The Table shows two groups of patients: (1) Those with mesenteric adenitis who have evidence of recent appendicitis—that is, are iron-positive—in whom appendicectomy coincides with cure in 24 of 25 cases (96%). This approximates closely to the cure rate of 98% which I have described for removal of acutely inflamed appendices.[4] (2) Those who have no evidence of recent appendicitis—that is, are iron-negative—in whom appendicectomy coincides with cure in only 9 of 15 cases (60%). This is well below the cure rate of 86% normally associated with emergency removal of a normal appendix.[4]

There thus appear to be two distinct groups of patients with mesenteric adenitis, one in whom the appendix is involved (whether as cause and effect or sharing a common aetiology), and the other in which the appendix is not involved—or at least has not yet become involved. Until the two can be separated clinically the surgeon making the diagnosis of mesenteric adenitis must weigh the risks of unnecessary operation against those of missing appendicitis. The findings described above would appear to make a diagnosis of mesenteric adenitis a less attractive justification for non-operative treatment than it is at present, at least for the adult patient.

Were my findings applicable to the problem of the acute abdomen of childhood, I feel Mr. Jones would have won his point. However, until they are confirmed or refuted for the patients in the younger age groups the criticisms of 1965 must unfortunately remain valid.—I am, etc.,

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Holmes-Adie Syndrome

SIR,—As your leading article (1 February, p. 267) shows, the pathological report of Harriman and Garland[1] has confirmed previous hypothetical postulates as regards the site of the pupillary lesion in Adie's syndrome. Your leader does not, however, cover two interesting aspects of this disorder.

The complete Adie's syndrome has been reported in association with other neurovegetative phenomena—for example, delayed gastric emptying. Secondly, and of more interest in explaining the pupillary phenomena, are various reports[2–5] which show that sympathetic (stellate ganglion) block can relieve the pupillary changes. This ties in with the pathological changes.

Six patients with unilateral Adie's syndrome were treated as follows: Two with guanethidine eye-drops 5·0%, and four with thymoxamine 0·5%. The two guanethidine-treated patients had a spontaneous recovery of light reflexes. Three out of four of the thymoxamine-treated patients had a recovery of pupillary reflexes to light and all four had a change in the pupillary response to dark adaptation.

From pupillographic studies, the pathology, previous reports of pharmacological responses, and the changes with sympathetic blockade, surgical and therapeutic, it is reasonable to assume that the pupillary changes arise from incomplete parasympathetic interruption. Further, that there is an intact peripheral neurone and that the size and shape of the pupil would depend on the volume of sympathetic activity.—I am, etc.,

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Strokes and the Pill

SIR,—The arrival of the *B.M.J.* on 22 March with your leading article (p. 733) coincided with the admission to this hospital of a 26-year-old Indian woman with benign intracranial hypertension. She complained of headaches and blurred vision for two weeks. There was bilateral papilloedema but no sign of focal neurological disease or other systemic disorder. Carotid angiography was normal.

She had been using an oral contraceptive (5 mg. lynoestrenol and 0·15 mg. mestranol) for two years. This was discontinued on admission to hospital. Thereafter there was steady improvement in her symptoms and the papilloedema had almost completely disappeared in three weeks. No specific treatment was given.

This appears to be a further example of pseudotumor cerebri developing in association with the use of oral contraceptives.—I am, etc.,

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Trichomoniasis and Gonorrhoea

SIR,—I have read with interest the comments raised by Dr. D. F. Hawkins (12 April, p. 116) and Dr. N. Rosedale (3 May, p. 315) in connexion with my letter (8 March, p. 642).

At present, methods available for the detection of Neisserian infection are far from satisfactory, especially in women and in respect to tests for cure. Frequently, repeated tests are necessary after treatment of trichomoniasis before gonorrhoea is detectable. Trichomoniasis is usually a more acute infection in the females, particularly when associated with gonorrhoea. I have repeatedly seen patients who were almost in tears with distress from being reinfected as their asymptomatic male contacts have not been treated at other clinics because of negative findings. In each case cure has only resulted after proper treatment of the patient and the contact. It is always more difficult to cure the infections than to clear the patients of their symptoms. Unfortunately, the disappearance of symptoms is too often regarded by both patients and doctors as a sign of cure, which is not always the case.

In the present state of affairs, perhaps these infections should now not be regarded as venereal and non-venereal with the implication, insinuation, and conclusion that can be drawn from them, but as sexually transmissible infections, when the management and treatment of the patients with these infections will be more successful. I await positive proof to the contrary.—I am, etc.,

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Doctors and the Practice of Nursing

SIR,—I share the sentiments of Mr. M. C. T. Morrison (19 April, p. 191) that the special relationship which used to exist between doctors and nurses is in danger of disintegrating.

Fortunately this is not the case between doctors and midwives. The Central Midwives Board will only approve hospitals as training schools for midwives if the consultant staff participate, with the midwife teacher, in the instruction and examination of pupil midwives. Hence since the formation of the C.M.B. by Act of Parliament in 1902 a happy relationship has existed between doctors and midwives. Every year eight examinations are held and hundreds of obstetricians each paired with a midwife teacher correct scripts and conduct clinical and oral examinations for about 9,000 pupil midwives. In several centres in Britain doctors of many specialties play an important part in the instruction of future midwife teachers.

The C.M.B. are deeply appreciative of the willing co-operation of the medical profession in the training of midwives, and they believe it is of mutual benefit to both professions and thus to the public we both serve.—I am, etc.,

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Midwife and Deputy Chairman of the Central Midwives Board.

London S.W.7.

Cyclator Ventilator

SIR,—I would be grateful if the attention of your readers could be brought to two faults which may occur in the Cyclator ventilator.

On several occasions it has proved impossible to ventilate a patient by hand using the Cyclator circuit although the ventilator has been apparently switched off. On squeezing the reservoir bag gas was vented at low pressure inside the machine, and inflation of the patient did not take place. To restore the situation a separate circuit had to be connected, and the time lapse might have endangered the patient. It was found that two minor faults could give rise to this situation and both happened to be present simultaneously.

Some rotation of the on/off switch while in the "off" position was possible on this particular machine. In certain positions this allowed a small leak through the switch permitting the driving chamber to pressurize, thus activating the bypass valve and preventing manual ventilation. This fault was rectified by replacing the valve seating.

The expiratory pause control on this machine allowed a pause in excess of the theoretical maximum (30 sec.), and, in fact, over the last half-turn of its travel the variable