the basis of its use in bacillary dysentery. Sulphadiazine, which is less soluble than sulphathiazole, appeared to be absorbed slowly, and when the wounds were reopened on the third day considerable quantities of the compound were always discovered.—I am, etc.,

National Institute for Medical Research,
London, N.W.3, June 24. F. HAWKING.

Unabsorbable Suture Materials

SIR,—I have been greatly interested in the recent correspondence in the *Journal* on the subject of unabsorbable sutures. For the past twenty years I have used nothing but linen thread (No. 60) for ligatures in the operation of radical mastectomy and have seen no ill effects result. Formerly I used thread exclusively for ligatures in thyroid operations, but an occasional subcutaneous sinus occurred. I therefore substituted fine catgut for ligation of bleeding points superficial to the deep fascia and continued with thread for the deeper ligatures with complete success.

For clean wounds in safe areas thread ligatures have the following advantages over catgut: (1) Thread can be boiled and its sterility is therefore guaranteed. Unfortunately an occasional " batch " of catgut appears to be far from sterile. (2) The tensile strength of thread is comparatively constant while that of catgut varies. With a little experience it is easy to sense how much strain thread will stand and, as a result, ligatures are unlikely to snap. (3) The surface of thread is rough while catgut is smooth and slippery. Consequently thread knots hold more effectively and " slipping " of a properly applied thread ligature is practically impossible. (4) Economy. In operations where a hundred or more ligatures are commonly necessary the cost of thread as compared with catgut is measured in terms of pence instead of pounds.—I am, etc.,

R. J. MCNEILL LOVE, M.S., F.R.C.S.
London, W.1, June 26.

Treatment of Osteomyelitis

SIR,—Mr. H. J. McCurrich's letter (June 14, p. 906) regarding chronic osteomyelitis following war wounds raises several important points in the treatment of this surgical problem.

Once the condition is established in certain situations, one of which he mentions, the problem of treatment is indeed great. Some cases following the last war had infection eradicated by wide guttering operations, notably in the hands of the late Naughton Dunn, but, as Mr. McCurrich points out, it is not uncommon for a man to have a discharging sinus for twenty-five years Having seen many cases of this type I am firmly convinced that, to improve results, we must concern ourselves more with prevention that cure, by recognizing in the initial stage those wounds which are likely to become the seat of a chronic infection. If this is done, more radical methods can be employed in the primary stage of treatment than would be possible some years later.

As an instance I cite the case of a man wounded in the shoulder in the evacuation from Dunkirk. The head of the humerus and part of the glenoid were shattered and numerous metallic fragments scattered in the region. When he reached me the wound was almost healed and surgical intervention was not indicated. Radiographs now show a number of metallic fragments embedded in a shapeless mass of bone at the upper end of the humerus. I do not think that the function of the arm would have been any worse had all these bony and metallic fragments been cleaned out in the first instance, but I do know from previous experience that a chronic infection is likely to supervene in later years, when it will be impossible to do a radical operation short of a fore-quarter amputation.

The upper and lower ends of the femur are notorious for their ability to hold infection in spite of all treatment, and the answer to Mr. McCurrich's question regarding amputation is that each case must be judged on its merits, and amputation performed before it becomes a life-saving operation. Many patients continue for years with a small dressing which is much less of a disability than an artificial limb.

The suggestion of a centre or colony for these patients is surely already met in the Ministry of Pensions Hospitals, where a large percentage of the cases treated are of chronic bone infections.—I am, etc.,

Liverpool, June 14 W. R. D. MITCHELL.

Marking of Gas-contaminated Clothing

Sir,—In many areas the handling and cleansing of gas-contaminated clothing is the duty of the district engineer, but I expect that some medical officers of health and first-aid post medical officers have taken an interest in the collection and marking of the clothing that may be handled in the cleansing stations attached to hospitals and first-aid posts.

The original suggestion was that the clothing could be marked with metal disks fastened to the garments and then collected in string bags, which could be similarly marked. It is now necessary for cotton and woollen garments to be kept separate, and it is suggested that a tape or disk be pinned to each garment. In this district we have worked out a scheme by which every garment has a tape label attached to it by a stapling machine. This altogether does away with the need for safety pins, which in practice will, in my opinion, prove unsatisfactory. The stapling machines can be efficiently handled by men or women even wearing the clumsy gas protective gloves. The scheme requires that a stapling machine, two rubber stamps, a length of tape, and a pair of scissors be supplied to each side of the cleansing station. When the station is at work every garment will have firmly fixed to it the initial of the station, the date of contamination, and the owner's number stamped upon a small tape. After decontamination it should be a simple matter to return the clothing to its rightful owner.

The advantages are that this scheme offers a simple and efficient method of marking clothing and saves innumerable safety pins.—I am, etc.,

W. F. CORFIELD,
June 27. Medical Officer of Health, Colchester.

Diabetic Coma in Young Diabetics

SIR,—I have read with interest Dr. Leslie Cole's article on diabetic coma in a series of young diabetics (June 14, p. 882), and, while I find myself in agreement with much that appears in it, there are one or two points on which further information would be of value, and one therapeutic procedure advocated which, I think, is not without possible danger. In the description of Case 6, in which severe ketosis, as judged by urinary examination, was absent during the early stages, no mention is made of the presence or absence of acetone in the breath. I have seen several such cases, one quite recently, in which the kidneys appeared to be unable to excrete ketone bodies, but in which a strong odour of acetone in the breath left the diagnosis in no doubt. In such cases it is wise to examine the *serum* qualitatively for ketone bodies by Rothera's test, as this may give a strongly positive result.

Dr Cole rightly stresses the importance of fluids and saline in the treatment of diabetic coma, the administration of which in large volumes in desperate cases was advocated by Lawrence in an article in the *British Medical Journal* of April 12, 1930, and thereby presumes the knowledge that peripheral circulatory failure is an, if not the most, important cause of death in this condition. He omits, however, in his series, to give any records of blood pressure before or during treatment, which is unfortunate because, from the point of view of prognosis and treatment, the level of the systolic pressure is of greater importance than that of the blood sugar, whose chief value is its guide to insulin dosage.

Lastly, under the heading of treatment, Dr. Cole advocates giving " usually not less than 50 units [of insulin] repeated every one or two hours according to the clinical and biochemical progress." In my experience in severe cases of coma the progress either clinical or biochemical made in intervals of one or two hours is often not significant enough to allow of its being safely used as a guide to insulin dosage, especially if such progress is apt to be the combined result of the treatment of dehydration and ketosis, a fall in blood sugar in the early stages of treatment being the outcome of an increase in blood volume as well as insulin action. But even if the progress of the case could be adequately estimated from hour to hour the practice of giving insulin at such frequent intervals is both unnecessary and unwise. Doses as large as 50 units do not exert their maximum action for at least three hours, and, consequently, if injected every one or two hours, constitute repeated additions to an amount of insulin which has not had time to show full evidence of its

action; the cumulative effect so produced not only detracts from the value of blood-sugar determinations as a guide to subsequent dosage but, in hands less skilled than those of Dr. Cole, may easily in children result in severe hypoglycaemia.—I am, etc.,

The Diabetic Department, King's College Hospital, June 17. WILFRID OAKLEY.

Chronic Sick in Bombed Towns

SIR,—The Minister of Health in reply to a question put by Sir E. Graham-Little on the subject of the "chronic sick" in bombed towns stated (*Journal*, June 21, p. 950) that he could not give "the total number of chronic sick still housed in public health and public assistance institutions," etc., "without elaborate and detailed inquiry from a large number of different authorities." The answer given by the Minister is, of course, obviously evasive, as anyone can tell from personal experience of Government Departments, especially in wartime. In other words, if the Minister really wanted to know the total number and to disclose it to the public he would soon find himself and his staff in very hot water. However, in order to help him to grasp the gravity and urgency of this question I can tell the Minister that the figure for London is about 5,000.—I am, etc.,

Criccieth, June 21. FREDERICK MENZIES.

SIR,—Permit me to "confirm by my testimony" the existence of the disgraceful state of affairs in regard to chronic sick patients which has aroused the just anger of Sir Frederick Menzies (June 7, p. 868).

Last October I was a medical officer at a hospital for chronic sick in London—and I should explain that the term "chronic sick" has a precise, defined meaning. It means a patient who is bedridden owing to an incurable illness and is not necessarily synonymous with "senile," as might be inferred from a recent reply given in Parliament by the Minister of Health.

In that hospital we had several hundreds of such patients (over 95% of whom were unable to get out of bed) and, in spite of the fact that we were doing no air-raid casualty work, those patients, strung out on three floors, were left there night after night while bombs missed the building by 20 to 30 yards.

Two questions arise:

(1) *Ought early evacuation to have taken place?*—On balance of reasonable probabilities the building was going to be hit. This was clear to us and clear to the local police authorities, who were gravely perturbed (as I happen to know) by the plight of such a large number of helpless patients. The suggestion that it may be necessary, in the welter of competitive and even Gilbertian priorities alluded to by Mr. Ernest Brown, to leave in the vaunted "front line" such unfortunate people is an unworthy one and one which would have appalled our fathers, who had a firmer grip of the spirit of Christianity than we have.

(2) *What of the future?*—In spite of the apathy of what a modern writer has called "our deplorable Press," the problem of disposal of the chronic sick will solve itself.—I am, etc.,

Portsmouth, May 25. J. C.

Paralysis accompanying Herpes Zoster

SIR,—The note on paralysis accompanying herpes zoster by Mr. G. I. Wilson (June 21, p. 930) suggests that this combination is not excessively rare. I think it never has been very rare, but I believe Ramsay Hunt was the first to describe it under the name "syndrome of the geniculate ganglion." There is an admirable illustration of the condition in Aldren Turner's *Textbook of Nervous Diseases* (my edition is 1910, p. 88). Another point in Mr. Wilson's note is that his patient exhibited a generalized vesicular eruption resembling chickenpox. This is not chicken-pox but *herpes generalisatus*—a phenomenon not uncommon in old people who suffer from herpes zoster. Stelwagon in his *Diseases of the Skin* mentions this form of herpes, giving some references. I have seen five instances of the condition occurring in the seventh or eighth decade of life.—I am, etc.,

Bristol, June 21. J. A. NIXON.

Bilateral Renal Colic due to Sulphapyridine

SIR,—I think it might be of interest to add to recent publications on this subject an observation of a case of bilateral renal colic due to sulphapyridine.

A private aged 36 was from May 1 to May 10, at the reception ward of his unit, treated for pleurisy. On May 15 he was taken ill again, and on the following day was admitted to our hospital, where the diagnosis of pneumonia of the right upper lobe was confirmed. Mild cyanosis and occasionally vomiting were noticed while on routine sulphapyridine treatment. On May 18 he complained of diffuse pain in the right hypochondrium and kidney region, radiating into the right testicle. The violent pain was controlled only after injection of morphine and atropine. On May 19 the patient experienced severe colicky pains on the left side, followed by complete suppression of urine. The total amount of urine passed in the following twenty-four hours was 3 c.cm., and this had the appearance of blood. Intensive treatment and immediate stopping of sulphapyridine was followed by rapid improvement. An *x*-ray film did not show the presence of calculi, and there were no stones or gravel in the filtered urine, which, however, contained albumin for a few days. The urinary output was almost normal by May 21. The total amount of sulphapyridine given amounted to 20 grammes.

When the first attack occurred we thought of a fortuitous association of renal colic with pneumonia, as it is well recognized that febrile conditions may aggravate latent nephrolithiasis. By the following day the latter diagnosis had to be reconsidered in view of the occurrence of renal colic on the other side, with no history of previous attacks. It was felt that sulphapyridine was the responsible factor, and this view was confirmed as rapid improvement followed the discontinuation of this drug.

This short record of a case of bilateral renal colic due to sulphapyridine is an addition to the considerable number of publications of more or less serious toxic effects of members of the sulphonamide group. In my opinion more careful consideration whether treatment with these preparations is necessary should be given to all cases prior to their administration. It appears to me that the use of sulphapyridine and sulphanilamide—our most potent weapons in the fight against serious infective conditions—should be limited to those diseases where their administration is strictly indicated, or where other measures are likely to fail. The habit of using them in order to be "on the safe side" should be deprecated, and the possibility of sensitization by previous administration should be borne in mind. A common source of overdosage could be avoided if colleagues in charge of military units or in private practice would not transfer patients to a hospital without a short note regarding the amount of sulphapyridine or sulphanilamide given, and the patient's reaction to this treatment.—I am, etc.,

An E.M.S. Hospital, June 5. EMANUEL KOST.

Medical Planning Commission

SIR,—We students in Edinburgh have been following with interest the letters and articles appearing from time to time in your columns regarding the above Commission. Like many of your correspondents we view with concern the composition of the Commission, including as it does not one medical student or recently qualified man. With as much concern we note the apathy with which medical students as a whole have so far acknowledged the presence of this Commission. We were delighted to read Mr. Kennish's letter in your issue of May 10 (p. 738), and tardily hasten to support his views; indeed, we would speak more strongly on the matter and, while fully realizing that the presence of a Medical Planning Commission does not necessarily mean that a plan will be formulated or, if formulated, will be adopted by the Government or medical profession, would point out that, even though the reports to be prepared may not be binding, they will be used as a basis for any future reorganization.

As a result, owing to the exigencies of war, a real wrong will be done to thousands of younger men, who, because they are serving with His Majesty's Forces, cannot give time or thought to the matter, or, because they are still students, cannot take an active part in planning the future of their profession. Realizing that to add more and younger men to the Commission might make it unwieldy, we have outlined the following alternative scheme for consideration.