help still further. To reduce our aid to these countries, who are incomparably poorer than our own, owing to our temporary financial difficulties seems both short-sighted and inhumane.

Repeatedly I asked myself whether we were giving postgraduates from the East the training they really need. Even though many of them had passed postgraduate diplomas I suspect that they felt inadequately prepared for these vast problems of malnutrition, infection, and overpopulation. We need to reconsider both the content of postgraduate education given to doctors from these countries while they are over here and to see how we can give them much more effective support after they return home.—I am, etc.,

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Foetus—or Fetus?

SIR,—A number of years ago, when we were engaged in the production of a new text on *Human Embryology*, our American collaborator, Professor Harland Mossman, pressed us to adopt the American spelling of *fetus* rather than the British and Continental *foetus*. At that time we sought the advice of the late Professor A. B. Cook, Fellow of Queens' College, Cambridge, and an outstanding authority on the use of classical terms, who informed us that *fetus* was more correct than *foetus*. Indeed, the incorrect spelling first occurs in the late writer Isidorus of Seville (A.D. 570–636), who fancied that the word could be derived from *foveo* (I cherish) instead of from **feo* (I beget). This mistake has been followed by later writers. The Romans used the term *fetus* for wild and garden fruits, thus *arborei fetus* (Virgil) and *triticei fetus* (Ovid).

Hyrtl (in his *Onomatologia Anatomica*, 1880) would admit both spellings as correct, but he stresses that it is curious that "foetus" should be preferred to "fetus" when we prefer *femina* to *foemina*, *fecundus* to *foecundus*, *fetura* to *foetura*, and *fenu* for *foenum*. The late Professor Cook assured us that etymologically there can be no doubt at all that "fetus," being certainly related to *femina* and *felix*, is correct. But notwithstanding this opinion he was reluctant to advise us to discard "foetus," considering that a term that had fulfilled a purpose for longer than a millennium required no greater sanction than this established usage.

We have ourselves, however, rather reluctantly come to the conclusion that the time has arrived when "fetus" should replace "foetus." "Fetus" is shorter, less ugly in print (in our opinion), and gives no alteration in pronunciation; it is the spelling Cicero would have used and which is correctly used by half of the English-speaking world. The change, therefore, could hardly be considered as mere rationalization or pandering to transatlantic foibles. But before committing ourselves irrevocably we thought it would be interesting and might be helpful to solicit a more general opinion on the issue.—We are, etc.,

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Bleeding Peptic Ulcer

SIR,—Dr. R. K. Carruthers and his colleagues (14 January, p. 80) refer to our mortality in emergency operations for bleeding peptic ulcer up to the middle of 1958. They make a strong case for "conservative" surgery in the form of a vagotomy and pyloroplasty for bleeding duodenal ulcer.

Since the beginning of 1960 we have also made increasing use of this operation, with an improvement in our operative mortality. Thus, in 86 emergency operations for severely bleeding duodenal ulcer there were 13 (15%) deaths, compared with 11 (20%) deaths in 53 such patients in the immediately preceding series. The recent 86 operations included a very ill patient who died after simple suture of the bleeding ulcer. There were 41 vagotomy and pyloroplasty operations, with 5 (12%) deaths in patients aged 63, 66, 70, 79, and 86, three of whom died from bronchopneumonia, one from coronary thrombosis, and one from chronic renal failure. One patient bled postoperatively, but stopped after adrenaline and Stypven. There were seven (16%) deaths in the 43 Polya partial gastrectomies, including two patients in whom pyloroplasty had been abandoned in favour of a partial gastrectomy.

Our overall mortality for 450 patients with bleeding duodenal ulcer (admitted under the care of Dr. J. C. Pease and Dr. J. P. Caley) has so far remained unchanged at 9% since the introduction of vagotomy and pyloroplasty. However, the overall mortality for over 1,000 admissions for bleeding peptic ulcer of all types has increased from 7% to 9%. We are examining the factors responsible for this increase and hope to report our findings in due course. We know there has been an increase in recurrent haemorrhages in patients over 60 years old.—We are, etc.,

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Mansfield, Notts. A. MCEWEN SMITH.

Drugs for Status Epilepticus

SIR,—We have read with interest the article by Dr. A. S. Brown and Dr. Jean M. Horton (7 January, p. 27). Although they have found intravenous thiopentone a safe and effective method of controlling status epilepticus in neurosurgical patients, we do not feel they are justified in their generalization that drugs such as paraldehyde are very unsatisfactory and should be avoided.

In neurosurgical patients status epilepticus tends to be short-lived and usually controllable by any of the accepted methods. This makes it difficult to compare their effect, and in most centres whatever method is preferred will be found to be effective.

So far as the treatment of status epilepticus in general is concerned, and especially the more severe varieties, paraldehyde still remains the drug of choice in view of its efficacy and safety. Unlike thiopentone it does not tend to depress the vital centres, and dosage can therefore be high when necessary. Diazepam (Valium) is now being increasingly used and we agree with Mr. P. J. E. Wilson (28 January, p. 239) that it is remarkably safe and effective and may soon be the drug of choice.—We are, etc.,

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New Wards for Old

SIR,—Your leading article "New Wards for Old" (21 January, p. 123) and the paper by Dr. Phyllis Rountree and others (21 January, p. 132) draw attention to methods for combating infection in a surgical ward.

I have worked for some years on the problems of bacteriology of air and dust and have found with others[1 2] that the concertina effect of pillows and mattresses is important. This can be overcome by regular sterilization and sealed plastic covers for mattresses and pillows. Blankets can be treated weekly, if possible, with formalin vapour and kept warm and moist in an ordinary hospital sterilizer. Ward floors can be treated with a polish that causes particles of dust to adhere to the floor. Curtains can be sprayed. Violence in bed-making can be controlled if the reason is explained to the nurses.

Results can be assessed by exposing plates of fresh blood agar every hour from midnight to midnight (one hour for each plate) before any treatment begins, and then again after establishing the routine outlined above. Before establishment of the routine optimal counts were obtained only during the hours between 1 a.m. and 3 a.m. After our routine had become well established optimal counts were the rule. Visitors were allowed in the ward, but new cases were isolated until shown to be non-infected. The results of this routine on the number of cases of infection in this hospital were favourable.

These results are brought to your attention here because some of the lessons we learned and published seem to be forgotten or neglected. Central sterile supply, though of great value, is not everything.—I am, etc.,

Epping, Essex. F. MARSH.

REFERENCES

[1] Marsh, F., and Rodway, Helen, E., *Lancet*, 1954, 1, 125.
[2] —— *Brit. med. J.*, 1956, 2, 999.

Malaria in Children

SIR,—It is certainly true, as Dr. A. F. Tuboku-Metzger points out (21 January, p. 174), that the intramuscular injection of chloroquine in children may have fatal results; but this possibility must be weighed against the likelihood of death from cerebral malaria.

Jelliffe[1] believes the degree of urgency to be such that intramuscular chloroquine, 5 mg. per kilogram, should be given as soon as cerebral malaria is suspected to be present in a child, even before the blood is examined for parasites.—I am, etc.,

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REFERENCE

[1] Jelliffe, D. B., *J. Pediat.*, 1966, **69**, 483.

Treatment of Drug Addiction

SIR,—New legislation in the immediate future may take the care of drug addiction out of the hands of general practitioners altogether. It may therefore be of interest to summarize some experience gained with heroin and heroin and cocaine addicts during the past five years in a London N.H.S. practice.