

one death occurred in a young soldier who had perforated 48 hours before admission: he died a week after the operation and, regrettably, no necropsy was allowed.—I am, etc.,

Epsom, Surrey.

S. M. VASSALLO.

SIR,—Mr. Hermon Taylor (*Journal*, April 4, p. 781), in discussing the conservative treatment of perforated ulcers, says, "Clearly the method of gastric aspiration can achieve all that can be obtained by the method of surgical closure, but with the not inconsiderable advantages of avoiding an operation." He further states that modern developments have made simple closure of perforations obsolete. To my mind, operation has several possible advantages: (1) fluid can be sucked out of the subphrenic spaces; (2) the size and situation of the ulcer can be assessed; (3) the possibility of malignant change can be largely excluded; and (4) appropriate treatment can be given if the diagnosis proves to be wrong—e.g., perforated cholecystitis, appendicitis with general peritonitis, pancreatitis, or even small-bowel obstruction.

Continuous aspiration has its disadvantages. It is usually necessary for four to five days, and entails intravenous saline with all its dangers and complications. A very high proportion of cases treated by operation only need gastric suction for about 36 hours. A rectal drip is then quite adequate to prevent dehydration.

Surely the discomforts and dangers of operation have been exaggerated during recent years. It has been my practice to combine local and light general anaesthetics, which give complete relaxation without any interference with chest or diaphragmatic movements. The patient usually wakes up almost free from pain. I have personal experience of 385 operations, and I think that a patient who cannot stand this line of treatment is most unlikely to recover from any other.—I am, etc.,

Farnham, Surrey.

STANLEY C. RAW.

### Research in General Practice

SIR,—Professor Robert Platt's address (*Journal*, March 14, p. 577) was indeed stimulating, but those who try, however unpretentiously, to carry his ideas into practice do not always find that things go very smoothly. Some years ago I was taunted by a patient that British medicine lagged behind the Soviet variety inasmuch as Russian doctors were completely relieving the pangs of childbirth by injections of vitamin B. This information had been gleaned from a Soviet propaganda publication which had considerable circulation in this country. I wrote immediately to a firm which is generous in the matter of circulars and samples, and is prominent as a manufacturer of vitamin products. I suggested that the matter might be very quickly tested by the issue to a sufficient number of general practitioners of enough vitamin B to be used in their cases, on condition that reports were sent of the results. The firm's medical adviser pooh-poohed the whole project.

On another occasion I wrote to the *Journal* on the subject of the long-term results of electric shock treatment in mental illness, because I felt that general practitioners would have more reliable views on the subject than those held by the more enthusiastic psychiatrists. If my memory serves me correctly there was no reaction, good, bad, or indifferent, from my colleagues.—I am, etc.,

Launceston.

DONALD M. O'CONNOR.

### Chloroform for Bronchography in Children

SIR,—Mr. Leslie J. Temple and Dr. T. Cecil Gray, in their letter (*Journal*, April 18, p. 883) commenting on our article on bronchography in children (*Journal*, March 14, p. 601), state that it implies that the child may suffer from hypoxia during the use of our technique. This is certainly not so. We attain rapidly a short, deep anaesthesia and at all times the child is well oxygenated. We do not suggest

that chloroform should be used by the inexperienced, but we think that explosive agents are better avoided in the x-ray room.

As regards the airway, it may be difficult to prevent obstruction without it in some of those children with enlarged tonsils and adenoids. Finally, an important difference between our technique and Gray and Temple's, not mentioned in their letter, is that we do not "drown" our patients with lipiodol, as we feel that in bronchiectasis there is enough foreign material in the bronchi without adding to it more than the minimum necessary.—We are, etc.,

MARGARET I. GRIFFITHS.

T. D. CULBERT.

Manchester.

SIR,—Having used the method of anaesthesia for bronchography in children described by Mr. Leslie J. Temple and Dr. T. Cecil Gray (*Journal*, April 18, p. 883) since I was first taught it by Dr. John Halton some five years ago, I can only agree with all the authors' remarks concerning the method.

Being worried about the possibility of explosion, I too tried chloroform and other agents, but soon realized, fortunately at the cost only of minutes of acute anxiety on more than one occasion, that as deep anaesthesia is necessary it is most safely produced by ether. I feel convinced that explosions as a result of ignition of ether vapour by x-ray equipment have been much rarer than fatalities from the use of chloroform, and would join Mr. Temple and Dr. Gray in pointing out the dangers of using chloroform where some degree of hypoxia is to be expected as a result of deep anaesthesia and the introduction of oil into a diseased respiratory system.—I am, etc.,

Manchester.

TOM DINSDALE.

### Antihistamines and Asthma

SIR,—Drs. A. W. Frankland and R. H. Gorrill (*Journal*, April 4, p. 761) ought to be congratulated on the skill with which they have refuted the assumption that antihistamine treatment of hay-fever causes asthma. Their further conclusion that antihistamines do not improve asthma is hardly justified by their experiments. They have given mepyramine, apparently in four separate daily doses of 100 mg., or another equivalent antihistamine, and have not seen any benefit from it. Nor have I. Antihistamines influence asthma only if a much larger dose is given than that effective in allergic rhinitis. There is ample evidence for their efficiency,<sup>1,2</sup> but I have never seen a beneficial effect with less than a single dose of 300 mg. of mepyramine. An amount of 100 mg. cannot be expected to influence asthma, just as one would not expect one minim of adrenaline to influence it. It would appear essential that in therapeutic trials, controlled or uncontrolled, the doses used are not subthreshold ones, as in this case.

The difficulty with antihistamines in asthma is that the large doses required often have side-effects which make their use impracticable during the day. They are best used in single doses at bedtime, when they may secure an asthma-free night. The use of one single dose in 24 hours also avoids the development of tolerance, which easily occurs with multiple doses.<sup>3</sup>—I am, etc.,

London, W.C.1.

H. HERXHEIMER.

### REFERENCES

- 1 Armitage, P., et al. (1952). *Brit. J. Pharmacol.*, 7, 625.
- 2 Herxheimer, H. (1952). *Management of Bronchial Asthma*. Butterworth, London.
- 3 Dannenberg, T. B., and Feinberg, S. M. (1951). *J. Allergy*, 22, 330.

### Television and the Patient

SIR,—I should like to endorse very strongly the opinion expressed by Dr. T. Hughes (*Journal*, April 18, p. 884) in the letter under the heading "Television and the Patient." In general, television programmes on medical subjects seem calculated to foster in the minds of ordinary people the

deplorable idea—already far too prevalent—that the attitude of the medical profession can be expressed as, “It doesn't really matter how you live: modern medical science is so wonderful that you can be made fit whatever happens—if you are properly treated.” The view that it is the business of the State, through its “Health” Service, to make and keep everyone healthy is thus still further encouraged instead of the true view that it is the duty and privilege of each individual to think and live in such a way as to attain the greatest possible degree of mental and physical efficiency.

Soon after I had a television receiver installed in my home (about two years ago) I was so impressed by the possibilities of television as an educational medium that I summoned up courage to write to the B.B.C. to suggest, humbly, that it might be a very good thing if a small amount of time (perhaps 20 or 30 minutes once a month) could be devoted to a health education series in which a plainly worded and interestingly illustrated exposition of relevant biological facts could be given, coupled with hints on “keeping fit” based on these facts. After some time I received a letter in reply which said that I should be glad to know that the sort of programme I advocated was being sent out from time to time, and went on to instance the very sort of thing that Dr. Hughes has referred to. I wrote again and tried to explain as carefully as I could the difference between that kind of programme and the educational programmes that I felt could be so beneficial, but again I got a reply which seemed to indicate a complete failure to see my meaning, and I am afraid I gave up the struggle as hopeless.

Would it be possible for representations to be made to the B.B.C. on this matter?—I am, etc.,

London, N.W.3.

A. DALBY.

SIR,—As one responsible for the section on anaesthetics in the “Pain” programme referred to (*Journal*, April 18, p. 884), I think that Dr. Trevor Hughes's letter has served a useful purpose in attracting attention to the subject in the daily press. The contribution of anaesthetics to the advancement of surgery is now freely recognized in the medical profession, and the consumers—the public—are entitled to information upon it. From the comments I have heard from time to time from lay members of the public, it is clear that interest in such matters springs from healthy intelligence and but rarely from morbid curiosity.

Whatever the merits of the “rag and bottle” administration of anaesthetics may be, to many people experience of it is a distasteful memory. It is fair that the public should know that in experienced hands more pleasant methods of anaesthesia are available to all in this country—as they should be under the Health Service. Television provides a useful medium for extension of this knowledge. Can Dr. Hughes suggest a better medium, or would he prefer his patients to be kept in ignorance?—I am, etc.,

London, W.1.

I. W. MAGILL.

### Polypharmacy

SIR,—Dr. A. T. Mennie (*Journal*, April 18, p. 887) overstates his case. While multiple deficiencies may be common in anaemia—though which is cause and which is effect may be hard to say—it is still a fact that the common so-called “nutritional hypochromic anaemia” can be treated adequately with iron alone. Even when combinations of therapeutic substances produce a more rapid rise in haemoglobin, speed of cure alone is seldom important.

There are those whose hypochromic anaemia responds inadequately or not at all to iron. After investigations have excluded haemorrhagic or other organic causes there may be a place for treatment with multiple agents, the nature and dosage of which should depend upon each patient's needs and not merely be determined rigidly by the contents of a capsule.—I am, etc.,

London, N.W.6.

J. I. E. HOFFMAN.

## POINTS FROM LETTERS

### Counting High Pulse Rates

Dr. R. J. K. BROWN (London, S.E.24) writes: Dr. E. Montuschi (*Journal*, April 4, p. 781) mentions a technique for counting high pulse rates. May I describe another which is equally applicable to both high and low pulse rates? . . . The number of beats are counted in three consecutive five-second periods: the highest and lowest figures so obtained are then multiplied by 12. For example, if these figures were 6 and 7, one could say the pulse rate was swinging between 72 and 84 (with a mean of 78). I have found this method particularly useful in paediatric practice.

### Drunk in Charge

Dr. C. RUTTER (London, E.6) writes: I was interested to read Dr. A. E. M. Hartley's article (*Journal*, March 28, p. 735) on “drunk in charge.” I would suggest, however, that the examination should take place immediately on arrival, before the essential questions are asked. The medical history might be long and take time to obtain in full, thus giving the person being examined time to sober up.

### Research in General Practice

Mr. A. P. BERTWISTLE (Birmingham) writes: In Professor Robert Platt's admirable paper on the above (*Journal*, March 14, p. 577) he instances the experiment of cleaning the teeth on one side to find out whether the tooth-brush prevented caries. There is an important snag—the subject must sleep on his back. Most of us sleep on the left side, with the result that tartar forms more abundantly on this side, and this may have its repercussion on caries.

### Comfort in Air Travel

Dr. FLORENCE ADAM THOMSON (Ipoh, Malaya) writes: I should like to refer to Part I of Sir Harold Whittingham's refresher course article on air travel (*Journal*, March 7, p. 556). I realize that considerable thought has been given to the design of aircraft seating so that passengers may have reasonable comfort in a confined space. Has it been brought to the notice of B.O.A.C. that, despite this, most passengers are quite unable to rest in comfort in the position allowed, and sleep is quite impossible except in very short snatches? I and many friends of average stature have found that after a journey there is such severe oedema of feet and legs that to walk or work in comfort is impossible for several days. Were a little extra space given on the longer runs, with tilted seating and leg rests similar to that on some American lines, passengers could rest and arrive refreshed even when no night stops are made.

### Slipped Disk

Dr. HUGH GARLAND (Leeds, 1) writes: I am not quite sure when and where the term “slipped disk” was coined, but it has now passed into common usage and indeed it has become one of the stock jokes of the comedian. It is a most improper term, carrying the implication that the whole disk has slipped in some direction in relation to the vertebrae above and below, and there is a popular corollary that, having slipped out, the disk is capable of slipping back. As far as I know such a pathological state has never been seen by the human eye. I think it is our duty to discourage this terminology, and I was perturbed to see the unhappy term used in the *Journal* (“Any Questions?” March 7, p. 575). Syndromes resulting from damage to intervertebral disks have been diagnosed with increasing frequency over the past 15 years, so that to-day the disk lesion is well known to the public. The main change in the disk is one of protrusion, usually of a very localized kind, and to which the terms “herniation” or “protrusion” are very properly applied—but not “slipped.”

### Chlorophyll and Asparagus

Dr. JOHN DICKINSON (London, W.C.1) writes: Dr. John C. Brocklehurst (*Journal*, March 7, p. 541) has suggested that doctors should experiment on themselves with asparagus, to determine whether the smell of their urine is reduced by chlorophyll. Since supplies of this drug are expensive there is a danger that the experiment may be invalid through shortage of either doctors or asparagus, or both. Might I suggest that the Medical Research Council should send regular quantities of asparagus to two large groups of doctors? Half of these could then receive chlorophyll and half act as controls. If the experiment was conducted on a sufficiently large scale, statistically significant results could be of the greatest value to the public. Clearly, several weeks or even months of patient trial would be necessary; but nevertheless I am pleased to offer myself as a volunteer—preferably in the control group.