SIR,—I regret that in my article on this subject (*Journal*, February 6, p. 415) I did not mention post-mortem examinations for the G.P. Of course we provide this service, and it is asked for with moderate frequency. We have indeed carried out a partial confirmatory post mortem in the home of the deceased, but normally the body is brought to the hospital mortuary. This is shortly to be enlarged and become a joint mortuary of the hospital and the Borough of Kingston-upon-Thames, so that all this type of work, whether from the hospital or the coroner, will be done under the one roof.

With regard to G.P. cases, we have to lay down certain conditions. The usual procedure is for the G.P. to ring the morbid anatomist and give a few details. He is then asked (1) to get consent, preferably written, from the next of kin, (2) to assure the pathologist that there is no question of reporting to the coroner, (3) to ring the undertaker and have the body sent to the hospital mortuary, (4) to set a time when he can watch the P.M. We have, so far, had no difficulty over transport. The ambulance cannot, of course, be used for the transport of dead persons, but the undertakers in this area are always very willing to co-operate, and, since many bodies are in any case moved to undertakers' chapels, there is usually very little difficulty in getting the additional service of bringing a body to our mortuary and removing it again later, since they are here all too frequently. I think Dr. S. L. Henderson Smith (*Journal*, March 5, p. 725) will find that this service is available in other areas, and, provided the laboratory is prepared to do such examinations, there is nothing in the N.H.S. regulations to prevent them doing so.

Perhaps I should add that we have a number of small hospitals without post-mortem rooms, and the bodies are brought from them to the central mortuary. In this case the hospital management committee can pay for transport.—I am, etc.,

Kingston-upon-Thames. D. STARK MURRAY.

SIR,—Dr. S. L. Henderson Smith (*Journal*, March 5, p. 725) may be cheered to know that there is no reason why he should not have the services which he requires and at present lacks. The hospital management committee is permitted to pay the cost of transport of the body to and from the hospital. It is necessary to get the support of the pathologist, who gets no extra remuneration for these P.M.s. We have this facility in this area, the H.M.C. having agreed to pay the transport cost, after being approached by the local medical committee. Discretion is given to the pathologist to refuse in a particular instance.

Credit for the granting of this permission to H.M.C.s must go to the B.M.A. negotiators.—I am, etc.,

Risca, Mon. MICHAEL WADE.

*** The following statement appeared in Annual Report of Council for 1957 (*Brit. med. J. Suppl.*, 1957, **1**, 169): "The G.M.S. Committee . . . secured the Ministry's agreement to the suggestion that, when a general practitioner requires a necropsy, if the pathologist agrees, then the cost of transport from home to hospital should be met from public funds."—ED., *B.M.J.*

SIR,—If it had occurred to him Dr. S. L. Henderson Smith (*Journal*, March 5, p. 725) could have made his own post-mortem examination by making use of the coffin-lid upside down as a slab. The late Mr. T. S. P. Strangeways suggested this to me, and I have found it very convenient in the few which I have made or helped to make. The question of payment did not arise, because the examinations were made only to satisfy our own scientific curiosity.—I am, etc.,

Beckenham, Kent. W. M. PENNY.

Conservative Treatment of Ulcerative Colitis

SIR,—I share Dr. R. W. Cockshut's concern (*Journal*, March 5, p. 731) with regard to the development of cancer in the long-standing case of ulcerative colitis. It is a complication to which those who have developed the disease in their youth seem particularly prone and one which is so insidious in its onset that its diagnosis in most cases is virtually impossible until widespread and incurable metastases have taken place. Amongst 140 cases under my care between March, 1952, and August, 1959, there were 10 patients in whom the complication had arisen, an incidence of 7%. Of these only one remains alive, and with two exceptions all who died were in their early adult life.

Medical treatment undoubtedly should always be given a fair trial, but I am quite certain that, if after a period of two or three years the symptoms of the disease in these chronic cases persist, operation should be undertaken, not only to cure the patient of his residual ill-health but to eliminate the hazard of a virulent form of cancer. It is rarely necessary to institute an ileostomy. Total colectomy and ileorectal anastomosis will effect a cure, the disease in the remaining rectum resolving once the whole of the ulcerated colon has been excised. At the Gordon Hospital the operative mortality on this type of case is little more than 1%. Compared with the risk of the development of cancer, this figure is slight.—I am, etc.,

London, W.1. STANLEY AYLETT.

Dangers of Halothane

SIR,—It is now well known that patients being anaesthetized with halothane in the closed-circuit apparatus may suddenly develop cardiovascular and respiratory depression, and must therefore be watched with the greatest of care. The use of low concentrations of halothane from a calibrated vaporizer on a semiclosed circuit has been considered to be relatively trouble-free. The three incidents described below indicate that this is not so, and that equal vigilance is required when halothane is given in a semiclosed circuit.

Case 1.—A male of 40 years was to undergo right frontal craniotomy for a large craniopharyngioma. He had a history of angina of effort and left ventricular strain. Occasional extrasystoles were apparent before operation. Premedication was with atropine 0·6 mg. by subcutaneous injection. Anaesthesia was induced with thiopentone 500 mg. and succinylcholine chloride 40 mg., followed by tracheal spraying with 4 ml. lignocaine hydrochloride 4%. A No. 10 flexometallic tube lubricated with lignocaine ointment was passed and the lungs inflated with nitrous-oxide (6 litres per minute) and oxygen (2 litres per minute) with a semiclosed circuit. Spontaneous respiration returned rapidly and the pulse was normal. Halothane 0.5% was added and then increased to 1%. Suddenly, after three minutes on this mixture, while the E.C.G. leads were being applied, the pulse became grossly irregular and of very poor volume, and the respiration very shallow. The halothane was turned off and the lungs inflated with oxygen. The tidal volume and pulse volume rapidly improved, but the arrhythmia persisted on nitrous oxide and oxygen for three to four minutes until diethyl ether was added. The pulse