

one death occurred in a young soldier who had perforated 48 hours before admission: he died a week after the operation and, regrettably, no necropsy was allowed.—I am, etc.,

Epsom, Surrey.

S. M. VASSALLO.

SIR,—Mr. Hermon Taylor (*Journal*, April 4, p. 781), in discussing the conservative treatment of perforated ulcers, says, "Clearly the method of gastric aspiration can achieve all that can be obtained by the method of surgical closure, but with the not inconsiderable advantages of avoiding an operation." He further states that modern developments have made simple closure of perforations obsolete. To my mind, operation has several possible advantages: (1) fluid can be sucked out of the subphrenic spaces; (2) the size and situation of the ulcer can be assessed; (3) the possibility of malignant change can be largely excluded; and (4) appropriate treatment can be given if the diagnosis proves to be wrong—e.g., perforated cholecystitis, appendicitis with general peritonitis, pancreatitis, or even small-bowel obstruction.

Continuous aspiration has its disadvantages. It is usually necessary for four to five days, and entails intravenous saline with all its dangers and complications. A very high proportion of cases treated by operation only need gastric suction for about 36 hours. A rectal drip is then quite adequate to prevent dehydration.

Surely the discomforts and dangers of operation have been exaggerated during recent years. It has been my practice to combine local and light general anaesthetics, which give complete relaxation without any interference with chest or diaphragmatic movements. The patient usually wakes up almost free from pain. I have personal experience of 385 operations, and I think that a patient who cannot stand this line of treatment is most unlikely to recover from any other.—I am, etc.,

Farnham, Surrey.

STANLEY C. RAW.

Research in General Practice

SIR,—Professor Robert Platt's address (*Journal*, March 14, p. 577) was indeed stimulating, but those who try, however unpretentiously, to carry his ideas into practice do not always find that things go very smoothly. Some years ago I was taunted by a patient that British medicine lagged behind the Soviet variety inasmuch as Russian doctors were completely relieving the pangs of childbirth by injections of vitamin B. This information had been gleaned from a Soviet propaganda publication which had considerable circulation in this country. I wrote immediately to a firm which is generous in the matter of circulars and samples, and is prominent as a manufacturer of vitamin products. I suggested that the matter might be very quickly tested by the issue to a sufficient number of general practitioners of enough vitamin B to be used in their cases, on condition that reports were sent of the results. The firm's medical adviser pooh-poohed the whole project.

On another occasion I wrote to the *Journal* on the subject of the long-term results of electric shock treatment in mental illness, because I felt that general practitioners would have more reliable views on the subject than those held by the more enthusiastic psychiatrists. If my memory serves me correctly there was no reaction, good, bad, or indifferent, from my colleagues.—I am, etc.,

Launceston.

DONALD M. O'CONNOR.

Chloroform for Bronchography in Children

SIR,—Mr. Leslie J. Temple and Dr. T. Cecil Gray, in their letter (*Journal*, April 18, p. 883) commenting on our article on bronchography in children (*Journal*, March 14, p. 601), state that it implies that the child may suffer from hypoxia during the use of our technique. This is certainly not so. We attain rapidly a short, deep anaesthesia and at all times the child is well oxygenated. We do not suggest

that chloroform should be used by the inexperienced, but we think that explosive agents are better avoided in the x-ray room.

As regards the airway, it may be difficult to prevent obstruction without it in some of those children with enlarged tonsils and adenoids. Finally, an important difference between our technique and Gray and Temple's, not mentioned in their letter, is that we do not "drown" our patients with lipiodol, as we feel that in bronchiectasis there is enough foreign material in the bronchi without adding to it more than the minimum necessary.—We are, etc.,

MARGARET I. GRIFFITHS.

T. D. CULBERT.

Manchester.

SIR,—Having used the method of anaesthesia for bronchography in children described by Mr. Leslie J. Temple and Dr. T. Cecil Gray (*Journal*, April 18, p. 883) since I was first taught it by Dr. John Halton some five years ago, I can only agree with all the authors' remarks concerning the method.

Being worried about the possibility of explosion, I too tried chloroform and other agents, but soon realized, fortunately at the cost only of minutes of acute anxiety on more than one occasion, that as deep anaesthesia is necessary it is most safely produced by ether. I feel convinced that explosions as a result of ignition of ether vapour by x-ray equipment have been much rarer than fatalities from the use of chloroform, and would join Mr. Temple and Dr. Gray in pointing out the dangers of using chloroform where some degree of hypoxia is to be expected as a result of deep anaesthesia and the introduction of oil into a diseased respiratory system.—I am, etc.,

Manchester.

TOM DINSDALE.

Antihistamines and Asthma

SIR,—Drs. A. W. Frankland and R. H. Gorrill (*Journal*, April 4, p. 761) ought to be congratulated on the skill with which they have refuted the assumption that antihistamine treatment of hay-fever causes asthma. Their further conclusion that antihistamines do not improve asthma is hardly justified by their experiments. They have given mepyramine, apparently in four separate daily doses of 100 mg., or another equivalent antihistamine, and have not seen any benefit from it. Nor have I. Antihistamines influence asthma only if a much larger dose is given than that effective in allergic rhinitis. There is ample evidence for their efficiency,^{1,2} but I have never seen a beneficial effect with less than a single dose of 300 mg. of mepyramine. An amount of 100 mg. cannot be expected to influence asthma, just as one would not expect one minim of adrenaline to influence it. It would appear essential that in therapeutic trials, controlled or uncontrolled, the doses used are not subthreshold ones, as in this case.

The difficulty with antihistamines in asthma is that the large doses required often have side-effects which make their use impracticable during the day. They are best used in single doses at bedtime, when they may secure an asthma-free night. The use of one single dose in 24 hours also avoids the development of tolerance, which easily occurs with multiple doses.³—I am, etc.,

London, W.C.1.

H. HERXHEIMER.

REFERENCES

- 1 Armitage, P., et al. (1952). *Brit. J. Pharmacol.*, 7, 625.
- 2 Herxheimer, H. (1952). *Management of Bronchial Asthma*. Butterworth, London.
- 3 Dannenberg, T. B., and Feinberg, S. M. (1951). *J. Allergy*, 22, 330.

Television and the Patient

SIR,—I should like to endorse very strongly the opinion expressed by Dr. T. Hughes (*Journal*, April 18, p. 884) in the letter under the heading "Television and the Patient." In general, television programmes on medical subjects seem calculated to foster in the minds of ordinary people the