similar shadow in another part of the lung field, together with a brisk rise of temperature. I no longer have the records of the case, but as far as I remember the blood leucocytes numbered about 20,000 per c.mm., with up to 92% eosinophils. Between attacks the total count was about 5,000 per c.mm., with 40 to 50% eosinophils. There was also anaemia. At all times during the illness, and particularly during the acute pulmonary incidents, the sputum contained very large numbers of eosinophils. The most interesting point about the case is that the patient died a few weeks later in another hospital, where at necropsy the morbid anatomical findings were those of a classical myeloid leukaemia. I did not have an opportunity of seeing the sections myself. Such cases of eosinophilic leukaemia, though rare, are described in the literature. The important point, however, is that in this case a high blood eosinophilia, caused by a primary marrow dysplasia, was associated with what might be considered a Loeffler's syndrome and a marked excretion of eosinophils in the sputum.—I am, etc.,

Liverpool, 7. C. H. JONES.

Ulcerative Colitis

SIR,—I read with interest Sir Robert Hutchison's letter on ulcerative colitis (*Journal*, January 9, p. 98), and, whilst not wishing to venture into the aetiology of the condition, I should like to mention one point of interest.

When Case 4 in Mr. Stanley O. Aylett's series (*Journal*, December 19, 1953, p. 1348) was admitted to hospital there was for some time doubt about the diagnosis in view of her extreme youth (in actual fact she was aged 9 years when first admitted). In view of this, exhaustive tests were carried out and much questioning of the parents took place. Eventually it was discovered that the bowel symptoms were of acute onset dating from a most peculiar incident. She had met her parents returning from a Jewish funeral and had rushed in hysterics to a friend living in a flat in the same block, where she remained at her own request for several days. During that stay her bowel gave trouble for the first time. I am aware that this can be dismissed as coincidence, but at least it is peculiar coincidence.

In all fairness I would say, and I think Mr. Aylett would agree, that none of the other patients in the series could be classified as "emotionally immature."—I am, etc.,

Fowey. MARTIN LUTHER.

SIR,—With reference to Sir Robert Hutchison's plea for the return of appendicostomy and colonic lavage as "far the best treatment" for ulcerative colitis (*Journal*, January 9, p. 98), I hasten to suggest danger. The results of our research in the *x*-ray department at St. Mark's Hospital for Diseases of Rectum and Colon reveal that quite a large number of cases labelled "ulcerative" colitis by the clinician have been shown at *x*-ray examination, and later confirmed by colectomy, to have no ulcers at all. Some of the so-called "fibrous strictures" have been found to relax after the employment of antispasmodics, as recorded at subsequent *x*-ray examination. Those that have had colectomy performed show only hypertrophy of the muscle wall and no fibrous changes. Perhaps most alarming of all has been the finding by Dr. Dukes at St. Mark's of seven microscopic cancers lined up in a section of the colon in a case of ulcerative colitis. Then there is the devastating, rapidly advancing destructive "polypoid" type of colon, studded with numerous groups of polyps, essentially inflammatory in nature, which do not turn malignant, whereas the familial variety do of course. The picture in these cases can alter so rapidly, showing in the beginning an almost normal bowel, and then within the short space of six months present a shrunken colon literally studded with polypi, with practically complete destruction of the mucous membrane. The patient goes downhill rapidly. Such cases are easily demonstrated by opaque enema examinations and especially if reduction density technique is carried out. Then there is tuberculous colitis, the syphilitic colon, the dysenteric colon, and our old friend diverticulosis with diverticulitis which essentially starts as a localized colitis (sometimes preceded by a period of obstinate constipation) and so ending eventually as a state of diverticulosis, with possibly from time to time recurrent diverticulitis. Modern medicine to-day does not approve of such crude methods of treatment as appendicostomy to dissipate seven microscopic cancers, or some of these tragic cases of polypoid colitis.

I have great respect and admiration for Sir Robert's brilliant talents and his numerous contributions to medicine, and therefore, as a countryman of my own, same university, etc., I make the following suggestion with great respect. Might it just possibly be that some of these cases Sir Robert treated with appendicostomy and lavage with such success were cases the clinicians labelled in those days as ulcerative colitis, but in the light of modern advances they were probably only cases of chronic colitis, admittedly of long duration, but not ulcerative ? Indeed, until recently some of the so-called "ulcerative" colitis cases were only labelled "ulcerative" for no better reason than that the course of the illness had been long and uninterrupted over a period of years. I have cases on record at St. Mark's of 5, 10, 20, and 27 years' standing labelled as "ulcerative" colitis, which at *x*-ray examination present a colon with circular and longitudinal muscle tone not far from normal and no signs of fatigue at all, and certainly no ulcers. In other words the clinical classification of "acute," "subacute," and the "chronic" is quite out of date, and in the *Lancet* (January 16, 1954, p. 159) I have briefly described our new *x*-ray classification of colitis which has now been in operation at St. Mark's for some time back.

No, as I see it, ileostomy is only performed essentially as a preliminary, prior to colectomy, and only resorted to in these true cases of ulcerative colitis where medical treatment has failed and appendicostomy or any other form of treatment has proved useless in what really amounts to a disease which is a potential precancerous disease of the colon.—I am, etc.,

London, W.1. NORMAN P. HENDERSON.

Antibiotics in Bacteriaemia

SIR,—In the discussion on antibiotics in bacteriaemia (*Journal*, December 19, 1953, p. 1376) Dr. M. Anthony Peyman states that "it is perfectly possible for a patient to be cured of a bacterial infection by an antibiotic while *in vitro* tests demonstrate the organism to be insensitive to that antibiotic." This rash statement is partly upheld by Dr. A. Lawrence (*Journal*, January 9, p. 100). I know of no satisfactory evidence whatever to support it.

The difference of opinion may be due to lack of definition of "*in vitro* resistance." Unfortunately there is no standard method for sensitivity tests and therefore reports vary from different laboratories. The popular and rapid paper disk method is a good indicator of sensitivity when inhibition zones are large, but it is not always appreciated that small zones, or even absence of inhibition, may not indicate an untreatable degree of resistance. If a weak solution of antibiotic is used to prepare the disks (for fear of overestimating sensitivity) and if the potency of each disk is not controlled on each plate culture, resistance is likely to be falsely reported from time to time. I would not consider a microbe isolated from the blood to be resistant *in vitro* until titration in a serum medium, in parallel with a control strain of known sensitivity, had shown its growth to be unaffected by a concentration of antibiotic higher than that obtainable in the patient's serum.

Cure of a patient suffering from bacteriaemia by a drug which has been reported inactive in the laboratory must not lightly be taken as evidence that conditions in the blood stream favour antibiotic action. It is an indication for further tests on "resistant" microbes, not for submitting patients to large doses of toxic drugs regardless of the laboratory report.—I am, etc.,

London, W.C.1. E. JOAN STOKES.

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