law courts. By the time that stage is reached the recollection of the caller may have been blurred (as may that of the doctor) so that the service committee or judge has to decide which of two conflicting accounts to believe as to the precise questions asked by the doctor, the information given to him, and the advice finally given. Both parties may be endeavouring to tell the truth and both may be mistaken. One knows that before certain tribunals the following argument is often used: (1) The doctor may deal with 60 patients per day. (2) A night telephone caller to a doctor is usually doing something unusual and is therefore unlikely to be confused in his recollection about what happened. (3) Accordingly the account of the caller is to be preferred to that of the doctor.

These are some of the dangers which surround a doctor who upon receipt of a night telephone call decides not to visit the patient unless he is called a second time.

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[1] Williams, B T, Dixon, R A, and Knowelden, J, *British Medical Journal*, 1973, **1**, 593.

SIR,—No doubt the debate on who should do night visits will continue for some time. Perhaps I am not made of the stuff that other doctors are made of as I work badly after missing sleep. It takes me two days to return to feeling normal after a badly disturbed night. As I see between 45 and 60 patients on a normal day this means that around 100 patients are at risk from my fatigue after one bad night.

The main argument against using a deputising service is that one's continuity of patient care is interrupted. I work in a partnership of six, and during the day we personalise our practice as much as possible by normally seeing our own patients. During the night the chance of a call being to one's own patient is obviously only 1 in 6.

During the past 10 years I have carried out well over 100 000 consultations and visits. Of these, 210 have been between midnight and 7 am. Probably a sixth of these—35—have been to my own patients. This represents less than 0·035% of the care given to my own patients. For this minuscule degree of continuity literally thousands of consultations and visits have been carried out when I have not been at my best because of lack of decent sleep. I feel that during the past 10 years my patients would have been better treated if I had used a deputising service for out-of-bed calls, leaving me fresher to cope during the day.

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Orf in Britain

SIR,—A clinical condition in man indistinguishable from orf virus infection derived from sheep (Dr M S Hall, 14 August, p 420) can be produced by milker's nodule virus infection. Of 32 patients with orf-like lesions seen during the past 25 years in West Dorset, 14 were considered to have milker's nodule virus infection. These 14 patients gave a history of milking cows but not of handling sheep. When the cows' teats were examined vesicles and characteristic ring sores were found. This infection of dairy cattle is enzootic in Dorset. Twenty-one herds were examined; all had evidence of infection, confirmed in 19 herds by electron microscopy and tissue culture.[1] There is evidence[2] that the viruses of orf and milker's nodule, although having some similarities, are biologically distinct.

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[1] Nagington, J, Tee, G H, and Smith, J S, *Nature*, 1965, **208**, 505.
[2] Huck, R A, *Veterinary Record*, 1966, **78**, 503.

Carpal tunnel syndrome in the blind

SIR,—I have recently had a blind patient with the carpal tunnel syndrome which seemed to have developed as a result of her using the long-cane technique for walking. In this instance the symptoms and signs were so severe that the patient was not able to use braille.

I have made some inquiries in my area and it is apparent that the association of the syndrome and use of the cane in blind people is not perhaps all that uncommon. I am anxious to find out if this is a common association, and I would be grateful, therefore, if anyone would get in touch with me and let me know of any other cases. Clearly it is of more than academic interest because, as in the patient mentioned above, a very serious disability arises if they are unable to use braille.

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Volvulus of the small bowel in a diabetic patient

SIR,—Dr L J De Souza (1 May, p 1055) reports 12 cases of primary volvulus of the small bowel in Ugandans associated with the ingestion of large amounts of local beer, which is known to contain high doses of serotonin. We would like to present a case of primary volvulus of the small bowel causing complete gangrene of the bowel in a diabetic patient.

A 56-year-old man was admitted for the control of unbalanced and labile diabetes mellitus of five years' duration. While in hospital he developed an acute attack of severe abdominal pain and vomiting followed by abdominal distention and signs of peritoneal irritation, giving rise to the suspicion of acute mesenteric occlusion. At operation the entire small bowel was found to be twisted clockwise 540° around its mesentery, which was of normal length and attachment. No anatomical anomaly was found to explain the volvulus. The bowel was gangrenous from the ligament of Treitz to the ileocaecal valve. Small-bowel resection was performed but to no avail and the patient died 36 hours later.

Searching the literature we were unable to find similar cases of primary small-bowel volvulus except for those described by Mr De Souza and the others cited by him. His cases and ours seem to be similar in that a motility disturbance may be the cause of volvulus.

Diabetes mellitus affects every organ system, the gastrointestinal tract being no exception. The gastrointestinal manifestations, such as gastric atony, diminished acid secretion, and diarrhoea, are ascribed to diabetic neuropathy.[1] Diarrhoea, the more common symptom of diabetic enteropathy, occurs in patients in whom neuropathy is severe and affects peripheral as well as autonomic nerves. As in our patient, diabetic enteropathy is usually encountered in patients with long-standing diabetes whose disease has been poorly controlled and is often punctuated by episodes of ketosis. Subclinical involvement of various organ systems in diabetes has been noted to occur for protracted periods before the onset of overt symptoms.[2] McNally *et al*,[3] in an attempt to determine the extent of this subclinical involvement of the small intestine in diabetic patients, found a progressive decrease in intestinal tone, a progressive increase in the large-wave activity produced by peristaltic complexes, and unchanged small-wave activity representing local segmental contractions. Their conclusion was that the subclinical involvement of the small intestine in diabetes is more common than is generally suspected and that these abnormalities become clinically manifest by diarrhoea in only a small number of patients. These changes in bowel tone and motility may well be the initiating mechanism in the development of a primary volvulus of the small bowel in a similar way to the changes produced by serotonin in Mr De Souza's patients.

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[1] Katz, L A, and Spiro, H M, *New England Journal of Medicine*, 1966, **275**, 1350.
[2] Ellenberg, M, *Journal of the American Medical Association*, 1963, **183**, 926.
[3] McNally, E F, Reinhard, A E, and Schwartz, P E, *American Journal of Digestive Diseases*, 1969, **14**, 163.

Porcine dermis dressing versus Bisgaard therapy for leg ulcers

SIR,—I read with interest the paper by Dr J S H Rundle and others (24 July, p 216). We also are achieving successful results with lyophilised freeze-dried porcine dermis. However, for their control group the authors state that "conventional 'Bisgaard' treatment consisted of bandaging (Calaband or Quinaband) and elastic support with weekly dressing changes." This is not Bisgaard therapy and I would like to refer readers to Bisgaard's original description of his method.[1] The importance of this technique is daily massage, pressure bandaging, and elastic support. It does not involve occlusion for a week as stated by Dr Rundle and his colleagues.

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[1] Bisgaard, H, *Ulcers and Eczema of the Leg, Sequels of Phlebitis, etc.* Copenhagen, Munksgaard, 1948.

Acute gastric dilatation after trauma

SIR,—I wish to add the following observations to the article on this subject by Mr A T Kasenally and others (3 July p 21)

Acute gastric dilatation does not occur only after abdominal operations and abdominal injuries. It can occur as a reflex phenomenon in response to injuries other than to the lower chest, abdomen, and pelvis, after application of a plaster jacket, and as a complication of shock.[1 2]

A 10-year-old girl was admitted to an orthopaedic ward after being involved in a road accident.