

dilatation. I cannot say whether this regimen is as effective against thromboembolism as that used by Mr. Kline and his colleagues.—I am, etc.,

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** Dr. Marshall sent a copy of his letter to Mr. Kline and his colleagues. A reply on their behalf from Professor L. E. Hughes is printed below.—Ed., *B.M.J.*

SIR,—I regret that it is not possible to provide definitive answers from our own work to Dr. Marshall's questions. Our use of 1000 ml of dextran 70 followed the trials reported by Bonnar and Walsh,¹ this dose being chosen because of their report of effectiveness and lack of side effects.

Jansen,² using a dose of 500 ml, found a prophylactic effect only in operations lasting less than one hour. This might suggest that 1000 ml is more effective than 500 ml, and for this reason we have been reluctant to reduce the dose for major operations. On the other hand we are concerned about the occasional case of apparent excessive bleeding and for this and other reasons we are at present investigating the use of 500 ml given the day before operation and 500 ml given peroperatively.

Stadil³ reported a regimen using 500 ml during operation and 500 ml 24 hours later in which he also increased the initial infusion in the presence of bleeding in an effort to maintain a plasma dextran concentration of 4 mg/l (0.4 mg/100 ml) for 72 hours postoperatively. This regimen also gave a considerable reduction in thromboembolic disease.—I am, etc.,

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¹ Bonnar, J., and Walsh, J., *Lancet*, 1972, 1, 614.

² Jansen, H., *Acta Chirurgica Scandinavica*, 1972, Suppl. 427.

³ Stadil, F., *Lancet*, 1970, 2, 50.

Haemophilus influenzae Cellulitis

SIR,—Since the first report of cellulitis due to *Haemophilus influenzae* by Alexander in 1953¹ some 33 cases have been reported in the U.S.A.² but only three in the U.K., all by Turk.^{3,4} Here we report a case in which *H. influenzae* type b has been isolated both from the lesion and from blood culture.

The patient, a 1-year-old girl, was admitted to Paddington Green Children's Hospital with a two-day history of swelling and redness of the right foot, irritability, and anorexia. On examination there was evident red-blue cellulitis of the right foot with a fluctuant area over the lateral malleolus. The inguinal lymph nodes were enlarged and tender. Other findings included temperature 38°C and W.B.C. $18.5 \times 10^9/l$ ($18\,500/mm^3$), with a neutrophil leucocytosis.

A drainage operation was performed, removing purulent material, and it was noted that the underlying periosteum appeared normal, confirmed by drill biopsies taken at that time. Culture of the purulent material yielded *H. influenzae* type b and the same organism was isolated from blood culture after five days' incubation. She was treated initially with parenteral penicillin and cloxacillin which was changed to ampicillin once the infecting organism was known. The child made a slow but complete recovery.

This case fulfils most of the characteristics described for *H. influenzae* cellulitis in that it

was in a young child below the age of three and presented with fever and acute cellulitis which was red-blue in colour. It differed, however, in that the cellulitis did not involve the face as has generally been described^{2,5} and that haemophilus cellulitis does not usually proceed to abscess formation (D. C. Turk, personal communication).

We are grateful to Dr. P. J. N. Cox for permission to publish details of this case and to Dr. D. C. Turk for performing the typing of this organism.

—We are, etc.,

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¹ Alexander, H. E., in *Pediatrics*, ed. L. E. Holt and R. McIntosh, p. 1200. New York, Appleton Century.

² Goetz, J. P., Tafari, N., and Boxerbaum, B., *Pediatrics*, 1974, 54, 504.

³ Addy, M. G., Ellis, P. D. M., and Turk, D. C., *British Medical Journal*, 1972, 1, 40.

⁴ Cartwright, K., and Turk, D. C., *British Medical Journal*, 1974, 2, 225.

⁵ Rasmussen, J., *British Journal of Dermatology*, 1973, 88, 547.

Freedom of Information

SIR,—An all-party committee under the chairmanship of Mr. Arthur W. J. Lewis, M.P., has been formed to seek the repeal of the Official Secrets Acts of 1911 and 1939 and the introduction of a new Freedom of Information Act. As custodians of dossiers on patients, doctors are intimately concerned with the issues which would be raised in such a change of legislation.

The medical profession is concerned with these new proposals on two counts. Firstly, it is interested in the preservation of the confidential nature of medical records. Secondly, we as doctors are concerned for the protection of our patients and ourselves against the abuse of the Official Secrets Acts by agencies hostile to the best interests of the individual. A State medical service gathers, for various reasons, a vast amount of data on the individual, much of which goes into computer banks. The bulk of this information is probably harmless to the person concerned, but some could possibly be used to his detriment.

It is known that dossiers are compiled on individuals containing information from many sources; medical records are not sacrosanct, and confidential opinions detrimental to the good standing of the patient may find their way into the files. Such dossiers may constitute a black list, holding information which may be secret and damaging and might, unbeknown to the individual, ruin his career. The abuse of the Official Secrets Acts to prevent the individual concerned or his legal advisers from gaining access to his dossier constitutes an infringement of his right to a fair trial.

The purpose of the proposed Freedom of Information Act is to make it possible for an individual or his legal representative to refute false reports detrimental to his good standing contained within these black files. It is not its purpose to make confidential medical reports available to all and there is no danger that professional secrecy would be violated. The Act would prevent the abuse of professional secrecy by Government agencies and intelligence networks.

The Official Secrets Acts were emergency measures brought in at a time of war. Their existence in peacetime has come to be abused. The individual must have a right to correct what is secretly and unjustly held against him. Doctors have unwittingly become the tools of data-collecting agencies. They must insist that the Freedom of Information Act goes on the statute book to ensure that the confidential information they collect about their patients is not abused.—I am, etc.,

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Oxygen Therapy for Pneumatosis Coli

SIR,—May I comment on the article by Dr. R. H. L. Downs and Mr. W. M. Castleden (1 March, p. 493)?

Firstly, cysts may relapse after oxygen,¹ disappearing after further therapy.²

Secondly, I question either interpretation of the idea that "the cysts are created and maintained by a fastidious anaerobic gas-forming organism." The first is that cysts are produced by a form of gas gangrene. This was rejected in the early literature, no such organism has been found, the histology is unacceptable for bowel wall infection and fatal septicaemia follows injections of gut bacteria into the bowel wall.³ The second is that some faecal organism produces peculiar gut gas which forms cysts. Cyst formation requires a pre-existing gas bubble in the bowel wall which is maintained or enlarged by diffusion of gas into it from the bowel lumen. A disruptive force must make this initial bubble, which could not result from gaseous gut distension. This could occur with dissection of air from the lung,⁴ or perhaps in this case sigmoidoscopy.⁵ No extraordinary organism is needed to produce cyst gas; rapid variations in gut gas occur in normal people; in pigs a tendency to form cysts follows feeding with polished rice.⁷

The idea that oxygen "kills the organisms and the gas is then reabsorbed" seems unlikely. Any cyst gas will resorb down the pressure gradient between cyst and tissue gas.¹ Some gas may survive oxygen therapy. To persist it must be continuously replenished by diffusion from the gut; in addition, cysts recur. Oxygen therapy will therefore cure cysts despite continued gas production capable of maintaining them.

I believe physiological mechanisms produce the necessary gaseous conditions to maintain cysts in a proportion of the population. If a cavity is then formed in the bowel wall a cyst results. Oxygen, by increasing resorption of cyst gas, allows their deflation and obliteration. New cavities or residual cavities may, however, lead to recurrence of cysts.—I am, etc.,

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¹ Forgacs, P., Wright, P. H., and Wyatt, A. P., *Lancet*, 1973, 1, 579.

² van der Linden, W., *Lancet*, 1974, 2, 1388.

³ Jaeger, A., *Verhandlungen der Deutschen Pathologischen Gesellschaft*, 1906, 10, 251.

⁴ Keyting, W. S., et al., *Radiology*, 1961, 76, 733.

⁵ Marshak, R. H., et al., *Journal of the American Medical Association*, 1952, 148, 1416.

⁶ Biester, H. E., et al., *Journal of the American Veterinary Medical Association*, 1936, 88, 714.

⁷ Eveleth, D. F., and Biester, H. E., *American Journal of Hygiene*, 1933, 27, 364.