no immigrant leaves the port health area unchecked.

May I suggest that in addition to the members already recruited for the B.M.A. working party the services of an experienced mass radiography unit director are secured. The planning and organization of a large number of people through a chest *x*-ray apparatus is a part of the normal work of a mass radiography unit medical director.—I am, etc.,

F. J. H. WALTERS.

Mass Radiography Service,
S.W. Metropolitan Regional Hospital Board,
Worcester Park,
Surrey.

SIR,—As regards the medical examination of immigrants, which is under discussion at present, I would like to advocate that Mantoux testing should be carried out as well as mass radiography. We have had quite a number of them as patients here with bone and joint tuberculosis without there being a demonstrable chest lesion. This might apply more to the immigrant from Aden than to the person from Pakistan, but this is only an impression. If the Mantoux test proved to be negative, B.C.G. could then be offered, and I think in many cases it would be readily accepted.—I am, etc.,

E. G. HERZOG.

King Edward VII Orthopaedic Hospital,
Sheffield 6.

Treatment of Ulcerative Colitis

SIR,—I was most interested to read of the experiences of a double-barrelled ileostomy in ulcerative colitis and Crohn's disease of the colon by Dr. S. C. Truelove and others (16 January, p. 150).

Having had a relatively extensive experience of these diseases, particularly of ulcerative colitis, I am rather dismayed at the advocacy of what appears to me to be a retrograde step which, if generally adopted, will perpetuate the miseries of many patients. I feel the time has come for the frank expression of experiences. After many years two principles of the surgical management of ulcerative colitis seem to have emerged. Firstly, that the faecal stream should be totally diverted from the inflamed and ulcerated colon by an ileostomy, and, secondly, after much tribulation and sacrifice, that a complete restoration to health cannot be achieved without ablation of all the diseased bowel. Recrudescence of the disease, sometimes fulminating, has occurred where any of the colon has been retained and complications remote from the bowel may still occur (iridocyclitis, arthritis, pyoderma, etc.).

A special study has been made in this centre of changes in the colon which represent a stage of the disease from which no recovery has occurred in spite of the use of *all known medical measures*. These changes, which can be recognized radiologically, have been followed in patients for months and years, and a relentless progression of the disease has been noted.[1] Many centres with a special experience of ulcerative colitis report a risk of carcinoma, when the disease has been present for ten or more years, that would terrify those concerned with the suppression of smoking had it been related to lung cancer. To me this risk justifies a prophylactic colectomy when the disease has been radiologically apparent for ten years or as soon as the patient himself comes to appreciate his position when irreversible signs have appeared. To continue to treat a disease which has become irreversible is merely to squander blood and expose patients to the continued use of adrenal corticosteroids, which themselves have come to be associated with sinister and sometimes dangerous effects.

Most surgeons with a special interest in ulcerative colitis have come to appreciate that their patients are of a dependent personality, have become demoralized by the repeated failure of medical measures, and are in urgent need of a treatment in which they may have full confidence. The psychological preparation, support, and follow-up of patients accepting the surgical cure of their condition far outweighs the technical arguments of the excision. From close observation of a personal series of almost 100 total colectomies without mortality, I have come to feel that in most instances attempts to preserve the colon had been unjustified. The account of the fates of patients in Table I makes unhappy reading. What cannot be expressed in such a table is an account of the individual privations, unemployment, the ugliness associated with steroid administration, shattered romances, and the miseries of a diet which is sometimes so restricted that the quality of life assumes the drabness of a mere existence. These features have certainly been the lot of many of my cases before surgery. My experience has been that the patient's recollections of past and failed surgical adventures enormously magnify his difficulties in his adaptation to a properly constructed permanent ileostomy. From the purely technical viewpoint the presence of scarring in the right iliac fossa from a previous ileostomy which has been closed at some stage prejudices the adhesive potential of the many excellent appliances on the market at the present time.

I have been constantly impressed by the gratuitous remark of the majority of members of a division of the Ileostomy Association that they wish they had been offered the surgical cure of their condition at a much earlier stage, when they could have avoided many months of anxious despair at a time when they could least afford it.—I am, etc.,

F. C. WALKER.

Department of Surgery,
The Medical School,
University of Newcastle upon Tyne.

REFERENCE

1 Walker, F. C., and Curtis, G. T., *Brit. med. J.*, in press.

Steroid Addiction in Ulcerative Colitis

SIR,—I was stimulated to write and comment on the letter on steroid addiction in ulcerative colitis (12 December, p. 1528) in that I am one of those who, according to Dr. M. Kelly, have "shut their eyes to the presteroid death rate in colitis of less than 2% per year." Though his presteroid mortality rate was in error, and your reply to his letter significantly lessens his arguments opposing steroid therapy to my satisfaction, I would like to call to your attention that one of the "steroid protagonists" has compared the death rates in colitis before and after steroids,[1 2] as he required, with a mean follow-up in the steroid era (9 years) reasonably approaching that in the presteroid era (12 years). This study revealed a fall in mortality rate from 21 to 12%. Most of the steroid-era deaths occurred early in the decade when experience was just being accumulated with hormonal therapy. The mortality rate of ulcerative colitis in the steroid era would be still smaller if it represented in addition the milder cases not treated with steroids.

I am sensitive to Dr. Kelly's expressive reaction to steroid therapy in ulcerative colitis when I recall the occasional case when a fatal complication had been steroid-accentuated. More optimistically, however, the course of ulcerative colitis has been altered by steroid therapy, so that the severe attack is terminated more swiftly, the patient is more likely to be completely well between attacks and spend less time in the hospital, an opportunity is offered for more elective and less urgent surgical procedures, and the fatality rate is markedly lessened. All of these advantages are proportional to the skill with which these drugs are utilized with regard to the natural course of the disease.

In summary, if one must have ulcerative colitis, he should prefer to have it in the steroid rather than in the presteroid era.—I am, etc.,

New York 28, U.S.A. BURTON I. KORELITZ.

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Double-barrelled Ileostomies

SIR,—I was most interested in the excellent article on the above subject by Dr. S. C. Truelove and others (16 January, p. 150), but was rather concerned that such authoritative people should use terminology so loosely. I had to read their opening paragraph several times before I realized that two quite separate ileostomies were described by them as "double-barrelled."

I do not wish to quibble, but as the operation of double-barrelled ileostomy has already been used in this condition one feels it is highly misleading to use the term for a quite different operation.—I am, etc.,

Ashford, Middlesex. ROBIN BURKITT.

Post-mortem Caesarean Section

SIR,—I was particularly interested in your leading article on post-mortem caesarean section (23 January, p. 204), as apparently I am one of the few doctors who have performed the operation. I was pleased to learn that I had done the right thing in the right way.

About 30 years ago when I was in practice in Derby I was called urgently to a woman whom I had advised to get as much bed rest as possible because I found she had hypertension when nearing her confinement. I found her unconscious; not having an eclampic seizure, but in a state of decerebrate rigidity, and decided she had suffered an intraventricular cerebral haemorrhage. She was obviously in a very bad way and while I was examining her and collecting my thoughts and telling the husband I was afraid she was going to die, she died.

We had been advised as students to carry a scalpel around when we were in practice in case we were called on to perform an emergency

tracheostomy for diphtheria, and I had also a needle in my case, so after waiting a few minutes to make quite sure the mother was dead and the baby alive I extracted a living boy, left the placenta in situ, and stitched up the wounds of the bloodless battle.

I'm afraid I did not ask the husband's consent. We were very autocratic in those days, and in any case the poor man, the father already of eight or nine children, was too distraught and full of guilt that his philoprogenitiveness had caused his wife's condition to be in a fit state to say yea or nay and not perhaps regret it later.

Fortunately the baby was taken care of and adopted by relations.

—I am, etc.,

Harrogate, Yorks. T. J. KIRKPATRICK.

New Dermatosis

SIR,—In a leading article in the *B.M.J.* under the heading "A New Dermatosis?" (19 December, p. 1547) you commented: "A distinctive illness not previously described has been reported by Dr. R. D. Sweet.[1]" In my experience this condition is not uncommon. I wrote about such hypersensitivity states in 1958[2] in connexion with management by antimalarials, and I would refer to Cases 4, 5, 6, and 7 in my paper, which closely resemble the disorders described by Dr. Sweet. My impression of the seven cases at the time was that the likely common aetiology was acquired sensitivity to a bacterial or chemical allergen.

Many instances of reaction states as observed by Dr. Sweet have been under treatment at Sefton General Hospital, Liverpool, particularly in recent months. At the time of writing the following patients have been investigated and remain under supervision:

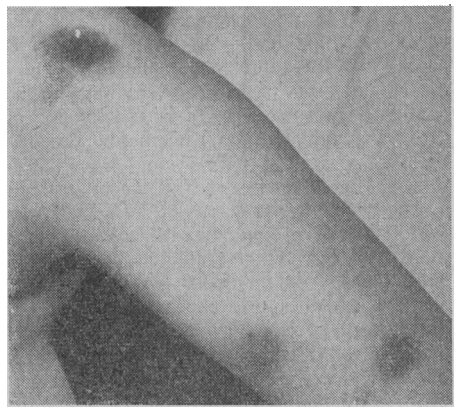
Mrs. A. B., aged 62.—No history of allergy or skin disorders in the past. In good health until four days after oral penicillin for an infected cut on her leg in September 1964; a few days later lassitude, low-grade pyrexia, and appearance of painful lumps on arms, legs, and buttocks as well as stomatitis developed. The skin eruption varied from small papules to indurated, raised, very tender infiltrations, measuring 3 in. (7.5 cm.) in diameter on arms, buttocks, and lower limbs. Some of the large infiltrations showed central scaling. In December continued fever with spikes of 104° F. (40° C.) was associated with anorexia, weight loss, and general malaise.

Investigations in this patient and the others under review included blood count, B.S.R., blood culture, *x*-ray chest, agglutination tests, viral studies, estimation of plasma protein and of antistreptolysin titre, Kveim's test, skin biopsy, and in the second patient renal biopsy and lumbar puncture as well. The only abnormal laboratory findings were neutrophilic leucocytosis and microcytic anaemia.

A diagnosis of hypersensitivity state, possibly initiated by penicillin, was made. Rapid fall of temperature, clearing of the skin lesions, with general improvement set in 24 hours after injections of corticotrophin, which were spread over 10 days.

Mrs. C. D., aged 38.—Erythema nodosum of unknown aetiology nine years ago. Recovery after four weeks. Well until September 1964, when she had tonsillitis. A week later she became feverish and painful lumps appeared on both legs. No response to salicylates and steroids. In October she developed papular urticaria on both arms. She entered Sefton General Hospital on 13 October with a high-continued fever, lesions resembling erythema nodosum on both legs, papular urticaria on arms, and splenomegaly. She remained very ill and continuously feverish for 10 weeks. She had several episodes of sudden, severe headaches with some neck stiffness and vomiting. There were also incidences of retrosternal chest pain. She required intravenous fluid and heavy sedation. Corticotrophin, antimalarials, and blood transfusions did not alter the course of the illness. She began to improve towards the end of December, the skin eruptions clearing and the spleen no longer palpable. She too had neutrophilic leucocytosis. The throat swab was positive for haemolytic streptococci. The antistreptolysin titre rose from 333 units on 13 October to 835 units three weeks later. There was slightly increased protein in the C.S.F. Periarteritis nodosa, the most likely diagnosis on clinical grounds, was not confirmed by renal biopsy. The final diagnosis was hypersensitivity state after streptococcal tonsillitis, with spontaneous recovery after four months of alarming illness.

Mrs. E. F., aged 38.—In good health in the past apart from appearance of tender, purple skin infiltrations over a period of three months in 1962. Well afterwards until June 1964, when tender, painful, purple, infiltrated patches appeared on both arms (see illustration) and in the



skin above the right breast. A few days later an effusion developed in the right knee-joint. In the seventh week of illness a very tender bluish infiltration of the skin and fat tissue was noted over the lower abdomen. She was pyrexial on admission to Sefton General Hospital on 31 December 1964. The skin lesions were almost identical with those we had just observed in Mrs. C. D. The skin and fat infiltration on her abdomen resembled the tissue changes of non-suppurative panniculitis (Weber–Christian disease). Neutrophilic leucocytosis and raised B.S.R. were recorded. On 4 January she was given Tab. Plaquenil (hydroxychloroquine sulphate) three times a day. The temperature settled within 48 hours of commencing the drug and all skin lesions had cleared within a week of treatment. She left the hospital with recommendation to continue taking hydroxychloroquine three times a day for six weeks. After a few days she stopped taking the drug and painful infiltrations of the skin and fat reappeared. They regressed on resumption of treatment.

The three cases described are recent examples of reaction states to agents which may be an antibiotic (Case 1), bacteria (Case 2), or unknown (Case 3).

The syndrome is not uncommon in our experience and affects females mainly. The illness may run an alarming and prolonged course. Some patients get better without treatment (Case 2), some seem to respond well to antimalarials (such as Case 3 and those published by me in 1958), while others recover after treatment with steroids (Case 1 and Dr. Sweet's patient). The causal agent is unspecific and the pattern of reaction varies in every patient. It seems hardly justifiable to speak of a new disease or to give such varied process a special name. Nevertheless, Dr. Sweet's article has served a very useful purpose in drawing attention to a disturbing syndrome in which treatment with antibiotics and sulphonamides is unwarranted and possibly dangerous, particularly in patients with a previous story of hyperergic reactions.

—I am, etc.,

Liverpool 1. H. FULD.

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1 Sweet, R. D., *Brit. J. Derm.*, 1964, **76**, 349.
2 Fuld, H., *Rheumatism*, 1958, **14**, 1, 12.

Expiratory Airways Collapse

SIR,—Dr. L. C. Lum (16 January, p. 188) rightly emphasized the importance of airways collapse during expiration. This is the cause of airway obstruction in emphysema, in contrast to obstruction in asthma (which is due to bronchospasm) and in bronchitis (where the lumina of the airways are narrowed by secretions and inflammatory changes in their walls). The mechanism of airway collapse has been demonstrated with theoretical models by Fry and Hyatt.[1]

The phenomenon of tracheobronchial collapse is often demonstrated during routine respiratory-function tests on patients with emphysema, but not all such patients show the distinctive notch in the expiratory spirogram which indicates this. Dr. Lum's observation of "abdominal bounce" appears to be an important clinical sign, the advanced stage of the disorder being thereby suggested even before the patient is referred for assessment with physiological tests.

By no means all the patients seen in this department who show tracheobronchial collapse adopt the "pursed lips" method of expiration. It is noticed, however, that most of them have difficulty in breathing through the mouth, being used to the help that the added airway resistance of the nasal passages gives to raising the intraluminal pressure in the airways and thus keeping them patent.[2] Physiotherapy in these patients must not only teach them to avoid forced expiration but also to inhale as rapidly as possible, thus allowing the maximum time for relaxed expiration, as pointed out by the authors mentioned above.[1] These authors also show that increasing the volume of the chest increases the expiratory flow rate. Many physiotherapists wrongly attempt to reduce pulmonary hyperinflation in emphysematous patients.—I am, etc.,

Department of Respiratory Physiology, Harefield Hospital, Middx. P. LOCKWOOD.

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2 Ferris, B. G., Mead, J., and Opie, L. H., *J. appl. Physiol.*, 1964, **19**, 653.

The Drinking Driver

SIR,—I would like to make a few comments on Dr. Simon Freeman's article "The Drinking Driver" (26 December, p. 1634), although I agree with most of it, particularly the conclusions.

Dr. Freeman gave a list of consistent and diagnostically significant signs: (1) slurred speech; (2) full bounding pulse; (3) impaired memory; (4) poor co-ordination; (5) widely dilated pupils with little or no reaction to light; (6) lateral nystagmus. I would suggest that such a patient is drunk and incapable, and not merely under the influence