the possibility of breakdown and the difficulty of gauging activity on one film, there is a laudable tendency in some quarters to notify all lesions, however insignificant, in order to facilitate the examination of contacts. It is argued that to refer all such cases causes a great deal of unnecessary worry to the patient and also that chest clinics would become overloaded. Economically it is less expensive to keep the "old scar" under regular surveillance than attempt to find it again by the relatively expensive method of mass radiography. Patients seem to accept this surveillance and even welcome it, and the argument that it causes worry seems to be overstressed.

What other comparatively unexplored methods of case-finding are there? Most clinicians experienced in the management of tuberculosis would agree that to speak of healed or recovered disease is rather glib. Tuberculosis is a chronically relapsing disease, and, once diagnosed, lifelong surveillance is necessary. In the past, and one suspects in some quarters at present, the criteria for regarding the disease as recovered were not as strict as they should have been. How often are laryngeal swabs done as a routine when the patient denies sputum? What, then, could be simpler than for all chest clinics to recall cases discharged from surveillance as recovered or healed and reassess them in the light of modern knowledge? As a minimum requirement chest *x*-rays should show the lesion to be stable and a series of at least three laryngeal swabs or sputum cultures be returned as negative. By this simple and inexpensive means, which involves the time of a clerk and health visitor, I feel a significant number of active lesions would be discovered. What seems most important is that these measures be adopted throughout the country and not confined to certain areas. If the volume of work proves too much, then further appointments should be made, but under no circumstances should the standard for assessment be lowered because of pressure of work.—I am, etc.,

Bournemouth. O. D. BERESFORD.

Pulmonary Emboli Following Artificial Hibernation

SIR,—I have just read with interest the article by Drs. R. S. Lambie, L. G. Joseph, and G. Wilson (*Journal*, April 14, p. 840). I regret that information on post-operative care and examinations was not more detailed. In effect, we think that the use of NaCl pre- and post-operatively is an important cause of thrombo-embolic accidents and various cardio-pulmonary complications. For a year we have instituted a sodium-restricted diet during the first days succeeding operative intervention and wait until sodium excretion has largely reappeared before administering NaCl again. We have no longer noticed thrombo-embolic accidents of the type reported by the authors, and which we previously encountered as frequently after artificial hibernation as after any other method of anaesthesia and resuscitation. The danger of massive transfusions of preserved blood or plasma lies, in our opinion, in the too considerable sodium contribution which they make. We have, however, enlarged upon this subject recently in *Presse Médicale*.[1]—I am, etc.,

Paris. H. LABORIT.

REFERENCE

1 Laborit, H., and Huguenard, P., *Presse méd.*, 1956, **64**, 605.

Femoral Neck Fractures

SIR,—Your contributors Mr. C. G. Attenborough and Mr. H. Osmond-Clarke (*Journal*, April 21, p. 912) in their precise and accurate exposition have failed to present the real clinical problem posed by femoral neck fractures in the elderly. The principal dangers are bedsores and pneumonia, and both these conditions may contribute further to the disorientation and incontinence which often ensue and which further complicate the nursing of these patients. These fractures present a more urgent nursing than orthopaedic problem. Internal fixation by nail or nail-plate is a life-saving measure because it permits mobility of the patient in bed and, better still, allows the patient to be sat in a chair. It is less dangerous to operate than to withhold operation. The more advanced the senility the more urgent is the operation, for without freedom to move without pain old people go downhill very rapidly.

Conservative measures must be reserved for the younger age groups, for it has been shown[1] that without superlative nursing and physiotherapy services some 30% of patients over 70 fail to survive three months of recumbency.—I am, etc.,

Staines, Middx. F. G. WARD.

REFERENCE

1 Evans, M., *J. Bone Jt Surg.*, 1949, **31B**, 197.

SIR,—A few recent experiences in casualty have well endorsed Mr. F. C. Dwyer's observations (*Journal*, May 19, p. 1173) on the ease with which the head of a dislocated humerus may be lifted back into the glenoid by the direct use of the fingers. In one case this was easily successful where other more widely recognized methods had failed. Under anaesthesia it has several times been easy to lift the humeral head directly into place even without traction on the shaft.—I am, etc.,

Carmarthen. A. R. KEMP.

Abdominal Migraine in Children

SIR,—I was greatly interested in Dr. H. G. Farquhar's article on abdominal migraine in children (*Journal*, May 12, p. 1082). It is to be regretted that in the several articles recently written on this subject scant reference has been made to the work of H. C. Cameron[1 2 3] at Guy's in the nineteen-twenties. If Samuel Gee's description is classical, Cameron's description falls little short in lucidity of clinical description. The syndrome would appear from recent articles to have been "rediscovered"; yet most practitioners must be well aware of the condition in its varying presentation. Two clinical features hardly mentioned, but repeatedly pointed out by Cameron, are pallor and amyotonia. These children are frequently brought by their mothers for treatment for their "anaemia," subsequent inquiry revealing that they are sufferers from the cyclical vomiting syndrome. The pallor is often striking, even in the intervals between attacks. Amyotonia is often seen. The child at the beginning of a bout is frequently clumsy, trips easily, and hyperextensibility of the joints can be easily demonstrated. Cameron frequently demonstrated the fact in out-patients that these children, by reason of their poor muscle tone, would be seen leaning against their mothers for support, while other children stood or sat normally. Dr. Farquhar rightly stresses the emotional factor, and might have also added that this is frequently noticeable in one or other parent. It should be realized that minor degrees of the condition are extremely common and that the more dramatic sufferers find their way to hospital under various labels.

Although the pallor of the stools has been shown not to be due to steatorrhoea, it is interesting to speculate whether or no there may not be some connexion between the two syndromes. The early history of adult sufferers from steatorrhoea has not, so far as I am aware, been the subject of detailed inquiry, but sufferers from coeliac disease have many symptoms in common with cyclical vomiting, and their family histories are sometimes similar. The term abdominal epilepsy should be dropped, if only by its implied connexion with the, to the lay mind, more sinister condition. Incidentally, the high fat diet at one time in vogue for epilepsy could hardly prove less suitable for these children. —I am, etc.,

Headley, Hants. S. T. WILLIAMSON.

REFERENCES

1 Cameron H. C., *Lancet*, 1926, **2**, 1244.
2 —— *Diseases of Children*, 1926, p. 102. Oxford Medical Publications, London.
3 —— *The Nervous Child*, 1946. Oxford Medical Publications, London.

SIR,—With reference to Dr. H. G. Farquhar's most interesting paper on abdominal migraine (*Journal*, May 12, p. 1082) and your leading article on children's headaches (*Journal*, May 19, p. 1154), I should like to make the follow-