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.,

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Eating and Corticosteroid Levels

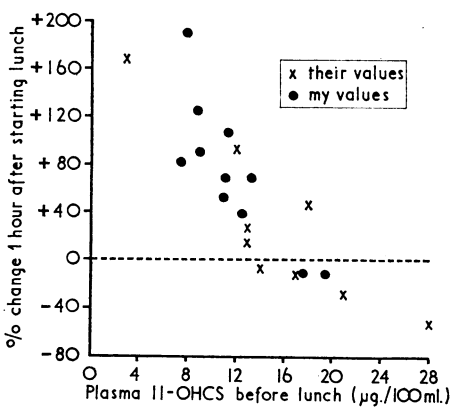
SIR,—I have read with distress the letter by Dr. G. Nuki and others (1 March, p. 574) who say that they have not found the same effect of lunch on plasma corticosteroid levels (11-OHCS) as myself (28 December, 1968, p. 833). I postulated that in normal people lunch may quickly increase the 11-OHCS level 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	22/8/68	10·3	Mrs. Y	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.,

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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.
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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

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