital, Duston, Northampton. J. E. OLIVER.

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[1] Pleydell, M. J., *Brit. med. J.*, 1954, **2**, 1121.
[2] Pleydell, M. J., *Brit. med. J.*, 1955, **2**, 889.
[3] Reid, J. J. A., *Brit. med. J.*, 1960, **2**, 650.

Medicine and Mass Media

SIR,—The fortuitous circumstance that the first heart transplantation was undertaken in Cape Town has bedevilled an issue that, for all the irrelevant mumbo-jumbo of morals, ethics, law, and economics, deserves dispassionate examination by surgeons and physicians who have not spent most of their working lives with eyes glued on the thorax and its contents.

Surgery is almost always a crude makeshift. Thus, as an instance, when hypotensive drugs became safe and effective, surgeons stopped doing sympathectomy. When we learn how to delay the onset of heart disease, and how to avert its consequences, we shall not need to transplant hearts, though no doubt valvular heart disease and congenital malformations will continue to be treated surgically. Meanwhile, desperately ill cardiac patients are in much the same situation as patients who have inoperable cancer. It is worth asking ourselves what surgery and/or radiotherapy can offer to patients with operable cancer, let alone to patients in whom the disease is far advanced. A comprehensive figure for cancer at all sites is about 20% for five-year survival. For the remaining 80% the figure is much less promising. Yet no one suggests that surgical intervention should cease until more effective methods become available or that patients should not be told of the outside chance of prolonging life by shouldering the risk of a possibly fatal outcome. In the case of breast cancer, patients have been pursued to within an inch of the grave with extended radical mastectomy, adrenalectomy, and disarticulation of the arm. Pelvic exenteration, with the formation of ileal bladders and colostomy, encounters no adverse comment. Heart transplantation, it would appear, is something else. Why?

Mr. W. J. Dempster and his colleagues (20 January, p. 177) answer that the problems of graft rejection are not resolved; we need to know much more before we can hold out hope of reasonable survival. But heart transplantation in laboratory animals has yielded some encouragement, and kidney transplantation is being carried out all over the world. Ah, but here we have dialysis to fall back on, and Mr. Dempster warns us that even kidney transplants are not all they are cracked up to be. One could justifiably argue that pelvic exenteration, cobalt therapy, and other radical procedures are equally not all they are cracked up to be. They are desperate and interim resorts, and so is organ transplantation.

At some point some one has to take the first step from the laboratory to the patient. There comes a time when a drug, elaborated in pharmaceutical laboratories and tested for toxicity and sublethal dosage, has to be submitted to clinical trial. Even here there is a calculated risk, and we have seen enough of the disasters which may follow this step to persuade us to be charitable to other workers who face similar setbacks. The first man who opened the abdominal cavity knew little of the attendant risks.

So, if a patient who is doomed to an early death is told that there is an outside chance that his life may be prolonged and that he runs the risk of not surviving, then if he and his family accept the risk they should be allowed to do so.

Mr. Dempster and his colleagues must be naive if they imagined that their cautionary pouring of cold water in their letter to you would not be picked up by every lay journal in the world. The reporter's pencil and the television eye are poised over every issue of reputable medical journals. Mr. J. M. Potter (10 February, p. 378) may lament this, but the days of cosy claustrophobic discussion confined to the medical press are over, and the medical innovator jostles the pop singer off the front pages of the daily press. Most of us deplore this invasion of our privacy, recognizing that publicity, like power, can go to the head. Yet I confess that I would have expected the Hammersmith workers to show some understanding of the impact of publicity on Groote Schuur Hospital, remembering what they had to endure on the occasion you recall in your leader columns (10 February, p. 330).

This said, I am forced to acknowledge that publicity went too far. I do this all the more sadly because, as a former colleague of his, I have the highest regard for Professor C. N. Barnard as a man and as a doctor solicitous of his patients' welfare. Moreover (and in this I know that those who have visited Groote Schuur Hospital will concur), the standard of medical care at that institution should occasion no surprise that this formidable enterprise should have been embarked upon there.—I am, etc.,

London W.8. GEORGE SACKS.

Danger of Airguns

SIR,—Doctors should lose no opportunity of warning patients of the danger of airguns and firearms in the hands of inexperienced people, especially children.

The photographs show pellets in the faces in two of six recent victims having to attend this hospital. In four cases the weapon was an airgun and in two a shotgun. In four cases the pellet narrowly missed the eye. In one case (Fig. 1) the pellet lodged in the eyeball and has caused blindness, and in another (Fig. 2) the pellet entered the medial aspect of the orbit, causing impaired vision. It

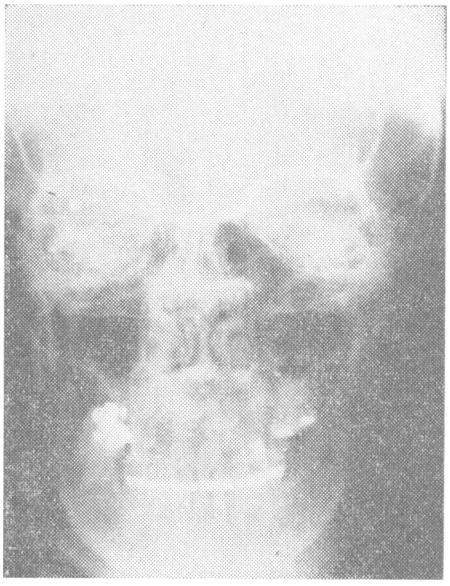


FIG. 1

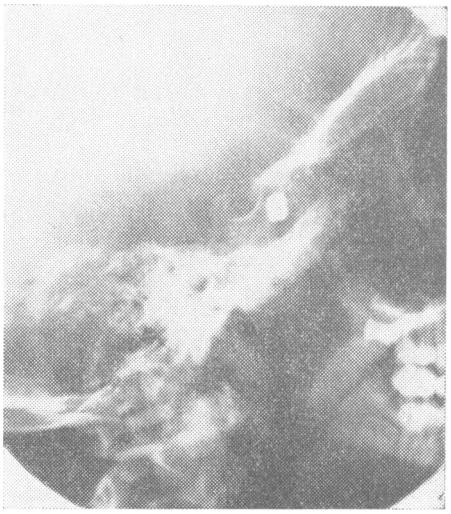


FIG. 2

finally lodged in the sphenoidal sinus, narrowly missing the hypophysis.

A new 16-mm. film, entitled "Dead Safe" and running for 27 minutes, illustrates the safe handling of guns. It is available for loan, without charge, from I.C.I. Film Library, Millbank, London S.W.1.

I am grateful to my colleague Mr. John Ogg for allowing me to see the two cases illustrated.

—I am, etc.,

Salisbury General Hospital, Wilts. BRIAN REEVES.

Oxytocic Drugs in Labour

SIR,—Might I suggest to Dr. R. H. G. Lyne-Pirkis (17 February, p. 447) that the compromise that he is seeking is to inject the oxytocic *immediately after* the baby has been completely delivered, and *not* with either the crowning of the head or the appearance of the shoulder.

It is my teaching that as soon as the child arrives the accoucheur—midwife or doctor—should first palpate the relaxed uterus to ensure that there is no "undiagnosed twin" present, then without any delay 1 ml. of Syntometrine (ergometrine maleate and oxytocin)—already in the syringe—is injected intramuscularly. This procedure has obviated the trapping of such a twin, and it has kept the incidence of postpartum haemorrhage in the unit in the region of 3%.

—I am, etc.,

St. John's Hospital, Chelmsford. DAVID BROWN.

Lead-poisoning from Unusual Source

SIR,—Dr. M. A. Warley and others (13 January, p. 117) point out the very real danger of lead-poisoning from a mascara-like substance ("surma") commonly used by the gentle sex originating from the Indian subcontinent. The following case shows that natives of this island are not exempt from similar hazards.

We found an apparently inexplicable case of lead-poisoning in a 15-year-old English girl admitted in October 1967 for the investigation of amenorrhoea and anaemia. There was a four-month history of fatigue, pallor, and a sickly feeling in the stomach making her disinterested in her breakfast. Two months previously slight jaundice of the eyeballs was noticed by her family. Moderate pallor and very slight subicterus of the sclerae were the only abnormal clinical findings. The blood count revealed a slightly hypochromic or normochromic anaemia with aniso-poikilocytosis and polychromasia (Hb 8.5–9.1 g./100 ml.; P.C.V. 29–31%; reticulocytes 15–21%). Many red cells showed coarse basophilic stippling and siderotic granules. The bone marrow exhibited a very active normoblastic erythropoiesis, numerous "ringed" and ordinary sideroblasts, siderocytes, and fairly rich reticulum iron. Haptoglobins were absent; the direct Coombs test was negative (on both reticulocytes and non-reticulocytes); the serum bilirubin was raised (3 mg./100 ml.); and haemoglobin A_2 was normal. The diagnosis of haemolytic anaemia due almost certainly to lead-poisoning was made.

When almost all hope of tracking down the source of lead intake was given up it was noticed by one of us (S. V.) that the patient had on a bright salmon-pink lipstick. This turned out to be ointment belonging to the patient's grandmother—used by her for various skin blemishes and bunions—a proprietary preparation sold over the counter, which the patient, being a lip-biter, had been using for the previous 18 months as a lip-salve and/or a lipstick for its pretty colour. It could be calculated that she had ingested about 3 oz. (100 g.) of this ointment containing 67% basic lead carbonate B.P.C. (A. H. Allen and Partners, Public Analysts Laboratory, Sheffield), the total intake being in the neighbourhood of 45 g. of elemental lead. Subsequent chemical investigations, as expected, were confirmatory of lead-poisoning (lead in urine up to 1,000 μg./l.). The patient is now well, her haemoglobin is normal, and she is menstruating.

The common denominator between the two forms of lead-poisoning, that reported by Drs. Warley, Blackledge, and O'Gorman, and ourselves, is the existence of potentially dangerous sources of lead accessible to unsuspecting individuals. Although in our case the jar carried on its label the warning "For outward use only," one wonders whether this is sufficient.

What will surely interest Dr. Warley and his colleagues is that when in November 1967 the diagnosis of lead-poisoning was established in our patient one of us (P. C. S.) suggested to a countrywoman of his, a lady doctor, that her complaints of irritability, weakness, and diminished appetite might be due to the use of "surma." Subsequently her urine was found to contain 118 μg. of lead per litre and the blood 28.6 μg./100 ml. Three weeks after discontinuation of this cosmetic she felt completely fit.

—We are, etc.,

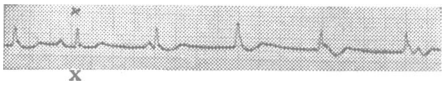
P. C. SRIVASTAVA.
S. VARADI.

Department of Haematology, Northern General Hospital, Sheffield, Yorks.

Scleroderma Heart Disease

SIR,—The report on the cases of scleroderma heart disease by Drs. E. Fletcher and P. Morton (16 December, p. 657) prompts us to write about a patient at present in hospital.

This is a 51-year-old male who was admitted in November 1967 with progressive shortness of breath of two months' duration. Other complaints were numbness of hands and loss of 2 stones (12 kg.) in weight over the same period. Bowels open twice a day on average, the stools often being pale. He had a slight cough but no chest pain. On examination he was dyspnoeic at rest, slightly cyanosed, but had no clubbing. Skin over hands and face was moderately "tight." Heart was clinically normal and blood pressure was 115/70 mm. Hg. Jugular venous pressure was not raised and there was no oedema. There were coarse crepitations over the lower chest on both sides. Investigations: Chest *x*-ray showed slight cardiac enlargement and dense mottling of the lower lung fields, Hb 10.2 g./100 ml., W.B.C. 7,000/cu. mm., E.S.R. 80 to 110 mm. (Westergren); urea 50 mg./100 ml., electrolytes normal; albumin 3.5 g./100 ml., globulin 2.6 g./100 ml. with an increase in the γ fraction; latex and Rose-Waaler negative; L.E. cells demonstrated three times; complement fixation tests to *M. pneumoniae*, *R. burneti*, and psittacosis-L.G.V. all negative. E.C.G. on the day of admission revealed nodal rhythm with interference-dissociation. The QRS marked "X" appears to be a captured ventricular beat. (He was not on digitalis.) Rhythm reverted to normal with atropine, and subsequent E.C.G.s did not show any evidence of myocardial infarction.



He has now recovered from the acute episode, though he is dyspnoeic on moderate exertion. Basal crepitations and *x*-ray appearances of diffuse pulmonary fibrosis persist. Vital capacity is 1.5 litres (predicted 3.3 litres) and $\frac{F.E.V._{.1}}{V.C.}$ 55%. Other respiratory function tests were not done because the patient with his "small mouth" could not tolerate the mouthpiece of the instruments. He probably has systemic sclerosis with primary cardiac involvement.

Though a variety of E.C.G. abnormalities have been described in such cases we found no record of nodal rhythm with A–V dissociation. This case exemplifies the non-specific nature of E.C.G. changes found in scleroderma.[1]

We thank Dr. Ian Short for permission to publish this case.

—We are, etc.,

FRANCES WREN.
M. GOVINDARAJ.

Knightswood Hospital, Anniesland, Glasgow.

REFERENCE

1 Oram, S., and Stokes, W., *Brit. Heart J.*, 1961, **23**, 243.

Malaria in Britain

SIR,—The correspondence on malaria in Britain has pinpointed the importance of early diagnosis of the species *P. falciparum*. For several years past we have been following up imported malarias as they have been officially reported. We have made it a practice of asking for the loan of the blood film on which the diagnosis of malaria and the species of parasite was made. The questionaries sent out by us have shown that with quite a number of patients they did not report sick for several days after fever began. Many patients said they did not think it could be malaria because they had taken prophylactic drugs regularly until the day they left the malarious area. In over 90% of all cases of *P. falciparum* malaria in this country prophylactic drugs were discontinued either on the day of leaving the area or a few days later. In not a single case investigated by us did the patient take his prophylactic drug regularly for one month after leaving, as advocated by Professor B. G. Maegraith.[1]

As Dr. P. Rees and Dr. D. H. Smith (20 January, p. 179) have pointed out, species diagnosis is of very great importance.[2] It is all too frequently assumed that if the films show parasites larger than the signet-ring forms then it must be other than *P. falciparum*. This is far from correct and of the very greatest importance. Primary infections of *P. falciparum* invariably show growing trophozoites if the attack remains untreated for more than seven or eight days. It cannot be overemphasized that developing forms of *P. falciparum* in the peripheral circulation are a danger signal and call for urgent and drastic treatment. The detection of these forms is very easy if it is remembered that never more than one or two lumps of pig-