patients cannot even face a public appearance in an outpatient waiting chair. The Dermatologists Group Committee, who know well the vastly differing standards of competence among those practising electrolysis in this country, felt that the existing ethic of prima facie covering was now unrealistic in the absence of any medical alternative, and moreover that it would seem medically much more reprehensible simply to advise electrolysis to deserving patients and then to leave them exposed to the incompetent charlatan rather than refer them directly to a fully qualified and skilled practitioner.

It is apparent that there are at present areas of the country without service from members of these organizations, though demands to their secretaries might in time redress this imbalance. But we feel strongly that, even where the service exists, prerequisites to a referral by a doctor should be confirmation of the presenting standards of medical knowledge, of equipment in a clearly professional suite, and of the quality and results of the work itself. Full information on these points can be gleaned from the publications listed below.[1-3] To avoid confusion, we find it necessary to regret and to dissociate ourselves from the relevant paragraphs in the B.M.A. Family Doctor publication, *So Now You Know about Your Skin.*—I am, etc.,

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1 *Which*, November 1966, p. 357.
2 Blair, S., *Journal of the Medical Women's Federation*, 1971, **53**, 92.
3 Dopson, L., *Pulse*, 1972, **25**, 4.

Cutaneous Lesions in Multiple Myeloma

SIR,—I note with interest in the article by Dr. D. G. Beevers (4 November, p. 275) the statement that cutaneous deposits of myeloma have not been reported in the British press before.

I should like to draw the attention of readers to an article by Dr. P. B. Haribhakti[1] entitled "Multiple Myeloma with Extramedullary Plasmacytomas," published in 1966, and to a second article, published in 1961 by Dr. M. A. Cowan, entitled "Ulceration of the Skin in Multiple Myeloma."—I am, etc.,

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1 Haribhakti, P. B., *British Medical Journal*, 1966, 2. 1118.
2 Cowan, M. A., *British Journal of Dermatology*, 1961, **73**, 415.

Septo-optic Dysplasia

SIR,—In their article on septo-optic dysplasia (30 September, p. 811) Dr. C. G. D. Brook and others did not mention an important diagnostic clue to the presence of midline cerebral anomalies associated with hypoplastic optic nerves—bitemporal hemianopia.[1] Blindness is not necessarily a feature of this syndrome as they state; visual acuity may be normal.[1 2]

Hypoplasia of one or both optic nerves without cerebral malformation may be associated with other abnormalities in the visual field, including small arcuate defects,[3] altitudinal hemianopia,[2] and centrocaecal scotomas.[4] Only bitemporal hemianopia, however, indicates selective involvement of ganglion cell fibres crossing in the optic chiasma and thus suggests that other midline forebrain structures are also dysplastic. (Unilateral temporal hemianopia may be present if the opposite eye is completely blind.) Does dysgenesis of the optic chiasma, a structure closer to the hypothalamic-pituitary pathway than the septum pellucidum, correlate with the presence of endocrinologic abnormalities?—I am, etc.

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1 Ellenberger, C., and Runyan, T. E., *American Journal of Ophthalmology*, 1970, **70**, 960.
2 Gardner, H. B., and Irvine, A. R., *Archives of Ophthalmology*, 1972, **88**, 255.
3 Ellenberger, C., and Burde, R. M., *American Journal of Ophthalmology*. In press.
4 Seeley, R. L., and Smith, J. L., *American Journal of Ophthalmology*, 1972, **73**, 882.

Closure of Colostomy

SIR,—It is a pity that Mr. T. P. S. Thomson and Mr. P. R. Hawley, in their informative review of the results of closure of loop transverse colostomies (19 August, p. 459), did not indicate the method of construction of the colostomy in comparing the incidence of complications.

Apart from problems at the primary lesion anastomosis, most of the troubles with closure of colostomy are related to fibrosis and scarring and the subsequent difficulty of dissection of the colostomy from the layers of the abdominal wall. I suggest that the time-honoured method of using a glass rod and the consequent secondary union between skin and mucous membrane encourage this fibrosis and make the subsequent colostomy closure difficult. (The Paul-Miculicz type of resection is even more culpable in causing pericolostomy fibrosis.) This can easily be avoided by performing a mucosa-to-skin suture at the time of construction of the colostomy. This can be done even in the presence of obstruction, making possible the immediate fitting of a colostomy apparatus or Coloplast bag. A glass rod is used during the procedure but is removed when the last sutures are placed; this manoeuvre creates an acceptable "bar" between the two colon openings. The ease of subsequent closure of the colostomy in these cases is quite remarkable and is accompanied by few, if any, complications.

The idea of mucosa-to-skin suture in the performance of a colostomy is certainly not new, and in fact was a feature of the earliest known colostomy (caecostomy) by Pillore in 1776.[1] Keynes[2] more recently advocated mucocutaneous suture, though he suggested leaving the glass rod in for three days, a procedure which I find unnecessary.—I am, etc.,

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1 Cromar, D. L., *Diseases of the Colon and Rectum*, 1968, **11**, 262.
2 Keynes, W. M., *British Medical Journal*, 1969, **1**, 187.

Plasma versus Serum

SIR,—A comparison has been made of the fasting blood glucose values obtained with plasma (using lithium heparin anticoagulant) and with serum prepared from the same sample of blood. Determinations were made immediately after preparation of the plasma and serum and again after 24, 48, and 168 hours' storage at −20°C.

The method of Sokoloff modified for use on the AutoAnalyzer II[1] was used and the following results were obtained (mean of 15 samples):

Period of Storage (hours)	Glugose (mg/100ml) Serum Value minus Plasma Value	S.E. of Mean Differences
0	−2	1·2
24	23	16·2
48	21	10·4
168	0	4·3

Values for stored plasma did not differ from initial values over the whole period, but standard errors were about five times as great for the serum series as for the plasma series, though this parameter decreased with storage. In determining blood glucose we consider it important, therefore, to use plasma samples, especially as our work often necessitates deep-frozen storage. I am, etc.,

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1 Sokoloff, P. A., unpublished information provided by the Boehringer Corporation (London) Ltd.

Pulmonary Aspiration after Fibre-endoscopy

SIR,—With reference to the paper on pulmonary aspiration after fibre-endoscopy of the upper gastrointestinal tract by Drs. B. J. Prout and Metreweli (4 November, p. 269) we would like to make the following observations. The induction of local anaesthesia by spraying the back of the throat with lignocaine in addition to sucking a benzocaine lozenge inevitably anaesthetizes the larynx as well as the pharynx. Obstructing the oesophagus with the fibre-endoscope in the presence of laryngeal anaesthesia not surprisingly increases the likelihood of aspiration if the patient is asked to swallow. Surely, patients should be requested *not* to swallow their saliva.

In contrast to the large doses used in this study we find an average of only 10-15 mg diazepam intravenously allows sufficient relaxation without completely abolishing the laryngeal cough reflex; if the instrument touches the cords the patient immediately coughs. Furthermore, correct positioning of the trunk and head allows saliva to passively run out of the mouth so that swallowing becomes unnecessary.—We are, etc.,

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Creatinine Clearance Tests

SIR,—The calculation of the renal clearance of creatinine from measurements made on a single specimen of plasma and a 24-hour urine collection presupposes a steady state of plasma creatinine during the 24 hours. Thus there is no special reason for taking the plasma sample half-way through the urine collection, as is the usual practice, and it would seem just as reasonable to take the plasma at the time of completion of the collection.