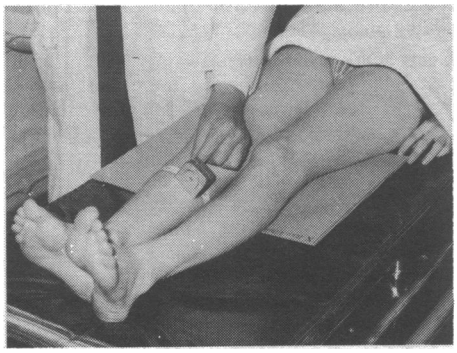
cerning the patient's objective condition.[1] Minor degrees of wasting can be revealed by measuring and comparing the girth of the affected limb with the opposite limb.[2]

The standard method of marking a line at a convenient distance from the anterior superior iliac spine and from the tibial tuberosity and of comparing the girth with the opposite side can be replaced by the following simpler method.

An *x*-ray envelope or another large rectangular paper or cardboard is moved along the margin of the couch or table to the desired (and recorded) level (Fig.) and the



circumference of the limbs measured and compared. In patients with shortening of a limb the *x*-ray envelope is moved higher according to the amount of shortening in the corresponding segment of the limb—for example, in shortening of the lower limb by ¾ in (19 mm) after a pertrochanteric fracture of the femur the *x*-ray envelope is moved ¾ in higher before the girth is measured on the injured limb.

This method has the following advantages. The human element and inaccuracy are reduced in a simple manner. It also avoids marking the skin of the patient by using an *x*-ray envelope, which is usually at hand. It is a useful and speedy clinical procedure. —I am, etc.,

A. BECK

Accident Unit,
St. David's Hospital,
Cardiff

1 Clain, A., ed. *Hamilton Bailey's Demonstration of Physical Signs in Clinical Surgery*, p. 57, Bristol, John Wright, 1967.
2 Dix, D. Knight, and Todd, A. H., *Medical Evidence in Personal Injury Cases*, p. 66, Lewis, London, 1961.

Foreign Body in the Appendix

SIR,—The incidence of acute appendicitis in Africans is much lower than in Europeans. The different diet and a possible reduction of lymphoid tissue may contribute to this low incidence. Mobile foreign bodies such as round worms can enter the appendix and produce severe obstructive appendicitis. We report here such a case.

A twelve-month-old African female was admitted to hospital with a history of swallowing a dress-making pin three days previously. There were no symptoms of abdominal pain, and no vomiting or melaena.

On examination the child had a slight temperature, 99°F (37·2°C), but exhibited no signs of abdominal tenderness or obstruction. A plain *x*-ray of the abdomen (Fig. 1) showed the pin, similar in shape

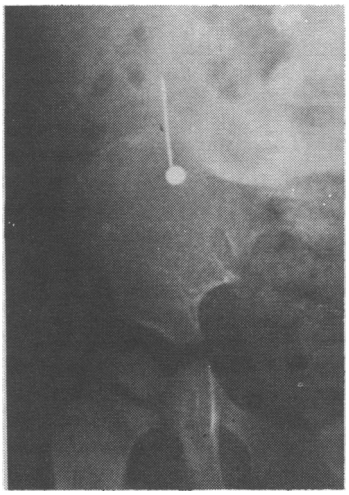


Fig. 1

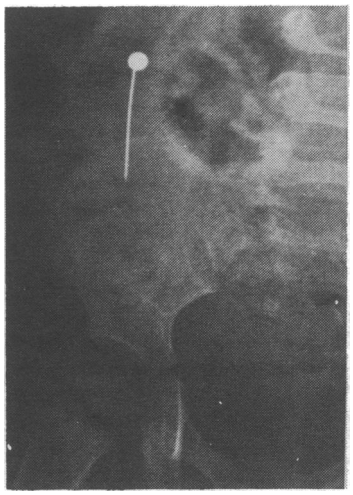


Fig. 2

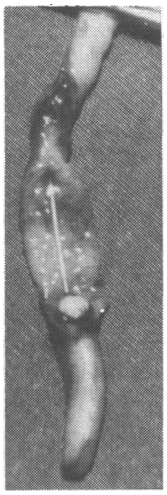


Fig. 3

to a small hat-pin, in the right side of the abdomen and in retrospect obviously outside the large bowel.

Conservative management was adopted and a further *x*-ray two days later suggested movement of the pin towards the hepatic flexure. The child continued to remain well and it was hoped that the pin would be passed per rectum. Two days later, however, another *x*-ray showed the pin in its original position. The decision was made to perform a laparotomy the next morning. A further *x*-ray (Fig. 2) immediately preceding operation showed the pin in an inverted position compared to the previous films.

At operation the pin was located in the appendix, and the definitive procedure consisted of appendicectomy. The opened appendix revealed the pin measuring 4 cm in length (Fig. 3).

In our case a large foreign body entered the lumen of the appendix but produced no obstruction or constitutional symptoms. On macroscopic examination of the removed appendix no evidence of inflammatory reaction could be noticed at the site of impaction.

It is essential to take radiographs of young children who have a definite or even suspicious history of inhalation or ingestion of foreign bodies. In the case of ingestion it is necessary to take serial *x*-rays of the progress of the foreign body through the intestinal tract, so that at any indication of hold up operative intervention may be undertaken.

We would like to thank Dr. D. Jenkinson for technical photographic assistance and Miss L. Etchells for secretarial help.
—We are, etc.,

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B. FERNANDEZ
B. L. DUFFY

Nchanga North Hospital,
Chingola, Zambia

Squelching Caecum in Acute Appendicitis

SIR,—The diagnosis of acute appendicitis remains an ever present clinical problem. In 1964 Sir John Bruce drew attention to the "squelching" or "gurgling" caecum as a useful negative sign, and he felt that if the sign was present the diagnosis of acute appendicitis should be reviewed.[1]

We have tested the validity of this in 50 patients with suspected acute appendicitis. A caecal squelch was not present in 23, and of these 18 had proven acute appendicitis. A caecal squelch was present in 27, and of these 14 had proven acute appendicitis.

It would appear from our results that a squelching caecum is not a very reliable sign for making either a positive or a negative diagnosis for acute appendicitis. Squelching depends on the stage of the inflammatory process at the time that the patient is examined. If early, and there is no guarding or rigidity of the overlying muscles, a squelch will be obtained. Later, however, when there is guarding or rigidity, it will be impossible to elicit the sign.—We are, etc.,

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J. H. LOUW

Department of Surgery,
University of Cape Town,
South Africa

1 Bruce, J., *Practitioner*, 1964, **192**, 731.

Large Doses of Fluphenazine Enanthate

SIR,—It is suggested that the patients with chronic schizophrenia who do not respond to the usual doses of fluphenazine enanthate (25-100 mg every four weeks) should be treated with much larger doses of the drug at shorter intervals. Kline *et al.*[1] reported a patient who was asymptomatic only when the dose of the drug was raised to 125 mg (5 ml) daily and relapsed on the reduction of the daily dose. They suggested such large doses of injectable fluphenazine enanthate as a possible method of treating patients suffering from chronic schizophrenia in whom progressive rehabilitation is hampered by the presence of active psychotic symptoms. Dr. D. M. Lewis and colleagues (20 March, 1971, p. 671) have similarly reported encouraging results with large weekly doses of up to 250 mg.

Over the past eight months at Bexley Hospital we have treated six patients suffering from paranoid schizophrenia with relatively large doses of fluphenazine enanthate. In each case the dose was gradually increased from 25 mg every four weeks up to 75 mg every week. Our experience is not in keeping with that of Dr. Lewis and colleagues or the American investigators. In our patients there was neither a reduction of unwanted symptoms nor did the drug in

the dose we prescribed facilitate further rehabilitation of the patients. Our experience, however, does confirm the findings of other workers that very large doses of the drug do not produce any parallel increase in iatrogenic Parkinsonian symptoms. We felt reluctant to inject the drug more frequently than once a week. The advantage of a long-acting parenteral phenothiazine drug lies in its infrequent administration. Daily injection at the dose suggested by Kline *et al.* negates any advantage that parenteral therapy may have over oral phenothiazines.—We are, etc.,

F. N. I. FAWZY
S. QARAGHOLI
R. GAIND

Bexley Hospital,
Bexley, Kent

1 Kline, N. S., and Swenson, G. E., *American Journal of Psychiatry*, 1970, **126**, 1799.

Stereophonic Auscultation

SIR,—Dr. J. G. Smith (12 February, p. 445) is just a little facetious about stereophonic auscultation by stethoscope. I also was not too serious when I put together my now-favourite stethoscope. I was trying to bring a little fun into repetitive chest listening, and particularly to correct an alarming tendency in myself to let the sensorium free-wheel when the earpieces are plugged in.

The manipulation of two chestpieces (in my case a pair of single diaphragm Eschmanns, initially daubed with port and starboard colours so that I was sure to which ear each was connected), added a distinct fillip to the manoeuvre. It changed a ritual into a procedure, psychologically. And I discovered things. For instance, when you are able to compare synchronously bits of lung 1 in (2·5 cm), or 2 in (5 cm), or 6 in (15 cm) apart, the pathologists' contention that asthma is due usually to localized plugging becomes an observable fact (with a large Sikh population much of my listening is to asthma).

Moving caterpillar-wise, a pleural rub can be quickly pinpointed. I am sure I have discovered patches of pneumonia in children a day earlier than I would have otherwise done many times. The fact that the volume of sound collected is roughly doubled is not necessarily an advantage, though in the thick-chested it can be useful. But for auscultating the heart I find the noises get out of hand, and I soon gave up in favour of a traditional instrument.—I am, etc.,

B. L. P. DALTON

Gravesend, Kent

Depressive Illness and Aggression in Belfast

SIR,—Dr. H. A. Lyons (5 February, p. 342) has shown that during a year of severe rioting in Belfast the number of new patients attending psychiatric facilities fell in comparison with previous years, but he has not shown that there was a decrease in depressive illness in the area during that time, as he claims.

One of the consequences of riot and violence is the disruption of normal life. Normal living includes visiting one's doctor and sometimes being referred for psychiatric consultation. One explanation of Dr. Lyons's findings may be that rioting and violence and the threat of rioting and violence interfere with people consulting their doctors or keeping psychiatric appointments. At any rate I should be interested in hearing from Dr. Lyons whether the numbers of new referrals for non-depressive psychiatric illness also fell during the same period.—I am, etc.,

DERMOT WALSH

Medico-social Research Board,
Dublin 2

Registration and the G.M.C.

SIR,—Prospective contributors to "Recent Retreats in British Medicine" will of course be most interested in the recent behaviour of the General Medical Council. It is now asking the Government to amend the Medical Act of 1956 so as to require all medical members of the Council to remain fully registered, so that persons who cease to be registered by reason of non-payment of the highly contentious annual retention fee will be unable to remain members. Although there has been no demand whatever from the medical profession or the general public for this move, it is not hard to appreciate likely reasons for it. It can be seen as a very clear move to disenfranchise certain democratically elected representatives of the profession who were elected, in good part, because of their bold public stand against the imposition of the fee. Those who are not democratically elected (and especially those who are unlikely ever to be so elected) may perhaps find it inconvenient to be reminded, at each meeting, of the very large number of doctors who utterly oppose the fee; but behaviour like this scarcely inspires confidence in these arbiters of ethical standards.

Historians will find this recent period of the history of the G.M.C. particularly interesting. Heretofore, the exercise of power without responsibility has been the prerogative of the leading members of another and somewhat older profession. Although none of the arguments in favour of the imposition of the G.M.C.'s medical tax have been able to bear close scrutiny, this present action has put paid to one of the commonest used excuses for it. We had to pay, we were assured, whatever was necessary to keep the G.M.C. in the manner to which it wished to become accustomed. If we did not, the control of the Council would move out of the hands of the profession. He who pays the piper calls the tune, we were told. Pshaw! He who pays the piper, pays the piper. The G.M.C. now shows no clear signs of being responsible to anyone but itself. It regularly ignores the opinions of the medical profession, whether expressed by the B.M.A. or the J.H.D.A., and certainly seems to display little responsibility to the wishes or needs of the general public. Other recent decisions of the G.M.C. will indeed mean that the number of non-medical members of the G.M.C. will be five out of 79, instead of the present three out of 47. Is this adequate representation of the public, whom the G.M.C. was set up to protect? If the G.M.C. is to be free to ignore the public and the profession, is it necessarily serving any useful function at all? *Folie de grandeur* can be a charming little foible, but it should not be indulged in at public expense.—I am, etc.,

MICHAEL A. SIMPSON

Guy's Hospital,
London S.E.1

Points from Letters

Place of Vasectomy

DR. M. ALTMAN (London N.W.11) writes: I cannot leave Dr. J. J. Slome (19 February, p. 511) unanswered. The evidence that there are 10,000 men on vasectomy waiting lists is to be found in *Hansard* of 21 January 1972, column 846.

In the House of Commons debate on Mr. Whitehead's Bill the Under Secretary of State for Health and Social Security accepted that figure put forward by Mr. Whitehead. In column 844, he also said that "the number of operations that can be performed in hospitals is of course limited by the resources available. . . ." The only equipment required for performing a vasectomy over and above that normally found in a properly equipped general practitioner's surgery is two pairs of vasectomy forceps. All other expenditure on premises comes within the ambit of general practice improvements. There is no question whatever of any clinics having to be built, least of all at the expense of the tax-payer as government involvement is neither desirable, necessary, or being requested. . . .

Transporting Patients with Chest Injuries

MR. W. E. COOKE (Chief Ambulance Officer, London Ambulance Service, S.E.1) writes: Belatedly I have just read Dr. A. E. Young's letter (6 November, p. 364) on the subject of transporting patients with chest injuries. Any journey undertaken by a sick or injured person must cause a measure of discomfort at best, and it is perhaps unfortunate that so little research has been undertaken to determine the best method of conveying people suffering from various injuries and illnesses. It is not generally appreciated by doctors ordering transport for patients that most ambulances in this country are fitted with one or two stretcher cots or trolleys. These offer a variety of patient positions and in most cases it presents no problem to load the patient feet first or to give him back support in one of several positions. The concern of myself and colleagues in ambulance services is the general lack of direction left for ambulancemen when they pick up the patient. At most this generally indicates walking, carrying, or stretcher case—only very rarely are precise instructions given. . . .

Sex of Human Offspring

DR. W. H. JAMES (Department of Human Genetics and Biometry, University College, Stephenson Way, London N.W.1) writes: I wish to collect data to test a hypothesis concerning the control of sex of human offspring. I should be most grateful if practitioners in artificial insemination would contact me at the above address.