published in your columns by Stewart[1] and by Thomson,[2] and of glutethimide by Rushbrooke *et al.*[3] Both drugs were found to be reliable hypnotics with no side-effects in ordinary dosage. However, there was one case of habituation to methyprylone and (at least) two cases of habituation to glutethimide, with features such as confusion, slight ataxia, and slurring of speech. No reports on habit formation with these two (fairly recent) drugs seem so far to have been published. Several cases of habituation to the non-barbiturate methylpentynol were seen by us in the past,[4] and cases of addiction to ethinamate, another non-barbiturate hypnotic, have been reported in the German literature.[5 6] The case of methyprylone habituation occurred in a young female alcoholic: she took the drug habitually in increasing doses after she had spontaneously recovered from a suicidal attempt in which she had ingested 25 to 30 (200 mg.) tablets of methyprylone. Recovery without special measures being taken also took place in another alcoholic woman who bought 50 (250 mg.) glutethimide tablets from a chemist, took five tablets "just for the experience," and shortly afterwards —without remembering it—apparently another 12 tablets. However, the literature contains reports of successful suicide attempts with each of the four non-barbiturate drugs referred to. Thus whilst on the whole the non-barbiturate hypnotics in our experience seem safer than the barbiturates, especially for unstable personalities such as many alcoholics, with their frequent suicidal attempts[7] and their tendency to drug habituation, these new drugs are obviously not completely free from the risks of accidental, habitual, or deliberate overdosage.—I am, etc.,

St. Bernard's Hospital, Southall, Middlesex. M. M. GLATT.

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Hula-hoop Syndrome

SIR,—Recent correspondence (*Journal*, December 20, p. 1531) should not be allowed to discourage the use of the hula-hoop as a means of exercise and pleasure. It is obviously bad for it to be practised for several thousands of revolutions at a time, particularly since habitually it is done only in one direction. Observation shows that a person who habitually tends to stand on the right leg will perform the action in a clockwise direction, while the left-leg-stander will reverse this procedure. Safety lies in insisting on the child being able to perform the exercises equally in both directions.—I am, etc.,

London, W.1. GUY BEAUCHAMP.

Iron in the Home

SIR,—Under Medical News (*Journal*, December 13, p. 1483), you draw attention to the importance of iron as a cause of poisoning in young children. When I read this I consulted three fairly recent textbooks of medicine and two standard first-aid books, the latter intended for Red Cross and St. John Ambulance use. None of these referred to any specific treatment for iron poisoning. It appears to me that this is a serious omission, and that an equally serious one is the failure of the manufacturers of iron preparations which can be bought over the counter to indicate on their containers the symptoms, dangers, and treatment of iron poisoning.—I am, etc.,

Dublin. JOHN FLEETWOOD.

Buzzers for Bed-wetters

SIR,—Referring to the article "Treatment of Nocturnal Enuresis by the Electric Alarm" by Drs. T. H. Gillison and J. L. Skinner (*Journal*, November 22, p. 1269), and the numerous inquiries received as a result of the letter from Dr. Margaret White (*Journal*, November 8, p. 1165), the following information may be of interest:

Enuresis clinics in Croydon form part of the School Health Service. Machines are bought from the Orphan Homes of Scotland, Bridge of Weir, Renfrewshire, and loaned as items covered by the loan of home-nursing equipment under Section 28 of the National Health Service Act. The Ministry of Health have agreed that this is permissible.—I am, etc.,

Public Health Department, Croydon. S. L. WRIGHT.

Psychotherapy in General Practice

SIR,—Emphasis has been given in your columns recently to the role of the general practitioner as a clerk who merely directs patients to hospital for treatment. This is certainly true in the field of psychological medicine. However, many of us must well remember the psychiatric out-patients of our student days, where the usual therapy was in tablet form, with some smooth words of reassurance. Little else can be expected, in view of the long waiting-lists and the small amount of time available for each patient. Surely it is here that the general practitioner could come into his own. Knowing the family, the background, and the home of his patient, he is in the key position to give psychotherapy. The only requirements are training and time.

I should like to suggest that a course in psychotherapy be established for general practitioners, with a diploma upon completion. The general practitioner should receive a fee for his therapy outside the normal remuneration, as with eye-testing and obstetrics. The possession of a diploma as envisaged could put one on the "Psychotherapeutic List." I should like to see this as a specialist service of the general practitioner with a corresponding reward. In the above context my definition of psychotherapy would be sessions of counselling, in which one of the most important factors is the confidence established by the doctor. Benefit could be given to patients suffering from conditions such as asthma, allergies, peptic ulcerations, dermatitis, migraine, and ulcerative colitis by a deeper understanding of their problems.—I am, etc.,

London, S.E.10 C. A. FOX.

Case for Diagnosis

SIR,—I wonder how many cases diagnosed in general practice at this time of the year as influenza are in reality mild forms of infective hepatitis?

A patient of mine, a man aged 36, called me to see him on November 26. He complained of general malaise, headache, anorexia, and vomiting. On examination there was a pyrexia of 103° F. (39.4° C.), pulse rate 120, but no

other physical signs. On November 28 I visited him again. His wife told me he had been semi-delirious at night and still afflicted with extreme nausea and headache, temperature 102° F. (38.9° C.), pulse 120. His urine was dark-coloured. On shaking the urine in a test-tube there was at least 2 in. (5 cm.) of froth on 2 in. of urine. The froth had the faintest yellow tinge, and only partially settled after standing for five minutes. On December 1 his condition had improved. Pulse and temperature were normal. Urine remained as before with persistent white froth. At no time was the patient tender on palpation in the right hypochondrium. He has continued to improve. There has been no clinical jaundice throughout. On December 4 there was still 1 in. (2.5 cm.) of froth on 2 in. of urine, the froth being quite colourless.

It would be interesting to hear whether other practitioners have seen cases of this kind, which I conclude was one of infective hepatitis without jaundice, the frothiness of the urine being due to the excretion of bile salts. The "froth test" can be applied in any clean empty medicine bottle, and might help to sort out at least some of the cases of P.U.O. we meet in general practice. When positive it gives also a useful indication of the progress of the disease, becoming noticeably less marked as the patient's clinical condition improves.—I am, etc.,

Huddersfield. S. L. HENDERSON SMITH.

Bronchograms for Asthmatics

SIR,—Dr. Forde Cayley's letter expressing his anxiety in doing bronchograms on asthmatic subjects (*Journal*, November 22, p. 1292) deserves some sympathy. Quite apart from the effects of hydrocortisone in such cases, it still does not appear to be generally appreciated that laryngeal and endotracheal local anaesthesia is quite superfluous in bronchography, provided an oily contrast medium such as propyliodone 60% is used and the crico-thyroid puncture method is employed. Patients who have undergone both the oral and crico-thyroid puncture methods always express preference for the latter.—I am, etc.,

Ormskirk County Hospital, Lancs. K. D. FORGAN MORLE.

Too Many Tonsillectomies ?

SIR,—Dr. I. M. Librach (*Journal*, October 18, p. 976), referring to tonsillectomy, asks: "Why operate at all in the average case ?" I dislike the term "average," but, as 20% of schoolchildren in this country undergo the operation, the question is still a good one. Dr. Librach goes on to exhort E.N.T. surgeons to examine conscientiously and scientifically their indications for operation and follow-up results. The answer is not so simple as this. The James Mackenzie Lecture on "The Art of Consultation" (*Journal*, November 29, p. 1349) deserves to be widely read. In this admirable address Dr. G. F. Abercrombie referred to the general practitioner as the captain of the team. This is particularly so in the case of childhood ailments for which removal of tonsils and adenoids is so frequently advised. The E.N.T. surgeon must obviously be responsible for the final decision to recommend operation; for the most part, however, he is entirely dependent on the presentation of the case by the family doctor.

I believe that E.N.T. surgeons to-day are increasingly conservative, and are well aware that, while in certain cases tonsillectomy remains a valuable procedure, it is no panacea in childhood. A major reduction in the frequency of this operation will take place when more general practitioners feel, as many already do, that with patience and reassurance surgery may be avoided.—I am, etc.,

Hull. J. S. MARTIN.

Malignant Melanoma

SIR,—A housewife, aged 33, was recently admitted to hospital, where a diagnosis of irreducible femoral hernia was made. At operation the lump in the groin was found to be extraperitoneal fatty tissue infiltrated by hard black nodules. Biopsy confirmed that these nodules were in fact secondaries from a malignant melanoma. Post-operatively it was discovered that a mole, which developed in a week at the site of a hypodermic injection, had been removed from the patient's thigh four years previously.

I feel it is a remarkable coincidence that the site of a needle puncture and a newly developed melanoma should be identical. Could it be that trauma can initiate the development of a malignant melanoma where there was no previous benign lesion ?—I am, etc.,

London, N.W.10. E. LARKIN, Medical Student.

Appendicectomy in the Obese

SIR,—It is usually the task of junior resident surgeons to operate on cases of acute appendicitis, and these operations, though frequently easy, may be exceedingly difficult. This is particularly so in obese people, especially those with protuberant or pendulous abdomens, when even the anterior superior iliac spine may be impalpable beneath a mound of fat.

In these circumstances one is inclined not to operate but to treat them conservatively, hoping that the acute phase will subside and the patients will be induced to reduce their weight prior to an interval appendicetomy. But this is likely to prove dangerous, for I have found that there is little attempt to localize the infection. The immense fibro-fatty omentum present in these cases seems quite incapable of adhering to an inflamed viscus and walling it off from the general peritoneal cavity, with the result that the appendix often perforates, leading to a general peritonitis.

I have operated on a number of these unfortunate people, weighing 17–20 stones (108–127 kg.), and had always found it difficult until recently. In the usual supine position the incision made into the protuberant abdomen is on the side of a steep slope and the appendix is lying beneath coils of intestine and pounds of omentum. However, by tilting the patient to the left to an angle of about 45° by means of sandbags, one finds that the fat of the abdominal wall falls away to the left and an incision, preferably a transverse one in the skin starting from the anterior superior iliac spine, can be made in a horizontal instead of a vertical plane. On opening the peritoneum it is found that the abdominal contents have also fallen away to the opposite side, and the appendix is found lying on top and can be removed easily, little or no retraction being necessary. This is true whether the appendix is retrocaecal or not. May I commend this simple manœuvre to any of those resident surgical officers who are faced with a similar problem ?—I am, etc.,

St. Alfege's Hospital, London, S.E.10. R. F. BOLAM.