issued with some of these outfits and instructions, and any detached R.A.M.C. group was issued with at least one outfit. I understand that this treatment in every case prevented death, but several cases evidently got a secondary infection and were admitted to hospital and survived. The *Vipera nasicornis* is still living in woodlands with undergrowth, in Cobham Woods, five miles from here; I have encountered two adult specimens on the golf links adjacent to the woods. I knew that they were not aggressive and I left them alone.—I am, etc.,

Rochester, Kent. C. W. Greene.

Phenylbutazone in Superficial Thrombophlebitis

Sir,—A number of observers, both abroad and in this country, have recently commented favourably on the use of phenylbutazone in the treatment of superficial thrombophlebitis. It might therefore be of interest to record a further 14 cases in which this treatment has been employed in general practice. Patients suffering from the known contraindications to the drug were excluded from the trial, but otherwise there was no selection of cases. All the patients were given 100 mg. thrice daily for one or two weeks, depending on the response in the first week, and the affected limbs were supported with crêpe bandages. All the patients were ambulant and no other treatment was given. Varicose veins were present in all the cases except one; this and one other followed trauma.

The treatment was successful in eight cases. In all these cases there was a considerable reduction in local symptoms within 24 hours to 3 days and a complete resolution of symptoms in from 2 to 11 days. There is a wide variation in these figures, which is only to be expected in cases of this type, but the early disappearance of most of the symptoms is quite striking. In three cases results were similar in the first week but no further resolution occurred thereafter. All these three were patients with gross varicosities who had had several previous attacks of phlebitis. In two cases no improvement was found at all, there being no obvious reason for this. In one case, after five days the treatment was discontinued because, in spite of some improvement, the patient developed a generalized morbilliform rash. In no case was treatment continued after two weeks in view of the possibility of toxic reactions. In any event, all those who responded to treatment did so from the very beginning and it was not necessary to prolong the treatment.

While it would be dangerous to draw definite conclusions from a small series of cases, it does seem likely that phenylbutazone is of some value in the treatment of superficial thrombophlebitis, particularly in the milder cases. The early resolution of severe symptoms is a great help to the ambulant patient. Cases which tend to respond poorly to other forms of treatment seem unlikely to respond to phenylbutazone. It is of course possible that a higher dosage might improve these results.—I am, etc.,

Dagenham, Essex. A. J. Levine.

Premedication with Methylpentynol

Sir,—Dr. R. M. Harrison in his letter (*Journal*, September 14, p. 642) states that, according to the research of P. Trotter,[1] methylpentynol speeds reaction and has a negligible deleterious effect on behaviour. Dr. J. P. Quilliam[2] states that, according to the research of Dicker and his colleagues, the effect of methylpentynol in certain experiments was attributed to a damping down of autonomic responses. Dr. Quilliam, in his experiments, found that methylpentynol can block transmission in the superior cervical ganglion of the cat, an action of this type which may account for the damping of autonomic responses observed by Dicker. A drug with such an effect cannot speed up reactions.—I am, etc.,

London, S.E.25. A. Fry.

References

[1] Trotter, P., *Lancet*, 1954, 2, 1302.
[2] Quilliam, J. P., *Med. Press*, 1957, **138**, 121.

Sale of Dangerous Drugs Abroad

Sir,—Recently an elderly female patient was admitted to this department complaining of a sore throat and of an increasing difficulty in breathing—both starting the previous day. On admission she presented stridor, was cyanosed, toxic, and afebrile. She had pitting oedema of the upper thorax, and her fauces were swollen and ulcerated and yielded a growth of β haemolytic streptococci. Blood examination revealed an agranulocytosis, and despite intensive therapy the patient died the following day.

Subsequently the relatives produced an empty bottle which had contained amidopyrine tablets which the patient had been taking. She had obtained them while on holiday in Switzerland from a chemist, on his advice, for the rheumatism which troubled her. Both her holiday companions had also finished their course of amidopyrine from the same source, for their rheumatic pains. The association of amidopyrine and agranulocytosis is well enough known, and other drugs, whose sale in Great Britain is controlled by Schedules 1 and 4 of the Poisons Regulations, are freely obtainable from retail pharmacists in most Continental countries without prescription. In the light of this case, it would seem prudent for the medical practitioner to advise his patients, particularly chronic invalids, who are going abroad against accepting drugs they are unfamiliar with, unless under medical supervision.—I am, etc.,

Edinburgh, 3. W. J. Newlands.

Chronic Bronchial Infection

Sir,—Your annotation on antibiotics in chronic bronchial infection (*Journal*, August 24, p. 459) is most timely with the approach of winter. In your final paragraph it is suggested that the interests of the taxpayer and patients taking costly antibiotics are in conflict. I do not think this is true. Patients with chronic bronchitis run a grave risk of contracting pneumonia in the winter. Such patients may require hospital treatment, and thus occupy an acute medical bed for perhaps two or three weeks. The cost of in-patient treatment is much greater than that arising from the process of "wintering" such patients with long-term antibiotics. Furthermore, these patients are kept going at their jobs at the time when they would otherwise be lost as far as their wage-earning capacity is concerned. Surely prevention, besides being less expensive, is also better medicine than cure.—I am, etc.,

New York. B. H. Bass.

The Forgotten Thomas Splint

Sir,—Mr. P. B. Roth's experience (*Journal*, September 14, p. 646) of three months' bed rest following a fractured femur, presumably at the neck, must have been particularly galling for an orthopaedic surgeon, and prompts me to mention a recent case in our practice.

My great-aunt, aged 90, fractured her left femoral neck nearly six weeks ago, and, as I am her doctor, she assured me that she would die if sent to hospital—some old folk seem to, when they want to. Knowing my aunt, I accepted her word. She had the classical external rotation of foot, together with pain and some deformity at the neck of femur. Not for the first time this year, I applied a Thomas splint with skin traction. However, blisters appeared under the strapping, and after suffering two weeks of castigation for applying "the contraption," I removed it, replacing it with the old-fashioned slipper and cross-bar of wood. At the third week a fair range of movement was possible and clinically there was some union; by the fifth week she was getting up for about 3–4 hours as of old and "walking," definitely weight-bearing, with cautious assistance to her chair. There is limitation of hip-joint movement, but hardly any pain, full movement of the knee-joint with a little eversion of the foot—a satisfactory result for all concerned, fortunately for me. She was a very poor risk for surgery and would not have survived bed rest for long.

There seems to be still a real place for the "splint and slipper" in elderly people, especially where patient and relatives are reluctant, quite naturally, to leave the comfort and security of the home. The science and asepsis of the hospital is, no doubt, a poor substitute for home, no matter how humble, when one is old. Getting up elderly people with fractured femurs really early is, I believe, not new—I learnt it from my respected senior registrar some ten years ago and have never forgotten the lesson.

It would amuse Colonel Alistair Whyte (*Journal*, August 17, p. 414)—to whom I sincerely apologize for causing many an exasperating hypertensive moment while serving under him—to see the look of surprise and horror when I advocate the one and only Thomas splint to first-aid classes: "But doctor, bach ! the Liston we use ! "—I am, etc.,

Garnant, Carms. F. I. POWELL.

Gastro-intestinal Polyposis

SIR,—In his interesting paper on gastro-intestinal polyposis (Peutz's syndrome) Mr. D. Bailey (*Journal*, August 24, p. 433) discusses its surgical treatment on the assumption that small-intestinal polyps have a dangerous propensity to malignant change. The literature, in fact, gives a *reported* incidence of 24% of malignancy. Such composite figures, however, must be approached with great caution. I believe that this one is particularly misleading, and that true carcinomatous degeneration in the jejuno-ileum, if it occurs at all, is exceedingly rare. The diagnosis of malignancy has been based in most reported cases on the histological appearance of polyps removed at operation, especially on the apparent invasion of the deeper layers of the gut wall. Many of these patients have been traced recently, and their subsequent clinical progress casts uniform doubt on the accuracy (or, rather, on the significance) of the pathological reports. No case, so far as I am aware, has yet been reported in which these supposedly malignant polyps have given rise to secondary deposits either in distant organs or even in lymph nodes. None of the deaths have been caused by carcinomatous change. Those original papers which already include a late follow-up report also suggest that the histological diagnosis may have been unduly pessimistic.

I was led to this inquiry from investigating five families,[1] which included four patients in whom the diagnosis of malignant change had been made at some stage of their illness. Two are alive and well ten years later; one, in whom the diagnosis had been made on two separate occasions 13 and 15 years ago, died in 1956 of carcinoma of the pancreas: and one, who in 1917 had been forecast to have only a few months to live, died recently of heart disease. None of them had radical surgical treatment. Such a uniformly benign course is in striking contrast to the natural history of the rapidly fatal primary carcinoma of the small intestine and to that of malignant polyps of the colon, rectum, and stomach. The difference cannot be accounted for by the timeliness of surgical treatment or by the young age-group of the patients. Mr. Bailey's observation that "the recorded incidence of carcinoma would probably be higher if all polyps removed were subjected to routine serial section" supports, I feel, my own contention. If some of these carcinomas did, in fact, remain undetected, it is the more remarkable that, in over 100 reported patients, there was not one in whom there was clinical, as opposed to histological, evidence of malignancy.

I think that, in this instance, the frequent discrepancy between histological picture and clinical course can be explained by the pathogenesis of the polyps. In several operative and necropsy specimens of small intestine from patients with Peutz's syndrome I found, on serial microscopic sections, that the bowel mucosa around most of the larger polyps, and even in some isolated segments which appeared normal to the naked eye, was grossly disorganized. The muscle layer was disrupted by primitive adenomata, ranging from simple diverticulum-like downgrowths to more complex adenomatous nodules which extended into the subserosa. It seems probable that the "malignant invasion" which, in all reported cases, has been the crucial evidence of malignancy, may reflect the origin and earliest phases of macroscopic polyps rather than signify late degeneration. (It is worth recalling that, in 1904, Bunting,[2] of Johns Hopkins, collected six cases of what he regarded as a distinct entity—"multiple locally invasive small-intestinal carcinomata" which showed no tendency to spread. Contrasting these growths with the common primary carcinoma of the small intestine, he drew the analogy of the difference between rodent ulcers and squamous-cell carcinomata of the skin.)

On this basis I cannot agree that "there is a need for prophylactic surgery," even if such surgery were possible. On the contrary, it strikes me as advisable to try to preserve at operation every inch of small bowel not visibly affected. Long periods of quiescence may elapse between the outcropping of new polyps, and it is impossible to predict on naked-eye examination where and when fresh polyps are likely to arise. "Prophylactic clearing operations" are not only unnecessary but also doomed to failure. If the surgeon still wishes to search for areas of early polyposis, direct endoscopy appears to me a more simple and accurate method than the manœuvre suggested by Vary.[3] A child sigmoidoscope can easily be introduced into the ileum through a small enterotomy near the ileo-caecal junction, and the whole small intestine can be folded over its sheath systematically and without difficulty.

Mr. Bailey does not mention whether in his patients the biopsies of the pigmented spots did, in fact, show the "vertical-band" distribution of pigment particles. This pattern was, I think, first mentioned by Jeghers *et al.*,[4] but I was unable to identify it in several biopsies which I examined myself, and I found no confirmation of it in the literature. On naked-eye examination these macules may be difficult to differentiate not only from Addisonian pigmentation but from the dark mucosal patches frequently seen in patients of mixed European–coloured parentage.—I am, etc.,

Iserlohn, B.A.O.R. T. L. DORMANDY.

REFERENCES

1 Dormandy, T. L., *New Engl. J. Med.*, 1957, **256**, 1093, 1141, 1186.
2 Bunting, C. H., *Bull. Johns Hopk. Hosp.*, 1904, **15**, 389.
3 Vary E. P., *Amer. J. Surg.*, 1956, **91**, 152.
4 Jeghers, H., McKusick, V. A., and Katz, K. H., *New Engl. J. Med.*, 1949, **241**, 1031.

Headache Mechanisms

SIR,—After reading the leading article on headache mechanisms (*Journal*, September 14, p. 633), and after hearing a speaker at the meeting of the Anglo-American Symposium on Psychiatry last September, I feel that I would like to endorse what Dr. Wolff has to say about the tension headaches, which are very often a somatic manifestation of the tension state. Contrary to what Dr. Partridge said at the symposium about mephenesin—namely, "that it is now a forgotten tranquillizer"—I found it useful, but not as a "tranquillizer."

In my experience with the tension headache I have found mephenesin, two tablets four times a day, the most helpful of all drugs which have been recommended so far. It is true that only symptomatic relief is obtained, but without it psychotherapy, which is almost always needed in these cases, cannot easily be applied.—I am, etc.,

Dartford, Kent. G. BRAM.

True Hermaphroditism

SIR,—I was most interested in the case described by Dr. C. N. Armstrong and his colleagues (*Journal*, September 14, p. 605), in which the presence of an ovo-testis on one side and an ovary on the other was associated with a remarkable blood group anomaly.

I should like to offer an alternative to the highly complex genetic explanation which the authors propose for this phenomenon. As they point out, freemartins in cattle may develop testicular and ovarian tissue in the presence of normal chromosomes. In this case sex chromatin was identified in the majority of the somatic cells with the exception of the blood neutrophils, where it was found in only 2–3 per 500 cells. The blood group anomaly was essentially that of a group-B secretor having blood cells of group O. Is it therefore not likely that this is another case of chimerism in which a male group-O twin was absorbed *in utero* after having been for a period in cross circulation with the