mass, measuring 20 by 20 cm. The cut surface showed it to consist of soft white tissue. Several areas of haemorrhage were seen. Section showed a dysgerminoma; the capsule appears to be intact in the sections examined, but histologically this tumour is certainly malignant." To date the pregnancy is progressing normally.

I should like to thank Mr. D. Jefferiss for permission to record this case.

—I am, etc.,

Exeter. JILL M. EVANS.

Oesophageal Atresia

SIR,—The article by Mr. C. Parrish and Mr. C. F. A. Cummings on oesophageal atresia (*Journal*, May 17, p. 1140) and the correspondence arising from it (*Journal*, May 31, p. 1297, and June 14, p. 1414) have been of great interest. My own experience of 16 cases has been very similar to that of the authors and most of the correspondents; i.e., an overall recovery figure of a little more than 50%, which would have been better but for associated abnormalities. There are some points of technique and management which have arisen in my experience and which may be of interest.

In general I agree with Miss Isabella Forshall and Mr. P. P. Rickham (*Journal*, June 14, p. 1414) that operative detail is of little importance compared to post-operative management, but there are two points which arise at the time of operation which have a great bearing on the survival prospects. The first of these is that these infants are often found to be reluctant to regain consciousness, and poor breathers, at the end of operation. This may wrongly be attributed to shock or to overdosage with anaesthetic agents; in fact it is due to a hypothermic state, and we have recorded temperatures as low as 88° F. (31.1° C.). This is not entirely due to exposure during operation, because a low temperature is also found pre-operatively; this seems due to the general exposure which the infants suffer during radiographic screening, the setting up of intravenous drips, transfers from one ward to another, or from one hospital to another, etc. This hypothermy is of little significance, and responds readily to simple warming in an incubator; it is important only in that it must be recognized.

A second point is that survival depends to some extent on the size of the fistula; usually this is a pin-point, and, if so, successful operation may be carried out several days after birth; but sometimes the fistulous orifice is the full diameter of the oesophagus, allowing free reflux of gastric contents and bile, which set up a far deadlier pneumonitis than does inhaled milk. Two such cases have come my way. Both succumbed from pneumonia, though operated upon within 24 and 36 hours, respectively. A narrow lower oesophageal segment may be a disadvantage to the surgeon, but it confers some protection on the patient. There is invariably a great disparity in size between the thick upper segment and the tenuous lower oesophageal segments. This can be overcome by not using for the anastomosis the ¼-in. (6.4 mm.) of lower oesophagus which entered the trachea. Mr. R. H. R. Belsey has maintained (unpublished) that this small length derives its blood supply from the trachea, and is avascular when detached from it; this may well be true. but it seems to me that it is also fibrotic and the lumen cannot be dilated easily; a little lower down, however, the oesophagus, though very thin, dilates easily, and the disparity in size to the upper segment can be reduced to a useful extent by gentle dilatation prior to anastomosis.

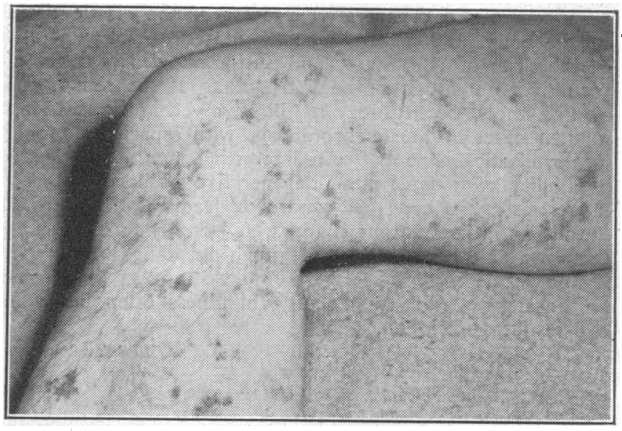
In the post-operative management, for fear of damage to the suture line, I have avoided an indwelling tube, and have relied upon intravenous fluids for a few days before breast-feeding is recommenced; but, since the advent of the very fine, soft polythene tubing, these objections have been overcome. But whether intravenous or tube feeding is used, there is no doubt that it should be in the hands of paediatricians especially skilled in this work. I have been fortunate that Dr. H. V. Finlay has always been readily available to undertake the all-important post-operative management of my cases.—I am, etc.,

London, W.1. KENNETH S. MULLARD.

Unusual Case of Herpes Zoster

SIR,—A case of herpes zoster is reported on account of an unusual feature—namely, the association of a relatively very small area of sacral herpes with a large area of petechial rash extending from the groin to the ankle on the same side as the herpes.

On February 4, 1958, a garage mechanic aged 41 complained of pain in the sacral region just to the right of the midline where, in the second lumbar and perhaps third sacral dermatomes, was a single patch of zoster vesicles of about 4 sq. in. (26 sq. cm.). The pain radiated to the thigh. Two days later the herpetic area was no larger but pain was much worse, and by February 10 it made the patient stay in bed. There was still no extension of the herpes, which had become haemorrhagic, but the buttock, thigh, and leg now showed a petechial rash (flat, discrete, bluish macules 1–2 mm. across) which did not blanch on pressure. On the external aspect of the buttock and thigh the petechiae were in the second lumbar dermatome, but not lower than about 3 in. (7.5 cm.) below the great trochanter. On the inner aspect of the



limb (see photograph) they extended from the groin to just above the internal malleolus, in the third sacral and second, third, and fourth lumbar dermatomes. No petechiae were seen over the rest of the body. Blood taken on February 11 showed: Hb 105%; W.B.C. 5,300, neutrophils 55%, lymphocytes 42%, monocytes 2%, eosinophils 1% (Dorset County Laboratory).

On February 13 the petechiae had begun to fade. Pain in the thigh and calf still prevented walking. By February 18 the petechiae had become invisible while the patient stayed in bed, but became obvious whenever he had been up for 10 minutes. On February 20 the sacral patch of herpes, still its original size, was red and scaly. The pain, still disturbing sleep, seemed to be in the femur and tibia; by the 25th it was spasmodic, and pruritus was a new and troublesome symptom. Rubbing or scratching served only to aggravate the pain. The petechiae were still to be seen whenever the patient had been up for 10 minutes, and blanched on pressure. The area of sacral herpes was now a pigmented scar. On March 1 the petechial rash had considerably faded, and the patient, now in less pain, returned to work. By March 6 the petechiae were scarcely visible. Not one of them had become vesicular.

—We are, etc.,

P. R. BOUCHER.

Winfrith, Dorset. MARGARET J. TURPIN.

Prevention of Lung Cancer

SIR,—The letter from Dr. Lennox Johnston, president of the National Society of Non-smokers (*Journal*, June 21, p. 1483), provokes me to say something on this subject. Dr. Lennox Johnston castigates the Medical Research Council for not having made any recommendations for preventing lung cancer by stopping people smoking. This side of the problem was not theirs to deal with, so far as I know.

Without denying some, but only *some*, causal connexion between smoking and lung cancer, it must be evident to anyone who has studied the many observations and letters of independent thinkers on this subject of smoking and lung cancer that the case against cigarettes has been very much overstated, and when one does that one spoils one's case.