doctors are possibly unaware that an estimate of 10% of all admissions to general wards have had an alcohol-dependency. Alcoholism is excluded from the curricula of medical schools. Few doctors therefore understand anything about alcoholism. Workers with alcoholics learn about the illness from the patients themselves.

If a true conception of illness is accepted there is no need for shame to be attached to alcoholism. Recovered alcoholics are fortunate people. Recovered medical alcoholics can greatly help by revealing their identity and assisting in information about this disease by enlightening their colleagues and making themselves available for consultation to sufferers from the disease. I hope my personal experiences can be turned to good effect.—I am, etc.,

NEIL PANTON.

Southampton, Hants.

Porphyrinuria

SIR,—In Dr. Norman Gitlin's recent communication (11 January, p. 96), the most significant positive finding is the "strongly positive porphobilinogen." Also significant, in a negative sense, is the very modest abnormality in urinary uroporphyrin excretion. This would argue against any "acquired porphyria." On the other hand, it is hard to attach much significance to elevated urinary coproporphyrin in a patient with obvious alcoholic liver disease.

Can we be sure that the patient's pain and even the hyperlipaemia[1] are due to "Zieve's syndrome" and not to acute intermittent or variegate porphyria (possibly precipitated by an alcoholic bout and/or inanition)?[2] What is badly needed in this case to put these factors in proper perspective is quantitation of urinary porphobilinogen (elevated in both acute intermittent and variegate) and faecal protoporphyrin (elevated in variegate).—I am, etc.,

JAMES KALIVAS.

Massachusetts General Hospital,
Boston, U.S.A.

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Sudden Death in a Young Asthmatic

SIR,—As pointed out by Dr. I. Gregg and Dr. J. Batten (5 April, p. 29) the laminar arrangement of mucus in the medium-sized airways found post mortem in their patient suggests that hypersecretion had been occurring for some time before death. Moreover, the blockage may even have persisted from the time of the severe attack of asthma two months earlier. This raises the question whether the mechanical removal of such mucous plugs by bronchial lavage might not have been of prophylactic benefit. The difficulty in such cases is of course to know when the procedure is indicated.

One useful guide is the spasmodic cough from which many such patients suffer. This is often most troublesome and persistent, especially at night, the patient having great difficulty in raising even a small quantity of sputum, which is jelly-like, stringy, and extremely viscid. As a rule it contains no pathogens but is teeming with eosinophils, often arranged in clumps. The picture reflects the situation within the medium-sized airways, and may be indicative of danger, particularly if increasing the steroid dose produces little or no improvement. As Leopold[1] says, the laminar arrangement or whorling of the plugs "speaks in graphic fashion of a type of movement of the mucus and cell mass which is ineffective in bringing about bronchial clearance . . . in a severe attack not only is effective clearing of secretions impeded but the altered dynamics of breathing positively encourage the movement of aspiration"—that is, the intense inspiratory efforts made by the patient actually drag the viscid mucus outwards into the smaller peripheral airways.

There would appear, therefore, to be good theoretical grounds for mechanical removal of the plugs not only in cases of status asthmaticus[2,3] but in some cases of chronic wheezing where there is reason to suspect their presence. Fortunately the procedure in competent hands is a safe one,[4,5] and though the effect is sometimes only temporary it does in a number of instances produce relief over a longer period, without, however, be it noted, significantly reducing the need for steroid therapy or the dose. The main difficulty is in deciding the exact indications, and here the type of cough and character of the sputum are of considerable help. The second useful indication, noted in the case reported by Drs. Gregg and Batten, is a fall in the peak expiratory flow rate from a previously recorded higher level. It is indeed advisable to take peak expiratory flow rate readings routinely in asthmatics at every outpatient visit.—We are, etc.,

NORMAN MACDONALD.
J. D. ROCHFORD.
SUSAN FUCHS.

Clare Hall Hospital,
South Mimms, Herts.

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Unusual Munchausen's Syndrome

SIR,—A 21-year-old female hospital laboratory technician, using a false name, recently presented in this hospital under Dr. J. B. L. Howell with abscesses over both hips. Though born in Manchester, England, she has worked since 1964 in various hospitals, mainly in New Jersey, U.S.A. She gives a history of repeated investigations for haematuria which had ultimately led to a diagnosis of disseminated lupus erythematosus in January 1968. She had been taking 6 mg. dexamethasone daily and was Cushingoid in appearance.

She suffers from a form of Munchausen's syndrome. Twelve admissions to hospitals in New Jersey and a previous admission to Withington Hospital, Manchester, during the past five years have been traced. The pattern of her behaviour has often been first to gain employment in the hospital laboratory, then subsequently to be admitted to that hospital for investigation of haematuria, malaise, or sepsis. She has told doctors in the U.S.A. that she had been diagnosed in the United Kingdom as having disseminated lupus erythematosus and vice versa. She provided a doctor in the U.S.A. with a letter purporting to come from a specialist in Manchester giving a detailed account of the investigations leading to her diagnosis of disseminated lupus erythematosus, together with a slide of the lupus erythematosus phenomenon and supporting laboratory reports. These were forwarded to us; the specialist is fictitious and the whole letter was fabricated by the patient. Confirmation was subsequently obtained that all this evidence had been handed directly to the doctor concerned by the patient herself.

After prolonged conservative treatment for her abscesses, assumed to be self-induced, the patient, not unexpectedly, took her own discharge, with one abscess still incompletely healed. She is attention-seeking, manipulative, and shows a self-gratifying personality disorder. She exhibits most of the features of Munchausen's or hospital addiction syndrome,[1,2] though she chooses an unusual form of self-damage through steroid therapy in addition to the abscesses, and is more widely travelled than most previously reported cases. Psychiatric treatment was offered but has not been accepted.

This case is reported in the hope that it will lead to her rapid recognition on subsequent hospital presentations and eventual psychiatric treatment. Full details of this and previously documented admissions will be supplied on request.—I am, etc.,

W. M. G. TUNBRIDGE.

Manchester Royal Infirmary,
Manchester.

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Stomach Rupture Complicating Traumatic Diaphragmatic Hernia

SIR,—Gangrene or rupture of abdominal viscera in the thorax is a rare condition even in patients with diaphragmatic hernia. We report here a case where the traumatic rupture of the diaphragm was followed a year later by strangulation and rupture of the dislocated stomach in the left thoracic cavity. The patient recovered after an emergency operation.

A 22-year-old man was admitted on 16 April 1968. One year before he had been treated in another hospital for a penetrating gunshot wound of the left thorax. On admission he gave a history of vague epigastric pain and intractable vomiting of 48 hours' duration. Examination revealed an acutely ill, undernourished, dehydrated man. Blood pressure 115/80, pulse 130, white blood cell count 11,000 cu. mm., haemoglobin 18 g./100 ml., blood urea, electrolytes, serum bilirubin, and thymol tests normal. An electrocardiogram revealed sinus tachycardia. Chest *x*-ray examination demonstrated an enormously dilated stomach with a high fluid level in the left chest, the heart being displaced to the right. Treatment consisted of hydration, analgesics, and repeated gastric suction. On 18 April his condition deteriorated, he complained of constant severe chest pain, and vomited repeatedly tea-coloured gastric contents.

Immediate laparotomy revealed about one-third of the stomach only in the abdominal cavity, and the rest could not be delivered from the chest. A left thoracotomy was performed, and a large volume of gastric contents evacuated from the thoracic cavity. The wall of the stomach was not gangrenous, but a few livid

discolorations were observed. On the anterior stomach wall an irregular rupture measuring 8 cm. by 2 cm. in diameter was found and closed. The large hernial defect of the diaphragm was found between the centrum tendineum and the muscular pars costalis, and was sutured after the herniated stomach and transverse colon had been replaced into the abdomen without difficulty. Convalescence was uneventful, and the patient left hospital on 9 May in excellent condition.

A few weeks later vomiting returned, and the patient had to be reoperated on on 12 June. This time adhesions were found around the stomach, which were divided. A retrocolic posterior gastroenterostomy was performed. The patient has remained well, and has had no further gastrointestinal complaints since the second operation.

Rupture of the stomach incarcerated in the thoracic cavity appears to be rare. In the literature available to us we could find only a few published cases.[1-7] Of the reported cases four had a fatal termination. The cause of the rupture was rising intragastric tension, impaired blood supply, and/or local factors in the wall of the stomach. In our case traumatic diaphragmatic hernia developed after a thoracic gunshot wound, and had led to rupture of the stomach one year later.—We are, etc.,

G. CSAPÓ.
J. PÁTKAY.

Department of Surgery and
First Department of Medicine,
Hospital, Dunaujváros, Hungary.

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Eating and Corticosteroid Levels

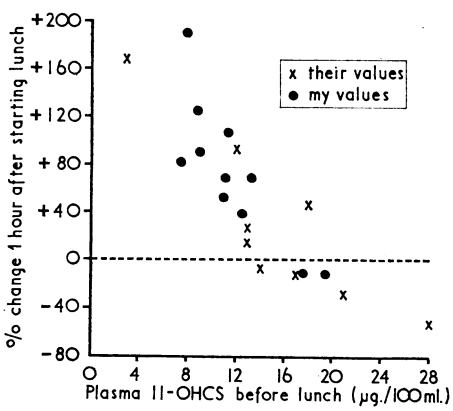
SIR,—I have read with distress the letter by Dr. G. Nuki and others (1 March, p. 574) who say that they have not found the same effect of lunch on plasma corticosteroid levels (11-OHCS) as myself (28 December, 1968, p. 833). I postulated that in normal people lunch may quickly increase the 11-OHCS level to an extent which is greatest when the pre-lunch level is low, and which may be nil or reversed at higher levels.

May I say, first, that out of their nine comparisons of 11-OHCS levels made before and one hour after lunch, five were higher after lunch, agreeing with nine out of eleven in my experiments. Three of theirs, which before lunch were more than 16 μg./100 ml., fell after lunch, like the remaining two of mine. Their remaining one had a pre-lunch concentration of 14 μg./100 ml., a level near which eating seemed to have little effect in my experiments—or in this one of theirs. A Scottish lunch is nae sae different fra' an English one. The accompanying Figure, which I have drawn from our results, shows how cannily their data fit with mine; especially considering that neither 3, 21, nor 28 μg./100 ml. can easily be considered normal midday levels. With regard to a possible non-conformer who rose from 18 μg./100 ml. to 26, perhaps rises cease to occur at a level which depends on the individual.

Secondly, referring to their comments about our differences, if there are any, they suggest that these may be due to the fact that my subjects were healthy, while theirs were hospital patients. I have recently been impressed with the steadiness from week to week of plasma 11-OHCS estimates in ambulatory inpatients suffering from anorexia nervosa, compared with those in two healthy people engaged in busy, non-residential hospital work. The latter estimates, made three times a week for a month at 10 a.m., ranged from 12·5 to 24·6 μg./100 ml. in a male doctor, and from 7·2 to 20·4 μg./100 ml. in a female scientist. The former are exemplified in the Table below.

Plasma 11-OHCS concentrations (μg./100 ml.) in Two Patients With Anorexia Nervosa

Miss X		Mrs. Y	
22/8/68	10·3	7/11/68	22·5
26/8/68	11·9	11/11/68	19·4
29/8/68	11·7	14/11/68	21·3
3/9/68	12·8	18/11/68	22·8
5/9/68	10·8	21/11/68	21·9
9/9/68	12·9	25/11/68	19·2
12/9/68	11·8	28/11/68	24·9



The percentage change of concentration of 11-OHCS in plasma 1 hour after lunch, plotted against the concentration before lunch (μg./100 ml.).

The uniformity may reasonably be due in part to a rather uneventful, routine life. It might also have resulted from a reduced reactivity to various stimuli. Certainly my lunch-time findings were not due to the effects of beer; nor has beer that effect. Most of my subjects are non-smokers. (Some of them barely eat.) The concentrations were calculated as in Mattingley's method,[1] and also as in that of Spencer-Peet *et al.*,[2] with little difference in the effects of food. The figures got with Mattingley's method are given above and in my previous letter.

Finally, in England, tests of hypothalamo-pituitary-adrenocortical functioning are not restricted to the effects of stimulatory agents, as Dr. Nuki and his colleagues imply. Stimulation, as far as that goes, is at least proof of a moderately functioning adrenal cortex, even if the stimulus is eating or fasting instead of Synacthen.

I am grateful to Dr. G. F. M. Russell for permission to publish the values in the Table.

—I am, etc.,

KATHARINE MONTAGU.

Kew, Surrey.

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Theatre Nurses

SIR,—Mr. D. W. Bracey's letter (22 February, p. 509) is timely, with the implementation of the Salmon Committee's recommendations taking place in our hospitals,[1] and the widespread reports of the shortage of theatre staff resulting in closure of some of our operating-theatres.

I would not disagree with the statement that operating-theatre technicians can be taught to carry out most of the techniques required by the surgeons and anaesthetists in our theatres, and Mr. Moore in his letter of 8 March has adequately summed up the situation in regard to the training and the present ludicrously low remuneration they receive for this valuable contribution to the theatre team.

I persist, however, in insisting that the "nurse" should continue to be employed in the operating-theatre, for her nursing skill to be utilized in the care of the patient, and for her influence on the training of these technicians, and, dare I say it, on the doctors and the medical students who are also learning their craft. I also believe that all nurses should have a period of experience during their training in the operating-theatre, so that they may understand better the subsequent treatment of these patients in the ward. A nurse should supervise this part of their training. To see the structures and organs which are being operated on is a most valuable experience to the nurse, and, for example, to see the insertion of drainage tubes and packs must surely facilitate their proper removal at a later stage in the patient's treatment.

I would also challenge the statement in Mr. Bracey's letter where he says that a patient who never sees the nurse does not need the attention of a nurse. The fact that nurses in theatre have always given good nursing care to patients who were quite incapable of being grateful to her underlines the inherent sense of real nursing which the patient needs at all stages of his hospital care. It would be a pity if this aspect were to be totally disregarded in the future composition of the theatre team. Of course nurses do not have the monopoly of the attributes of human sympathy and compassion, but nurse training ensures they are correctly fostered and directed.

Somehow we must ensure that the technician can be given the suitable training and status, and the nurse with the technical bent be encouraged to develop it, so that the best possible team can assist the surgeon at a time of high risk to the patient.—I am, etc.,

H. R. FLETCHER,
Chairman (London Branch) National Association of Theatre Nurses.
Hammersmith Hospital,
London W.12.

REFERENCE

1 *Report of the Committee on Senior Nursing Staff Structure*, 1966. H.M.S.O.

SIR,—We read with interest the letter from Mr. D. W. Bracey (22 February, p. 509). We agree that theatre work is not nursing. However, we are sure that a much more formal and comprehensive training is required than that which we infer from his letter. We cannot agree that anyone could become efficient both as assistants and in taking the case without any knowledge of