Trilene anaesthesia is now used in a Mapleson A-type circuit or a non-rebreathing circuit, and therefore with a continuous flow of fresh gases the temperature will never rise above room temperature. In the case reported the patient was dipping the articles into a bath of warm trichloroethylene. The temperature of the bath is not stated, but since "fumes occasionally escaped in sufficient quantities as to be visible" the temperature must have been in the region of 60° C. (Boiling point of trichloroethylene 87° C.) This temperature in itself is surely sufficient to cause degradation into toxic products without incriminating the preservative.—I am, etc.,

E. L. LLOYD.

Department of Anaesthetics,
Toronto General Hospital,
Toronto, Ontario, Canada.

REFERENCE

[1] Lee, J. A., and Atkinson, R. S., *A Synopsis of Anaesthesia*, 1964, 5th ed. Bristol, John Wright.

V.D. Patients and Contacts

SIR,—A private member's Bill for compulsory treatment of venereal disease was withdrawn after opposition from both sides of the House of Commons on 21 March.[1] The annual figure for gonorrhoea now exceeds 40,000 experienced in 1930 and is rising steadily towards the peak of 47,300 seen in 1946. It is understandable that new legislation regarding contact tracing should be considered, but it should be related to the findings of a new question which could be introduced in the V.D. annual return.

Alcohol and a dark night are no aid to the patient seeking to identify his consort and give a clear description of her name and address to the clinician or social worker. Although tracing is encouraged and actively carried out, reliable statistics for the case of compulsory notification can only be based on those contacts with a clear name and address who refuse to attend a clinic. These were the contacts who were served with Form 2, and then on failing to attend were prosecuted under 33B during the war. A consensus of opinion could determine what would be an acceptable level of non-attending named consorts above which further action would be deemed necessary. I feel we should be able to stave off the threat of coercive legislation by rapidly implementing the spirit of the latest memorandum on Contact Tracing HM (68)84 by employing more V.D. social workers.—I am, etc.,

A. L. HILTON.

Rotherham, Yorks.

REFERENCE

[1] *Hansard*, 21 March 1969, **780**, No. 83, 144.

Synacthen Depot in General Practice

SIR,—We cannot let pass without comment the misleading letter from Dr. J. A. Weaver (8 March, p. 639).

Firstly, we did not, as he says, advocate the use of Synacthen depot "in a variety of 'rheumatic' disorders." We said that the results in our first 60 patients treated in general practice seemed interesting enough to report. We concluded by saying that the true value of the preparation in minor rheumatic conditions could not be assessed without a double-blind trial, which is now in hand.

Secondly, we too received, and happen still to have, the circular he complains about. Dr. Weaver quotes seven lines but omits the eighth, which reads ". . . and the results of controlled trials are awaited with interest." When read in full, it does not seem to us that the circular gives "very specific endorsement" to something we did not advocate in the first place.

Thirdly, he seems to have missed the point that for the minor rheumatic conditions we were using short courses of usually two to four injections. The question of long-term adverse effects does not arise, so that much of his argument is irrelevant. There is no difficulty about stopping Synacthen depot (as there may be with oral steroids), and many of our patients who have been incapacitated by previous attacks have been very grateful for the rapid relief. Far from encouraging its indiscriminate use, we are seeking to define the types of case for which it is justified, and our letter was by way of preliminary communication. Our longer courses of treatment were all in patients with established indications.

Finally, we would respectfully suggest that the incidence of side-effects that he has observed may reflect poor injection technique and inadequate attention to dosage. We have now treated nearly 100 patients, besides 25 so far in the double-blind trial, and our experience continues to be as stated in our letter.—We are, etc.,

J. ERIC MURPHY.
J. F. DONALD.

Northampton.

Cerebellar Ectopia Presenting in Adult Life

SIR,—The interesting article by Dr. Julius Smith and Dr. Alan Ridley (8 February, p. 353) prompts me to report a further patient with this condition, who presented at this department three years ago with pain and weakness in the right arm.

In June 1965 a 27-year-old woman noticed a prickling sensation in the right side of the neck, thumb, and index finger, followed by aching and "deadness" in the right arm and hand. Examination at this time revealed slight limitation of neck movements and no neurological abnormality. A radiograph of the thoracic spine showed upper thoracic kyphoscoliosis. A course of cervical traction was ineffective in relieving the symptoms. Three months later she noticed an odd sensation in the right side of the tongue and weakness of the right leg, and examination revealed increased deep reflexes in the right arm and leg, and right ankle clonus. The right plantar reflex was extensor and the left one equivocal. All abdominal reflexes were absent. There was impaired pain and temperature sensation, but not touch, in the C2–C4 dermatomes bilaterally, but more on the right than the left.

Investigations were as follows: Radiographs of skull (including submento-vertical views), cervical spine and chest normal. C.S.F.: protein 100 mg./100 ml., no cells; W.R. negative. Lumbar air encephalogram: no air entered the ventricular system, cisterna magna was small but no definite tonsilar protrusion was seen. Myodil ventriculogram: the fourth ventricle was low in position but did not reach to the foramen magnum. Films at 24 hours showed the contrast had left the fourth ventricle and was lying in the subarachnoid space; no definite tonsillar protrusion was seen.

A suboccipital decompression was carried out in February 1966 by the late Mr. J. V. Crawford. An Arnold–Chiari malformation was revealed. The cerebellar tonsils were elongated but thin: they reached down to the level of the axis, and were bound to each other, the medulla, and upper cervical cord by adhesions. Post-operatively there was marked improvement—she was virtually symptom-free, the deep reflexes were normally brisk and equal, and the plantar reflexes flexor. However, the right arm remained weak, and following a fall downstairs on to her neck and head both legs became progressively weaker and more spastic. In June 1967 the posterior fossa was re-explored, the laminae of C2 and C3 were removed, and several fibrous adhesions between the cerebellum and dura were divided. Unfortunately, the neurological signs have since worsened progressively and she is now severely spastic in all four limbs, though she is still able to work about the house with difficulty and can just about manage stairs.

This case illustrates cerebellar ectopia as a rare cause of brachial neuralgia in adults, and, as pointed out by Drs. Smith and Ridley in their paper, underlines the importance of warning these patients about avoiding trauma to the head or cervical spine.—I am, etc.,

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Vasectomy for Sterilization

SIR,—It seems that, despite the excellent literature distributed by the Simon Trust, there are still a number of surgeons who are not fully conversant with some of the precautions necessary in connexion with this operation. It is essential that patients have seminal specimens examined after the operation until two have been obtained which are free from spermatozoa. In most patients this is about four to five weeks after the operation, although others may take several months. If, however, this has not occurred at the end of three months then the possibility of the presence of a second vas should be suspected. This condition, like congenital absence of the vas, is uncommon. It is obviously of vital importance when a sterilization operation is being performed. If the patient is examined carefully beforehand it is possible to palpate the second vas quite easily, and the operation can still be carried out through the usual small incisions. I have also on one occasion seen a patient where the surgeon had in error ligated the artery instead of the vas. This should not occur if the operation is carried out under proper conditions with adequate lighting in an operating-theatre. It is unwise for it to be performed under lesser circumstances.

Another hazard sometimes overlooked is that patients collect the seminal specimens from a condom. This is a danger, as the presence of a spermicidal substance may be misleading when examining the fluid, especially if the specimen had been sent by post and delayed.

Above all, however, I should like to stress the importance of making sure that the patient realizes that it is essential for him to use normal contraceptive precautions until azoospermia has been proved.—I am etc.,

GEORGE WATTS.

Edgbaston,
Birmingham.

Br Med J: first published as 10.1136/bmj.2.5649.119 on 12 April 1969. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.