Dr. Harding is perfectly correct when he suggests that rupture of a follicle may lead to the mistaken diagnosis of "appendicitis." There are, however, two other conditions in females which may cause errors in diagnosis—namely, pyelitis and salpingitis. In both of these conditions headache is a common symptom which does not occur with uncomplicated appendicitis. All gynaecologists are well aware of two maxims which are based upon this fact, but comparatively few of my general surgical colleagues seem to have heard of them. The maxims are: "The only common causes of acute abdominal pain and headache in women are pyelitis and salpingitis"; and "An acute abdomen associated with headache is not an acute abdomen."

During the war I performed several hundred appendicectomies in the Emergency Medical Service and never once did I find a case of appendicitis associated with a headache. There was, however, one apparent exception to the rule when a young girl of 14 was admitted with gross generalized peritonitis which clinically appeared to be due to a ruptured appendix. Noting that she had a severe headache I remarked to the anaesthetist, Dr. Denzil Lewis, "This is the first case of appendicitis which I have ever seen with a headache. I wonder whether she has salpingitis as well?" On opening the peritoneal cavity pints of pus poured out and a ruptured gangrenous appendix was found adherent to the right Fallopian tube which macroscopically showed signs of gross interstitial salpingitis. The left tube was, however, only very slightly affected. The clinical history, and macroscopic appearances, clearly indicated that the salpingitis was secondary to the appendicular infection. Once again the rule that headache does not occur in uncomplicated appendicitis had been vindicated.

I feel confident that if all general surgeons were to realize that headache excludes appendicitis, as all gynaecologists do, far fewer normal appendices would be removed in both sexes.—I am, etc.,

St. Austell, Cornwall. D. G. WILSON CLYNE.

SIR,—May I take over where Dr. H. E. Harding (October 20, p. 1028) left off? His article supports a thesis I have taught for years—namely, that disease in the female pelvis is better treated by a gynaecologist. I entirely agree with him that no one likes removing the appendix unnecessarily; even when doing routine laparotomy for other reasons I remove the appendix from fewer than two out of three women under the age of 50 and fewer still in older women. One suspects that many of the cases which would form material for a series as described by Dr. Harding present as acute abdominal emergencies at awkward hours and tend to be treated by a surgical registrar or even a house-surgeon.

Nowadays one seldom sees the ugly spreading scars and puckered drainage-holes of the previous generation; to-day's wounds apparently heal cleanly, leaving neat linear scars. However, one still sees far too many young women who have undergone a superfluous laparotomy, superfluous in that too much or too little was removed. Apart from the immediate risk of operation and anaesthetic such operations may prejudice the reproductive capacity of the woman and limit the scope of treatment for gynaecological disorders that may arise in the future.

I strongly support Dr. Harding's plea for wider recognition of this factor and suggest that in the case of young females where there is the slightest possibility of doubt in the diagnosis a gynaecologist should be consulted.—I am, etc.,

London W.1. G. DALLEY.

SIR,—Dr. H. E. Harding's article on "A Notable Source of Error in the Diagnosis of Appendicitis" (October 20, p. 1028) draws attention to the frequency of the diagnosis of "acute appendicitis" in young females, but surely these cases are labelled thus for want of any other abnormal condition being found? Probably no other condition calls for such a high degree of surgical honesty, and to complete a set of case notes with "N.A.D." or with the diagnosis of "Pain R.I.F." is unthinkable to many. Most of these young women are a headache to both family doctor and surgeon, and though Dr. Harding emphasizes the mortality, the wastage of hospital beds, and nurses' and doctors' time, it is often more satisfactory to remove the "lilywhite" organ to avoid further trouble (assuming that all investigations are negative). It is interesting to note that many of these cases are cured by removal of a normal organ; with these patients there is often a big appendix complex in the family.

In the case of young females, if the ovary be the cause of the pain, why should the right side be more frequently affected than the left? These young women often suffer from a latent constipation, with a lazy colon; even though the rectum is empty on examination, a loaded descending colon can be felt on abdominal examination, and this is confirmed at operation. Possibly in these cases the "appendicular" pain is due to gaseous distension of the caecum.

I should be interested to know if others have noted, as I have done in a high proportion of these patients in whom a normal appendix is removed and no other abnormality found, that the caecum is unduly lax and hangs low in the pelvis. Could the pain be somehow related to this finding, and if this is the case is there any justification for hitching up the caecum to the parietal peritoneum of the iliac fossa (a "caecopexy")?—I am, etc.,

The Royal Hospital, Sheffield 1. S. GRAHAM THOMPSON.

Halothane in Anaesthesia

SIR,—The role of halothane as an "introducing agent" for ether–air anaesthesia was referred to by your expert in "Any Questions?" (August 11, p. 428). This suggestion prompts me to record that halothane can, with advantage, be employed in this way when agents other than ether are to be used for the maintenance of anaesthesia. For the past year, in suitable cases, we have been inducing anaesthesia with thiopentone–halothane–oxygen sequence (with or without added nitrous oxide) and, when stabilization of anaesthesia has been achieved, maintaining anaesthesia with nitrous oxide, oxygen, trichlorethylene.

The advantages of this method are threefold. The induction is both more smooth and more rapid than when thiopentone with nitrous oxide, oxygen, and trichlorethylene are used from the beginning. Maintenance of anaesthesia with trichlorethylene is far less expensive than with halothane throughout.