of these cases was strongly positive on the bone marrow, though only very weakly positive on the peripheral blood. The anti-D antibody titre was 1/1,024. Examination of this infant's blood showed that virtually only Rh-negative cells (that is, like those given by transfusion) were present.

This observation supports the hypothesis that the late anaemia seen in very severe Rh disease is due to the persistence of antibodies in the blood. This phenomenon has become apparently more common recently, since, because intrauterine transfusion is now performed, these infants do not require large exchange transfusion at birth, and also there is an increasing survival of severe cases.—We are, etc.,

G. MASERA.
A. MARINI.

University of Milan, Italy.

Gastritis, Aspirin, and Alcohol

SIR,—We were interested in Dr. C. E. Astley's letter (25 November, p. 484), and particularly his last paragraph in which he suggests that regular beer drinking over a number of years eventually leads to duodenal ulcer. Our practices are in Middlesbrough and Redcar, the same area as Dr. Astley's consulting practice. Recently, together with Dr. G. R. Freedman, of Newcastle, and Dr. I. C. Fuller, of Sedgefield, we made a survey of cases of duodenal ulcer in our practices. In this survey various factors in our cases of radiologically proved duodenal ulcer were compared with ulcer-free controls selected by a statistically sound method using random numbers. The figures quoted below are from the Middlesbrough and Redcar practices only. Superficially, at least, our figures do not support Dr. Astley's contention.

In Middlesbrough there were 42 male cases of proved duodenal ulcer, of which 20 (47.5%) were beer drinkers. The average weekly consumption was 6.3 pints (3.6 l.) of bitter beer. Controls numbered 24, including 17 beer drinkers (71%), average consumption 6.5 pints (3.7 l.). In Redcar out of 34 proved cases 19 were beer drinkers (56%), average consumption 11.1 pints (6.4 l.), whereas 25 controls included 16 drinkers (64%), average consumption 11.0 pints (6.3 l.). The difference in the beer consumption between the two towns probably reflects different social patterns in the two practices, the Redcar practice having a higher percentage of steel workers, who have a long-standing tradition of beer drinking.

It is possible that some patients with duodenal ulcer have stopped drinking because of previous advice or adverse effects of alcohol upon their symptoms. In the combined practices, 17 proved cases admitted that alcohol aggravated their symptoms, but 10 were still drinking beer. If the 7 who were apparently deterred are added to the beer drinkers, then the percentage of beer drinkers in controls is still higher than in the cases of duodenal ulcer. The pattern of drinking among ulcer cases and controls in each practice is remarkably consistent, and suggests that if advice to stop drinking has been followed it has been on the all or none principle. This advice too would probably have included smoking in its restrictions. There were, however, in the combined practices 58% of smokers in the proved cases, compared with 45% in the controls.

This illustrates the difficulties which arise when environmental causes are attributed to duodenal ulcer, and more work must be done on a prospective basis before Dr. Astley's contention can be accepted.

With Dr. Astley's stricture on aspirin, particularly Alka-seltzer, we are in complete agreement.—We are, etc.,

G. K. H. HODGKIN.
J. WHEWELL.

Middlesbrough, Yorks.

Alcoholic Content

SIR,—In 1961 I made a suggestion that it was time that the alcoholic content of beverages was properly described on the bottles in terms of approximate percentage by volume. Labels which refer to degrees of proof spirit convey precisely nothing to most people.

It is not only spirits, usually about 40% by volume of alcohol, which should be properly described: various beers and stouts can vary from 3% up to, in one case, 11%. Sherry, port, madeira, and marsala may contain 18%, and wines from 9 to 15%. These must serve as examples of the problem.

In view of new legislation, and a new sense of awareness of road dangers, surely the time has come when drivers, cyclists, and pedestrians are entitled to know just what they are imbibing, and have we not a duty to help the populace to educate itself by learning how and what to drink, and how not to ?

To avoid over-elaboration in a letter, may I refer anyone interested to the summer and autumn editions of *Health Horizon* 1961, which go more fully both into the matter of per cent. labelling and alcohol and the driver ? What seemed important then seems to be highly relevant today.—I am, etc.,

GUY BOUSFIELD.

Broadbridge Heath, Sussex.

Endocarditis and the Mitral Valve

SIR,—In our paper "Prolapse of the Posterior Leaflet of the Mitral Valve: A Clinical, Familial, and Cineangiographic Study" (8 July, p. 71) we suggested that bacterial endocarditis was unlikely to be a complication of this lesion although other authors had suggested that these patients should receive penicillin prophylaxis for dental work. We now wish to report a case of *Streptococcus viridans* endocarditis in one of our patients who had previously been found to have prolapse of the posterior leaflet of the mitral valve.

The patient, a male aged 35 years, was investigated by means of left ventricular cineangiography in May 1967, after a systolic click and late systolic murmur had been found on routine examination. Investigation revealed the typical abnormality of prolapse of the posterior leaflet of the mitral valve into the left atrium with late mitral incompetence. The patient was seen again in October, with a four-week history of malaise and fever for which he had received several short courses of penicillin. (Shortly before the onset of this illness he had been bitten by a dog on the left calf.) On examination he had a fever, but there was no change in his cardiac auscultatory findings and no other findings to suggest the diagnosis of bacterial endocarditis. E.S.R. was 34 mm. in one hour, white cell count was 8,000. Blood cultures were performed and *Str. viridans* was grown from three cultures. The patient was treated with 8 million units of crystalline penicillin intravenously daily for one month and made an uneventful recovery.

We therefore consider that prolapse of the posterior leaflet of the mitral valve may predispose to bacterial endocarditis and that patients with this lesion should receive prophylactic antibiotics for dental work and other conditions which may lead to bacteraemia.—We are, etc.,

MARY STANNARD.
ALAN J. GOBLE.

Cardiac Department, The Royal Melbourne Hospital, Victoria, Australia.

Jaundice in Pregnancy

SIR,—I was interested to read your leading article on jaundice in pregnancy (2 December, p. 499), with particular reference to recurrent intrahepatic cholestatic jaundice of pregnancy. Perhaps it should be emphasized more strongly that this is a benign condition, and the prognosis for mother and child are excellent. No special treatment is needed in the antenatal period, such as induction of labour or caesarean section, on account of the jaundice alone. There is an increased tendency for premature delivery in the 38th week, and some authors have noticed a tendency for the prothrombin level to fall and lead to postpartum haemorrhage if not promptly dealt with.

Thorling[1] in 1955 produced the classical account of the disease, and he and other authors are agreed that the jaundice usually fades first in the puerperium and that the pruritus resolves within about a week or two after this—this point being at variance with your editorial view. Probably generalized pruritus without jaundice occurring in the last few weeks of pregnancy is part of the same syndrome, and Fast and Roultston[2] pointed out that these patients may have elevated serum bilirubin and alkaline phosphatase levels. They also thought that recurrences occur in at least 50% of cases. The condition is probably a great deal more common than realized, and the recent influx of case reports seems to suggest that obstetricians are becoming more aware of it.—I am, etc.,

J. E. A. ONI-ORISAN.

Stobhill General Hospital, Glasgow.

REFERENCES

1 Thorling, L., *Acta med. scand.*, 1955, **151**, Suppl. No. 302.
2 Fast, B B., and Roultston, T. M., *Amer. J. Obstet. Gynec.*, 1964, **88**, 314.

Massive Overdose of Adrenaline

SIR,—Dr. Michael A. Lewis (7 October, p. 38) speculates on the reasons for the prolonged period of hypotension and tachycardia displayed by his patient without reaching any firm conclusions. Is he able to say what volumes of fluid were administered to this