adherent to the oesophagus. When the neuroma was dissected away the oesophagus filled out but none the less dilators were passed.

The "neuroma" had a cotton ligature incorporated in it. Since then I have ligated only the distal vagal end, sometimes burying it under a serosal suture to obviate (?) such stump neuromata.

The patient has had no recurrence of symptoms since. This case tends to support the view that stump neuromata may by themselves cause symptoms as suggested in your leader.—I am, etc.,

University College, Galway. E. N. MACDERMOTT.

REFERENCE

[1] Guiney, E. J., and MacDermott, E. N., *J. int. Coll. Surg.*, 1960, **33**, 297.

Prolonged Latent Period with Plasmodium falciparum Infections

SIR,—The letter from Dr. A. Mahmood (26 February, p. 544) reporting a recrudescence of *Plasmodium falciparum* infection in a pregnant Nigerian 16 months after leaving her country coincides with a similar case here. The lady is a Nigerian primipara, five months pregnant, who left Nigeria in March 1964. Her age is 20 years, her haemoglobin 6.8 g./100 ml., and her M.C.H.C. 27%. Her faeces shows a few *Entamoeba histolytica* cysts and a considerable number of *Ankylostoma* ova. Scanty ring forms but no gametocytes of *P. falciparum* have been found in the blood smear, which is routinely done when the haemoglobin is low. The interval between finding these parasites and the patient leaving Nigeria is over 20 months.—I am, etc.,

Devonport Laboratory, London S.E.10. G. L. ROBINSON.

Tonsillectomy

SIR,—The article by Dr. H. B. Holden and Dr. J. J. Maher (4 December, p. 1349) comparing blood loss in adenotonsillectomy under ether and halothane anaesthesia plus the numerous ensuing letters on tonsillectomy make interesting reading.

Dr. R. I. W. Ballantine (12 March, p. 676) makes the point that reflex disturbances can occur with light anaesthesia, but in neither the original article nor in later observations does the question of blood loss appear to have been considered in relationship to depth of anaesthesia.

Perhaps depth of anaesthesia plays a larger part in blood loss than is widely recognized. In 1955–7, to settle a difference of opinion on the conflicting claims for deep or light anaesthesia in dissection tonsillectomy with adenoidectomy, Mr. P. H. Golding Wood and I did a carefully controlled (unpublished) series of over 100 cases aged 5–8 years, all with the same team. We compared blood loss under deep ether and under light ether barely deep enough to tolerate the Boyle-Davis gag. Swabs were weighed and sucked blood measured. The operating conditions were better under deep ether, and this group lost on average approximately half the amount of blood of the group under light ether. We also compared a smaller number using suxamethonium chloride, an endotracheal tube, trichloroethylene, and very small doses of gallamine. These gave similar blood loss results to the light ether group.

It would be of interest to know comparable blood loss figures with anaesthesia as light as Dr. E. V. Slaughter's ½% halothane and with halothane at an appreciably greater depth. It would also be instructive to compare the number of cases causing anxiety on extubation under these same conditions.

Mr. P. H. Golding Wood and I have, as a routine, largely discarded deep ether and the simple insufflating Boyle-Davis-gag technique only because, (1) induction is time-consuming, working single-handed, and operating and waiting-lists are long; (2) potential dangers arise if cautery or diathermy is used in following cases; and (3) the soporific effect on personnel is accentuated in a small hot operating theatre.

A few more factual series with strict controls would help give real perspective and perhaps do away with much conjecture and the often misleading personal opinion. My own preconceived notions were certainly proved wrong on the subject of adenotonsillectomy blood loss under light and deep ether.—I am, etc.,

Harrietsham, Nr. Maidstone, Kent. C. H. BOYD.

SIR,—We have read with great interest all the recent correspondence concerning tonsillectomy and anaesthesia. With particular reference to Dr. D. C. Hughes's letter (19 February, p. 483), it may be of some interest to readers to learn that at St. James's Hospital, using endotracheal anaesthesia and the Doughty modification of the Boyle-Davis gag, we have measured the blood loss in 50 consecutive children under the age of 10 years.

The average blood loss for the 50 cases was 70 ml., as compared with the 128 ml. of the 50 cases studied by Holden and Maher.[1]

The average blood loss for 30 adult tonsillectomies was 106 ml.

The presence of blood in the oropharynx as in tonsillectomy is an absolute indication for intubation, and the advantages are to the benefit of the patient, the surgeon, and the ward staff.—We are, etc.,

J. A. CLARKE.
St. James's Hospital, London S.W.12. A. W. HALFHIDE.

REFERENCE

[1] Holden, H. B., and Maher, J. J., *Brit. med. J.*, 1965, **2**, 1349.

Cot Deaths

SIR,—As a coroner I am of course concerned with the question of cot deaths, and one possibility which appears to have been omitted from every investigation is the possibility of an ante-mortem fall in body temperature.

In many cases the child has been in a cold bedroom or in a pram in the open air when it is found dead.

Investigation by the coroner into the question of room temperature or air temperature might be useful, but even more useful, particularly where the time of death can be approximately determined by other evidence, would be a recording of the body temperature with a subclinical thermometer taken by the first doctor or nurse to see the body after death.—I am, etc.,

Stoke-on-Trent. F. G. HAILS.

Contact Dermatitis from Spandex Yarn

SIR,—I was most interested to read about brassière dermatitis due to Spandex yarn in the letter from Dr. C. F. Allenby, Dr. V. Kirton, Dr. K. D. Crow, and Dr. D. Munro-Ashman (12 March, p. 674). I have investigated over the past few months four similar cases, all of whom had positive patch tests to Spandex. Three of these developed the dermatitis after approximately one month of wearing the brassière, the fourth within 24 hours, but the patient had been employed by the firm manufacturing the brassière, and presumably she had become sensitized to the antioxidant at work.

It seems likely that this type of dermatitis will become increasingly common with the widespread use of synthetic yarns.—I am, etc.,

Western Infirmary, Glasgow W.1. W. N. MORLEY.

Albustix Test for Urine Protein

SIR,—I refer to the letters by Dr. Phyllis Dagnall (4 December, p. 1369) and Dr. R. M. Emrys-Roberts (12 March, p. 677) on the subject of Albustix for detection of urinary protein. We have found that Albustix and Uristix frequently give false positives, so that in our routine testing in hospital the heat or salicyl sulphonic acid test is always applied when positives are obtained by the "stix" test.

However, I believe Dr. Emrys-Roberts is basing his false negative assertion on the false premise that the presence of proteinuria is a good screening test for urinary infection. It is common for urinary infection to be present in the complete absence of protein in the urine by the usual methods of detection, so that it is quite wrong to confirm or refute the existence of urinary tract infection on the basis of any test for the presence of protein alone.—I am, etc.,

DENIS M. FREEMAN.
Warrington General Hospital, Warrington.

Skin Pigmentation by Phenindione

SIR,—Dr. N. H. Silverton's interesting letter (12 March, p. 675) prompts me to report my personal experience of this peculiar phenomenon. I have been taking this drug in varying dosage for some ten months, and within the past three months have noticed recurrent pigmentation, presenting as circumscribed bright orange patches on the centre of the left palm and less commonly on the distal finger tips of right thumb and index finger.

I have confirmed that this can be produced by contact with the drug plus soapy water, though this combination had not previously appeared significant to me.

I had noticed that this pigment occurred when using half tablets and it appeared to be