

in whom the serum phosphorus and urinary excretion of calcium were normal. In 1958 the serum calcium levels were 11.6 and 12.8 mg. per 100 ml. At this time the serum phosphorus was low and the urinary calcium was greatly elevated. A parathyroid adenoma measuring  $1.0 \times 0.8 \times 0.5$  cm. was removed.

I make a practice of personally taking the blood samples at the clinic, using the technique precisely as advocated by Professor Dent in order to avoid introducing technical error due to stasis. I therefore cannot agree that "... one quite normal value for total calcium obtained with impeccable technique makes the diagnosis [of hyperparathyroidism] most unlikely."

A possible explanation of the diverging views on this aspect of the investigation of hyperparathyroidism is that Professor Dent's experience of the bone form of the disease is much greater than mine, which is mainly of the stone form. Professor Dent believes,<sup>2</sup> and I agree with him,<sup>3</sup> that there are fundamental differences between the "with-bone-disease" and "without-bone-disease" forms of hyperparathyroidism. It may well be that a marked tendency for the serum calcium to fluctuate is a feature of the stone form of the disease which is not found, or is less obvious, in the "with-bone-disease" form. Hyperparathyroid bone disease can usually be diagnosed without delay, and the patients are unlikely to be under observation for months before operation. In my 13 patients with bone disease the diagnosis was made and operation performed within a few weeks of first being seen, with one exception. In the exceptional patient the serum calcium levels varied between 10.0 and 14.1 mg. per 100 ml. The evidence for variation in the serum calcium in patients with hyperparathyroid stone disease will be reported elsewhere. In other diseases in which hypercalcaemia occurs the level of the serum calcium is much less variable.

In common with Professor Dent, I consider that there is overwhelming evidence that hyperparathyroidism is a common disease, and I think that fresh cases are most likely to be uncovered amongst the patients attending a renal stone clinic.—I am, etc.,

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#### REFERENCES

- McGeown, M. G., and Morrison, E., *Postgrad. med. J.*, 1959, **35**, 330.
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- McGeown, M. G., *ibid.*, 1962, **2**, 799.

#### Trendelenburg Sign

SIR,—In these days of "do it yourself," I thought the following might be of interest to your readers.

A patient from the West Country who had undergone a "top tie" operation found out for himself a year later that if he lay down and elevated his leg and then pressed hard in his groin the veins remained empty when he stood up. This relieved his aching limb. The correctness of his testing was shown when exploring the groin wound, which showed that the internal saphenous vein was still intact.

This test, as we all know, was first described by Sir Benjamin Brodie in 1846, and Trendelenburg's description of the test some 50 years later was an almost verbatim translation of Brodie's observations. In the past 40 years, however, I have never come across a patient who had discovered this test for himself.—I am, etc.,

London W.1.

R. ROWDEN FOOTE.

#### Mental Health Act

SIR,—It is time that it was publicly admitted that the Mental Health Act is a cruel failure. This is, of course, well known to general practitioners, mentally ill patients, and their relatives. It is cruel because those whom it was designed to help have been the chief sufferers—namely, the patient requiring treatment, care, and protection.

There are frequent reports of the unhappy drifting fate of patients allowed under the Act to take their own discharge without being well enough to decide. The courts wishing to remand cases for treatment or protection find that mental hospitals refuse patients if they are likely to prove "difficult," and the unfortunate sufferer then enters prison as there is no alternative. The Act allows attempted suicides to leave hospital after a day or so with little apparent regard to future attempts. The evidence of two doctors as to the need for hospital treatment is often doubted, even in an emergency.

Mental welfare officers appear to have lost their duties completely. Many patients suffering from advanced senile dementia lie at home amongst their own filth. Their lot is neglect while the general practitioner is badgered and harassed to arrange admission by relatives, public health officials, neighbours, mental welfare officers, police, etc. Quite apart from the problem of an ageing population, all the difficulties mentioned above have become more urgent since the passing of the Mental Health Act, and are consequent upon it either directly or indirectly by the unhealthy climate it has created.

The G.M.S. Committee is seeing the Minister about some of the difficulties, but many of us, made anxious by what has gone on during the past few years in the name of progress, pray that the Association will initiate an early realistic comprehensive inquiry.—I am, etc.,

Ealing W.13.

R. E. W. OLIVER.

#### Rupture of the Rectus Abdominis Muscle

SIR,—We were interested in the memorandum by Mr. A. G. Horsburgh (October 6, p. 898) and the letter of Mr. W. Love (October 27, p. 1130). In the past nine months we have seen two similar cases in general practice, the second in fact occurring on the day of publication of the latter's letter.

The first case in January, 1962, was a woman of 57, who presented with severe pain and swelling in the left lower abdomen. She had had a cough for a few days, and said that she felt something "go" in her tummy the previous night during a bout of coughing. On examination, a swelling of about 6 in. (15.2 cm.) in diameter could be felt to the left of a midline scar of a previous caesarean section. The mass was tense and tender, but not mobile. Its edges were clearly palpable, and it appeared to be arising from the pelvis. Vaginal examination revealed a tumour in the left fornix. Pulse and blood-pressure were normal, and her haemoglobin was 85%.

She was admitted to hospital with a provisional diagnosis of torsion of an ovarian cyst and laparotomy was arranged for the following day. At operation, a midline incision was made, excising the previous scar. Old blood clot was found in the sheath of the left rectus abdominis, and the torn muscle fibres were seen. No bleeding points were isolated. The peritoneal cavity was opened and no intra-abdominal abnormality was detected. The torn ends of the muscle were sutured. Total blood clot removed was 15 oz. (425 ml.). A drainage tube was inserted and the abdomen closed.

Post-operatively, haemoglobin was 63%, and the patient was transfused with 2 pints (1.1 litres) of blood. Investigation showed bleeding- and clotting-time to be normal.

The drainage tube was removed after 48 hours. There was a little oozing for the next few days and the patient was discharged well three weeks after admission.

The second patient, whom we saw in October, 1962, was a young married woman aged 31, para 2, who had also had a nasty cough for two weeks. She had abdominal pain on coughing for a few days, and this became much worse one evening, when we were called to see her. She complained of sudden severe pain in the right iliac fossa, and felt nauseated. She did not vomit, but in the next hour had two bouts of diarrhoea. Straining at stool and rising from a lying position caused extreme pain. Pulse was 94/min., temperature 99.2° F. (37.3° C.). Micturition was normal. Her last menstrual period was two weeks before. She was not shocked. B.P. 120/80. There was a tender mass to the right of the midline, ovoid in shape, with the long axis in the line of the rectus measuring about 4 in. by 3 in. (10.2 by 7.6 cm.). It was extremely tender, not movable, and felt relatively superficial. With the memory of the previous case fresh in our minds, a diagnosis of ruptured rectus abdominis was made and she was admitted to the surgical wards of the Gloucester Royal Infirmary.

At operation on the following day a lower midline incision revealed a haematoma behind the right rectus muscle and the posterior wall of the rectus sheath. Blood clot amounted to 5 oz. (142 ml.). There was no evidence of torn muscle fibres or bleeding points. The abdomen was explored: the ovaries and uterus were normal. Routine appendicectomy was performed. The post-operative period was uneventful, the patient being discharged well after 11 days.

Although this condition is said to be most common in middle-aged and elderly women with chronic bronchitis, it is of interest that our second case occurred in a well-nourished healthy woman of 31 during an isolated episode of mild bronchitis.

We should like to thank Mr. E. M. Edwards and Mr. W. J. Wilkin, of the Gloucester United Hospitals, for permission to publish details of their operation notes.

—We are, etc.,

City Health Centre,  
Gloucester.

D. MCCARTHY.  
T. E. DURKIN.

#### “Ancoloxin” and Foetal Abnormalities

SIR,—The facts so hastily published by the College of General Practitioners about “ancoloxin” (meclozine and pyridoxine), far from constituting mounting evidence against it, do not add up to any evidence at all. They neither incriminate nor absolve it.

In the matter of the 784 cases, the College must have discovered, in addition to the published facts, the answers to the following questions: (a) How many abnormalities were there in the 660 cases where no anti-emetic was taken; (b) how many of the 124 took ancoloxin; and (c) what was the nature of the three malformations?

If there were only three mothers who took ancoloxin, and these three gave birth to grossly deformed babies, and if there were no abnormalities among the 660, then obviously ancoloxin should be at least temporarily withdrawn. On the other hand if the three deformities were trivial, if nearly all the 124 took ancoloxin, and if there were some severe deformities among the 660, then ancoloxin would be virtually cleared.

Of the 29 other cases of congenital abnormality culled from an unknown number of pregnancies, all that can be said is that ancoloxin and certain other unnamed anti-emetics do not absolutely prevent the occurrence of

foetal abnormalities. One could doubtless find a similar mixed bag of abnormalities ranging like these from the trivial to the severe among mothers who, for example, smoke, had influenza during pregnancy, themselves suffered from congenital abnormalities, or conceived when there was no “r” in the month.

I cannot believe that this preliminary, one might say premature, report is putting the information sent into the College to its best use.—I am, etc.,

Southsea, Hants.

J. R. JAMES.

#### Chlorpropamide and Foetal Damage

SIR,—Earlier this year Dr. W. P. U. Jackson and I uttered a preliminary warning in the correspondence columns of the *South African Medical Journal*<sup>1</sup> about the unusual findings in a paper of ours<sup>2</sup> where the perinatal mortality in a series of insulin-independent young diabetics treated throughout pregnancy with the sulphonylureas was described. Briefly it was found that the perinatal foetal mortality of 50 control pregnant diabetics treated with insulin and/or diet was 20%. A series of 40 patients (plus two in an addendum) were treated throughout pregnancy with the sulphonylureas: in 20 cases treated with tolbutamide the perinatal mortality was 23%, but in those 22 treated with chlorpropamide (including the two added cases) the perinatal foetal mortality was 65%: these differences appeared statistically significant ( $P < 0.01$ ). Previously we had described<sup>3</sup> multiple congenital abnormalities in the foetus of a patient well controlled throughout pregnancy with tolbutamide, but we found it impossible in this case to incriminate the drug; more recently<sup>2</sup> we said that “the danger to human pregnancy does not appear to lie in the production of multiple congenital abnormalities.”

The chlorpropamide cases can be tabulated as follows:

Drug dosage (daily)	Number of pregnancies	Foetal mortality (No. of cases)
500 mg.	19	14
250 mg.	3	—

Thus of the 19 pregnancies which were controlled with 500 mg. of chlorpropamide daily, only five foetuses survived.

As might be expected, the survivors have been followed carefully. One mother defaulted between the third and the tenth months after delivery, which had been terminated by caesarean section at the thirty-seventh week, after good diabetic control during the course of the pregnancy. She returned again because of the apparent failure of the child to thrive. On examination, it was apparent that the child was suffering from an advanced degree of microcephaly, and that it had a spastic quadriplegia. We had noted previously that death in the perinatal mortality cases following chlorpropamide was of a respiratory nature: in this case the paediatrician reported that “the child nearly died twice because of apnoeic attacks in the immediate post-natal period.” Unfortunately skull circumference at birth was not noted.

In view of our experiences and the immediate post-natal history in this patient we feel that there is a stronger case for regarding these abnormalities as the result of chlorpropamide therapy than was so in the tolbutamide-treated case,<sup>3</sup> as this latter case had a very bad obstetric history and in the 14 months since details of the case were noted she has had three miscarriages. The more recent case has made us even more certain