

said they had noticed "many ants in their chamber pots the next morning"?—I am, etc.,

Plaistow Hospital, A. F. TUBOKU-METZGER.
London E.13.

Portable Pharmacy

SIR,—I possess a portable pharmacy similar to that described by Dr. P. W. Mathew (3 June, p. 641). The measurements are $11\frac{1}{2} \times 8 \times 10$ in. ($29 \times 20.3 \times 25.4$ cm.). It is probably a hundred years old. Many are of greater antiquity.

One was offered recently at an antique shop in Towyn, North Wales, for £40. *Fama habet* that a leading London auctioneer sold the same article later for £600.

I trust that Dr. Mathew's box has a similar remote lineage.—I am, etc.,

High Wycombe,
Bucks.

G. S. W. EVANS.

Blood Pressure Monitoring

SIR,—It is at least 40 years since a medical practitioner in charge of an antenatal patient became ashamed if his patient's abnormal rise of blood pressure went undetected.

The report of Dr. W. E. Miall and Mr. H. G. Lovell (10 June, p. 660) raises the question of how long all patients are to wait before the medical profession comes to regard itself responsible for seeing that each patient has the blood pressure examined yearly, and if necessary an attempt made to return the blood pressure to the safe zone.—I am, etc.,

London S.W.19.

AMY M. FLEMING.

Muscle Stiffness and Vitamin C

SIR,—With reference to the published findings of Drs. L. Corbett and A. Barr (8 July, p. 113) on muscle stiffness and vitamin C, I regret to note that the dosage scheme found effective by me had not been followed—namely, 500 mg. of vitamin C *in one dose* one hour before the unaccustomed exercise—and 400 mg. *in one dose* directly after it.—I am, etc.,

London S.W.7.

I. H. SYED.

Folate Deficiency in the Elderly

SIR,—Attention has been drawn to this subject in the *B.M.J.* (10 June, pp. 652 and 670).

During a recent trial concerning the efficacy of total-dose infusion of iron dextran in correcting iron deficiency anaemia in the elderly¹ serum folate levels were estimated, using the method described by Spray,² on the patients before and six weeks following treatment. The patients' age range varied from 69 to 89, half being treated in the day hospital and half as in-patients. The serum folate range in 37 pre-infusion subjects was 1-19.7 $\mu\text{g./ml.}$ (mean 5.3; S.D. 3.4 $\mu\text{g./ml.}$), and at six weeks post-infusion their range was 1.5-26 $\mu\text{g./ml.}$ (mean 4.6; S.D. 2 $\mu\text{g./ml.}$). Six pre-infusion patients had values below 3 $\mu\text{g./ml.}$ and nine post-infusion patients had values below 3 $\mu\text{g./ml.}$ Twenty-eight patients with an initial serum folate level below 6 $\mu\text{g./ml.}$ had a mean haemoglobin of 61% (S.D. 11 $\mu\text{g./ml.}$) and six weeks after treatment had a mean haemoglobin of 75% (S.D. 11 $\mu\text{g./ml.}$), while nine patients with initial folate levels over 6

$\mu\text{g./ml.}$ had a mean haemoglobin of 65% (S.D. 8 $\mu\text{g./ml.}$) and a post-treatment haemoglobin of 75% (S.D. 11 $\mu\text{g./ml.}$).

Attempting to correct iron deficiency in the elderly by total-dose infusion of Imferon (iron dextran) does not seem to influence the serum folate levels of the patients concerned, and probably the initial serum folate level does not influence their response to iron dextran as judged by the haemoglobin rise. However, as serum folate levels probably do not accurately reflect tissue state, the diagnosis or exclusion of folate deficiency on serum folate levels alone appears unjustified.—I am, etc.,

JAMES ANDREWS.

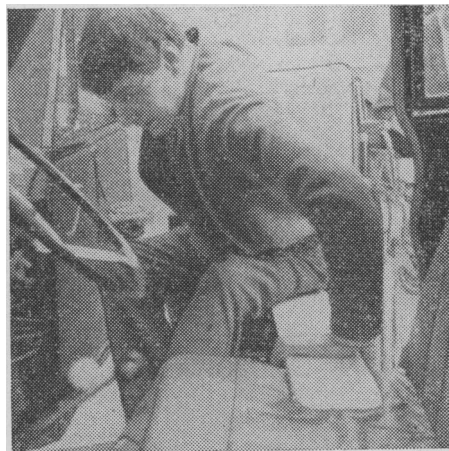
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REFERENCES

- Andrews, J., Fairley, A., and Barker, R., *Scot. med. J.*, 1967, 12, 208.
- Spray, G. H., *J. clin. Path.*, 1964, 17, 660.

Sliding Board for Severely Disabled Patients

SIR,—Now that the more severely disabled are able to drive, with the introduction of automatic gear change in smaller cars, greater independence can be obtained by the use of a sliding board. Whereas before it was necessary for tetraplegics to be lifted bodily into their cars, now they can transfer from wheelchair to motor car, if not entirely alone, with the minimum of assistance.



A "sliding board" has been developed by several tetraplegics and paraplegics at the Chaseley Trust for Disabled Ex-Servicemen at Eastbourne, and is made in their own workshops by them. It is constructed quite simply and cheaply from selected wood covered with Formica, which provides a smooth non-abrasive sliding surface. A small cushion may be placed under the buttocks as extra padding, but we find that the board is sat upon for so short a time that this is not usually necessary.

Although we have not tested the board among geriatric or other types of disabled patients, we feel sure that they too could easily benefit from it, and apart from use with the car it can also come in handy in the house to transfer from bed to chair, chair to lavatory, etc.

The ideal size was found to be 2 ft. 6 in. by 6 in. by $\frac{3}{8}$ in. (76 cm. \times 15 cm. \times 1.9 cm.). Further information about the sliding board

can be obtained from Handcarved Signs, Chaseley, Southcliff, Eastbourne, Sussex.—I am, etc.,

Eastbourne,
Sussex.

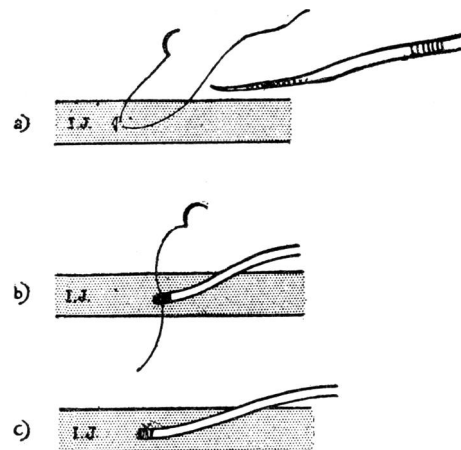
MARY SEIFFERT,
Senior Physiotherapist,
The Chaseley Trust.

Ventriculo-atrial Shunt for Hydrocephalus

SIR,—Ventriculo-atrial shunt procedure is now the commonly accepted treatment for progressive hydrocephalus in infants. It appears to be the common practice to tie the internal jugular vein over the venous catheter during the operation. Tying the internal jugular vein will result almost certainly in formation of a thrombus between the site of ligation and the beginning of the superior vena cava. This thrombus may be an important factor in causing septicaemia and in blocking the shunt mechanism.

It is quite feasible to insert a venous catheter in the internal jugular vein without tying that vein.

The internal jugular vein is dissected above the sterno-clavicular joint and two loops of thread (No. 40) are passed around it. The two loops are pulled apart to stretch the vein and a suture is placed in the vein wall between them using 4/0 silk on an atraumatic needle. This is left untied (see Fig). A small nick is made in the vein wall by sharp-pointed scissors just distal to this suture. The venous catheter is introduced through this and pushed in until the tip is believed to be in the atrium. The loose ends of the suture in the vein wall are now tied over the nylon ring in the venous catheter. If the nick in the vein wall is small enough no further sutures are needed. The scalp wound is closed next and the neck wound is closed last, after the loops of thread round the vein are removed.



Showing the technique of inserting the venous catheter into the internal jugular vein (I.J.).

The first two patients in which this technique was used are alive and well six months after the operation. There was no leakage of blood from the site of insertion of the venous catheter into the vein.

The venous catheters used were made by The Holter Company, Bridgeport, Penn., U.S.A., and the valves used were those made by Mr. Stanley C. Wade and Mr. Ronald Dahl for Mr. Kenneth Till.

—I am, etc.,

VASANT TALWALKER.

Bombay, India.