is likely to be nearer the upper than the lower of these limits." The comparable ratio between affected and control patients in our original study was 3 to 1, which again suggests a bias of 2–3 to 1.

Parity	Rates (per 1,000 Population)
0	0·7 (5)
1	1·5 (15)
2	1·9 (21)
3	2·9 (15)
4 and over	5·0 (18)
Not known	(1)

The only alternative explanation to a bias would be that thromboembolic episodes produced in oral contraceptive users were more severe than those produced by pregnancy or the puerperium or in those who are suffering from so-called idiopathic thromboembolism. In the earlier paper[1] we showed that when patients who were pregnant were excluded the proportions in each category of severity for oral contraceptives and non-oral contraceptive users were similar, and supported the assumption that there was no over-reporting or recording by general practitioners of thromboembolic disorders in patients on oral contraceptives compared with those not using oral contraceptives.

We would stress that the estimates in our earlier study, and also in the present study by Drs. Vessey and Doll, are both based on relatively small numbers of patients in any one category. We feel that most of the difference in these two estimates is attributable to the increased admission rates for women on oral contraceptives, compared with those who are not using them, when they get a thromboembolic episode. The differences in the College study are certainly not due to any increased severity in these episodes in oral contraceptive users compared with non-oral contraceptive users.—We are, etc.,

D. L. CROMBIE.
K. W. CROSS.
Royal College of General Practitioners General Practice Research Unit,
Birmingham 16.

REFERENCE
1 Royal College of General Practitioners, *Journal of the College of General Practitioners*, 1967, **13**, 267.

Nasal Obstruction in Babies

SIR,—In concluding their medical memorandum Mr. B. D. Birt and Dr. Eveline B. Knight-Jones (2 August, p. 281) describe three methods of nursing babies with nasal obstruction, and a recent article from Sweden recommends tracheostomy as the method of choice.[1]

I wonder if any of these techniques are necessary. In this hospital there have been three babies in the last twelve months with bilateral choanal atresia, each with severe respiratory obstruction, and each was treated by inserting an oral airway (Guedel type) and holding it in place with a tape round the neck. One baby had multiple deformities and subsequently died, but the airway was no problem. The other two went home.

These airways are very well tolerated by babies, which is not surprising considering the popularity of dummies. When a few weeks old both started to learn the art of mouth breathing. So satisfactory was the method that one parent began to question the need for operation. This method is certainly simpler and safer than those mentioned, and infinitely preferable to the barbarous technique of forcing a trochar blindly through the nose.

Though respiratory obstruction is severe in such cases it is not always fatal. I have operated on one young Irish seaman with bilateral choanal atresia, and gathered that his nasal obstruction had never been considered more than a joke.—I am, etc.,

ANTHONY E. HOWARTH.
Children's Hospital,
London S.E.26.

REFERENCE
1 Hogeman, K. E., and Toremalm, N. G., *Journal of Laryngology and Otology*, 1968, **82**, 913.

Oestrogens and Prostatic Hypertrophy

SIR,—Under the heading of "Oestrogen Treatment of the Male" (Today's Drugs, 2 August, p. 285) the writer says: "Because of their feminizing action oestrogens should be given to males only in special circumstances, such as carcinoma of the prostate and prostatic hypertrophy, where they may be useful in controlling the disease."

As a practising urologist I am surprised that the writer recommends use of oestrogens in simple prostatic hypertrophy, for they have never been shown to be of any value, and, moreover, as he says, may, among other things, produce hypertrophy of the breasts and cause considerable embarrassment to the patient without doing him any good at all.

I cannot too strongly deprecate the use of oestrogens in simple prostatic hypertrophy, and I hope that you will draw the attention of your readers to this, for I think that it could cause considerable trouble.—I am, etc.,

S. HENRY C. CLARKE.
Brighton, Lewes, and Mid-Sussex Hospitals,
Sussex.

Malignant Granuloma

SIR,—I read with some interest the leading article on malignant granuloma (2 August, p. 254) and the subsequent brief correspondence (23 August, p. 471), as I have reported several cases.[1,2] One of these cases is still alive and well, having had no further trouble since treatment with a very small dose of irradiation. This is, by many years, the longest surviving case ever recorded. Several other cases of mid-line granuloma have been treated similarly with equal success, though one or two others have failed to respond.

I realize that many other methods have since been developed, but, as none of the results has approached anywhere near the success of the cases I reported, perhaps the treatment then suggested should not be completely overlooked as it has been in your leading article and the subsequent correspondence.—I am, etc.,

MAXWELL ELLIS.
London W.1.

REFERENCES
1 Ellis, M., *British Medical Journal*, 1955, **1**, 1251.
2 Ellis, M., *Annals of Otology, Rhinology, and Laryngology*, 1957, **66**, 1002.

SIR,—Dr. C. H. Brown (23 August, p. 471) believes in antibiotic and chemotherapeutic treatment, combined with corticosteroids and cytotoxics. I agree with him, as I know from experience that steroids alone are useless. It should be emphasized that steroids and antimitotics both depress the immune mechanism. Thus a suitable antibiotic in maximum dose is essential. The results reported by Dr. C. H. Brown are very encouraging; it was brave of him to report them.—I am, etc.,

Epping, Essex. FRANK MARSH.

Asymptomatic Bacteriuria

SIR,—For 18 months now all Manchester schoolchildren, at school entry, are having urine microscopy carried out at school medical examination.

They are screened for bacilluria, pyuria, and haematuria, as well as the routine tests. The children with pathological counts are then referred to one of three hospitals in the area which have a paediatric urology department. The children are then fully investigated, careful history is taken, and further urinary microscopy performed. If indicated, full renal investigations may then be undertaken.—I am, etc.,

R. EIREW.
Booth Hall Children's Hospital,
Manchester.

Febrile Convulsions

SIR,—It is a constant surprise to me that paediatricians—particularly the more eminent ones like Professor R. S. Illingworth (30 August, p. 529)—should still apparently believe that there is some subtle difference between the convulsions that a child gets when febrile and other manifestations of epilepsy. It is surely well recognized that the younger a patient is the lower the epileptic threshold, that fever—as well as some other things—lowers this threshold further, that in some of these patients one need not treat them too seriously, and that in these circumstances the prognosis is usually good.

To suggest, however, that these are not epilepsy is, though comforting to the parents, surely quite untenable. Or is it that they really know this quite well and are bending the truth for the sake of propaganda?—I am, etc.,

N. S. ALCOCK.
Royal Devon and Exeter Hospital,
Exeter, Devon.

Intestinal Obstruction and Hypothyroidism

SIR,—We read with interest the case reported by Dr. J. S. Chadha and others (16 August, p. 398) and were reminded of a recent similar case of our own.

A 63-year-old female developed colicky abdominal pain one week before admission. For many years she had complained of constipation and intermittent abdominal distension. On admission the pain appeared to be slight compared to the degree of distension. The

abdomen was tympanitic and high-pitched bowel sounds were heard. The bowels had not moved for a week, but the rectum was empty. Sigmoidoscopy was not contributory. General examination confirmed the signs of myxoedema. *X*-ray confirmed the diagnosis of volvulus, and a Paul-Miculicz resection of sigmoid colon was carried out. The volvulus was very large with two turns at the base, and appeared to be chronic. The 68-cm. resected length of colon attained a maximal luminal diameter of 12 cm., and histologically the bowel wall showed a flattened colonic mucosa and distended veins.

Further investigations were as follows: P.B.I. 1·1 μg./100 ml.; radioiodine tracer studies, including T.S.H. stimulation, confirmed primary hypothyroidism; and antithyroid antibodies present.

L-thyroxine was cautiously administered, and four months after admission the patient is euthyroid and asymptomatic. The colostomy was closed at a second operation.

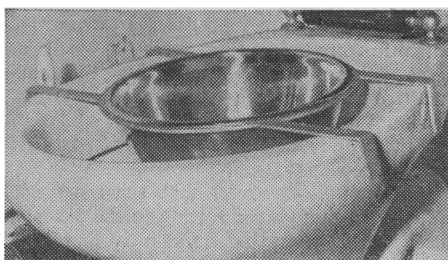
Neither hypothyroidism nor volvulus is uncommon, and their appearance in the same patient may be coincidental. However, if the diagnosis of hypothyroidism were considered more often in patients with chronic constipation and abdominal distension a few potential cases of intestinal obstruction could be treated prophylactically—with thyroxine.—We are, etc.,

PETER COLE.
JAMES C. PETRIE.
P. D. BEWSHER.

Aberdeen.

Stool Collection

SIR,—The direct microscopical examination of stools for intestinal protozoa should be carried out on a freshly passed specimen which has not had time to cool. Ideally the specimen should be passed at the laboratory, but most laboratories are equipped only with normal W.C. pans. The equipment illustrated has proved convenient and is not difficult to make locally.



A strip metal frame has a circular hole to accept a standard 8 in. (20 cm.) stainless steel bowl and four hooked supports. This is placed across the W.C. pan as shown; the support does not interfere with the normal lowering of the seat.—I am, etc.,

R. MORTIMER.

R.A.F. Institute of Pathology and Tropical Medicine,
Halton, Bucks.

Drinking Drivers

SIR,—A further discrepancy in the breathalyser test is becoming apparent. This is due to the considerable difficulty in deciding whether a driver is above or below the breathalyser dead-line. Some feel that any yellow crystals below the line mean safety, while others think that any green crystals above the line mean danger. The wise duty officer in the police station will obviously ask for blood tests when he is in doubt. This means that the efficiency of a police division may well be indicated by the percentage of blood tests which is under 80 mg./100 ml.

The hard practical lesson which I have learned through sleepless nights is that the colour end-point of the breathalyser is not satisfactory.—I am, etc.,

J. H. HENDERSON,
"A" Division, Police Surgeon,
Renfrew and Bute Constabulary.

Greenock,
Renfrewshire.

Management of Unconscious Poisoned Patients

SIR,—Dr. E. G. McQueen (19 July, p. 177) states that "short- and medium-acting barbiturates are markedly longer acting than phenobarbitone in *gross overdosage*" (our italics). We would be interested to examine his supporting evidence, as our experience differs markedly. The following Table shows the duration of coma after admission to hospital in 47 consecutive episodes of gross overdosage as judged by clinical criteria.[1]

Barbiturate Type	Grade of Coma	Number of Patients	Average Duration of Coma
Short and medium acting	III	25	19 hours
Long acting	III	8	37 „
Short and medium acting	IV	10	24 „
Long acting	IV	4	38 „

The short- and medium-acting barbiturates were pentobarbitone, quinalbarbitone, butobarbitone, amylobarbitone, and cyclobarbitone. The long-acting barbiturates were phenobarbitone or barbitone. Coma due to overdosage with long-acting barbiturates is significantly longer ($P<0·05$) than that produced by short- and medium-acting forms.

These comments must not detract from Dr. McQueen's important plea that barbiturates should be avoided and safe hypnotics used if drugs are required for insomnia. We recently confirmed that nitrazepam is efficient as a hypnotic and yet safe in overdosage.[2]—We are, etc.,

N. WRIGHT.
JOHN A. RAEBURN.

Regional Poisoning Treatment Centre,
Royal Infirmary,
Edinburgh.

REFERENCES

[1] Matthew, H., and Lawson, A. A. H., *Treatment of Common Acute Poisonings*, Edinburgh, Livingstone, 1967.
[2] Matthew, H., Proudfoot, A. T., Aitken, R. C. B., Raeburn, J. A., and Wright, N., *British Medical Journal*, 1969, **3**, 23.

Automation in Pathology

SIR,—Your leading article on automation in pathology (16 August, p. 374) reminds me of a problem that is of even greater interest to the clinician. It has recently been the subject of a correspondence in your contemporary the *Lancet* (12 July, p. 106). Whether the results of investigations are arrived at by a computer or by a technician, or the consultant pathologist himself, the problem for the clinician is the delays before the report is in his hands.

A consultant colleague, who had the great advantage of many years' experience as a general practitioner, once remarked, "Better the scruffiest bit of paper with the patient than the most beautiful report three months later." He was referring to letters about discharge of patients, but the same applies to reports of investigations.

If the necessary research effort were available, perhaps Britain could give a lead in the development of a system which would put the clinician in possession of such reports within hours rather than days.—I am, etc.,

ROBERT NIVEN.

London W.1.

Cigarette Advertisements

SIR,—The *New York Times*[1] is now to follow the lead of the *Listener* and apply strictures upon cigarette advertisements. These overdue precedents remind one of just how extraordinary it is that anything causing 50,000 deaths a year can still be advertised to the general public. One is simultaneously reminded of the situation which obtained in your own distinguished columns over a decade ago.[2] Incidentally, may we be reassured on this point, please?—I am, etc.,

J. P. ANDERSON.

Chest Unit,
Cheddon Road Hospital,
Taunton, Somerset.

REFERENCES

[1] *The Times*, Saturday, 30 August.
[2] Anderson, J. P., *British Medical Journal*, 1957, **1**, 285.

⁂ The *B.M.J.* ceased carrying advertisements for tobacco products in 1962.—ED., *B.M.J.*

Plight of Long-stay Hospitals

SIR,—I am sorry that Dr. J. T. R. Bavin (23 August, p. 470) has drawn the wrong conclusions from my letter (9 August, p. 361), written on behalf of the Clwyd and Deeside Group Medical Advisory Committee, concerning the diversion of funds to long-stay hospitals. His assumption that my committee consists entirely of general hospital staff is also inaccurate, since we have three long-stay hospitals in this group and approximately one-fifth of the members of my committee are doctors who are responsible for the care of long-stay patients.

It was not our intention, as Dr. Bavin suggests, to imply that subnormality and other long-stay hospitals should wait a further period while politicians find more money to rectify their long-standing problems. Nor did we express the belief that the needs of general hospitals should take priority over those of long-stay hospitals.

We recognize the need for a considerable amount of money to be spent urgently on the hitherto neglected long-stay hospitals. Our purpose was to sound a warning of the adverse effect that it would have on the hospital service generally if the necessary im-