

**Aneurysm or Angioma?**

SIR.—Dr. A. Kahan's diagnosis of rupture of a berry aneurysm in the three cases of spontaneous subarachnoid haemorrhage in children (March 17, p. 567) should not pass unchallenged. Spontaneous subarachnoid haemorrhage is an uncommon condition in children, but in my own small series of cases haemorrhage around a haemangioma of the cerebral cortex of congenital type has been at least as common a cause as a rupture of a berry aneurysm. Neither diagnosis should be made on the clinical signs alone; cerebral angiography is necessary. The development of percutaneous injection of the carotid artery has made carotid angiography a much less serious affair than formerly, when open operation was necessary. I have been able to secure satisfactory pictures by the percutaneous route in children as young as 6 months, though I prefer surgical exposure of the artery in patients who are aged less than a year.

While the whole point of this letter is to suggest that angiography is necessary to establish the exact diagnosis in these cases, it is interesting to notice that in every one of Dr. Kahan's three cases there were residual neurological signs. This is certainly not the case in all nor even in the majority of cases of subarachnoid haemorrhage due to rupture of a berry aneurysm in adults, but is very much commoner after haemorrhage from a cortical angioma.—I am, etc.,

Manchester.

A. N. GUTHKELCH.

**A Cause of Emphysema**

SIR.—Dr. K. Robson, in his excellent review of emphysema (March 10, p. 521), repeats the time-honoured explanation of inspiration being more powerful than expiration. A far more important factor in the production of emphysema, lung distension, and tension cavities is the change in the diameter of the bronchi and presumably the bronchioles on respiration. On inspiration the bronchi dilate, allowing free passage of air into the alveoli. On expiration the bronchi contract, making the return journey of the air far more hazardous. When the bronchi are further narrowed by swollen mucous membrane, secretion, and "spasm," expiration becomes difficult or impossible. This dilatation and contraction of the bronchi is probably passive and due to the elastic pull and relaxation of the lung on respiration. It can be observed bronchoscopically and the dilatation element demonstrated, in the temporary state in atelectasis, and in the permanent state in bronchiectasis, by "lipiodol."—I am, etc.,

Chichester.

JOHN D. WHITESIDE.

**Abrams's Box Revived?**

SIR.—Recently I had occasion to see a hospital patient who had received a lumbar puncture the week before as a test of cure for well-treated lues. Following the test he developed a headache and could not rise from his bed. Claiming "that it was impossible to get a proper doctor to visit the home these days for a trivial condition like a headache," he was nursed by his wife. He told me that his progress was slow and after a day or two she met a fellow tenant in the hall of the same block of flats who was what is sometimes called "an unqualified practitioner." He accepted with alacrity the invitation to see the husband as an opportunity to display the virtues of his new diagnostic box. This was an electrical contrivance which, it was said, could "tune in to the wave band" of an individual person after a drop of blood had been collected for the purpose. Having done this it could further diagnose from what the patient was suffering, from abscess to zoster. My patient admitted to a history of the lues venerea, which enabled the practitioner to state from the figures produced by the box that he had either secondary syphilis or yaws. (Actually both his serum and spinal tests were completely negative.)

Prior to this experience I had heard say that a well-known London firm was interested in apparently similar diagnostic boxes which, when given a drop of blood, if I understood the claims correctly, could "tune in" to the patient at a distance of some miles, register abnormal waves due to disease, and even produce a photographic record of the diseased area. An inquiry to the firm in question confirmed their interest, but it was stated that the first of these boxes is not yet available for demonstration.

It was about the turn of the century that Abrams<sup>1</sup> produced his diagnostic box, embodying the very latest of electrical equipment. It too depended on a drop of blood, taken on a piece of filter paper, and, after an electrode was placed on the forehead of the patient and the abdomen solemnly prodded, an electrical reading (measured, I believe, in ohms of resistance) was obtained. Thus a diagnosis of cancer or tuberculosis could be confirmed.

In a recent article<sup>2</sup> discussing the future of quackery the writer considered that the end was near, as magic has now become rationalized and even penicillin ceases to excite our wonderment. However, as science advances, with the impossible being achieved almost daily, perhaps this is not so and the public is actually more gullible. Surely persons who gather round a box and watch a boat race at a distance of many miles are to be forgiven for considering that the mere diagnosis of disease in a patient connected by wires to another type of box in the same room is but child's play for the modern scientist. Thus there is a danger that the quacks will exploit scientific advancement as it occurs, and, who knows, "atomic boxes" are perhaps already in existence and an era of "fission faddery" on the way.

It is clear that all spurious claims should be exposed, not only to the doctors but to the patients themselves. The British Medical Association could do good service by examining the pretensions of those interested in this type of work, stating what nuclei of scientific fact, if any, exist in the claims and exposing those aspects which are patently false. They now have in *Family Doctor* a way of conveying such information to the public at large.—I am, etc.,

London, W.2.

R. R. WILLCOX.

## REFERENCES

- <sup>1</sup> Fishbein, M. (1925). *Medical Follies*.  
<sup>2</sup> Craig, J. Donaldson (1950). *Medicine Illustrated*, 4, 518.

**POINTS FROM LETTERS****Thumb Sucking**

Mr. J. H. BADCOCK (Bury St. Edmunds, Suffolk) writes: Apropos of the thumb- or finger-sucking habit mentioned in Miss L. Clinch's article on orthodontics (February 24, p. 406), it should be remembered that this is only one part of a syndrome, the other being the fumbling by the child's other hand of something soft and warm, a soft toy, the blanket, a "woolly" kept for the purpose (or sometimes its own hair), without which the child will not go to sleep. When trying to effect a cure this should always be looked for and when possible removed, possibly at the expense of one or two disturbed nights. I have known the deprivation of a "woolly" stop the habit without other means.

**Corrections**

Professor CHARLES WELLS and Mr. RICHARD WELBOURN (Liverpool) write: It has been pointed out to us that the statement in our paper (March 17, p. 553, para. (c)) that iron is excreted in the bile pigments is misleading. There is, of course, no iron in the bile pigments themselves, but (to quote Whitby and Britton) "it is logical to deduce that biliary iron excretion is entirely associated with pigment excretion and that the iron is bound to the pigment." Also, in the same paragraph the figures "about 5 mg." and "about 10 mg." should, of course, be "about 0.5 mg." and "about 1.0 mg.," respectively.

Drs. W. H. H. MERIVALE and L. FORMAN point out two errors in their paper, "A Case of Masculinovoblastoma" (March 17, p. 560). (1) The serum cholinesterase level given in Table I should read "Serum cholinesterase—105  $\mu$ l./ml./minute." (2) In the references, the 17th reference should read "Novak, J. (1947). *Gynaecological and Obstetrical Pathology*. Saunders, Philadelphia and London."