In this closed community a young child with chicken-pox spread the infection rapidly, as the mother refused to co-operate. About three cases of herpes occurred in this small group.—I am, etc.,

Watford. A. SCOTT.

Polycythaemia Vera

SIR,—In your leading article on polycythaemia vera (*Journal*, December 8, 1956, p. 1354) it is stated that "sporadic venesection, while contributing to the blood banks, is of little benefit to the patient. . . ." From this it might be inferred that such blood could be used for routine blood transfusions. Since the cause of the malady is still uncertain, such a course would appear highly undesirable.—I am, etc.,

Scarborough. KENNETH FROOME.

Rapid Transfusion in Children

SIR,—I was interested to read the article on rapid transfusions in children by Dr. Leslie G. Andrews and David J. Coleman (*Journal*, January 5, p. 19), but would like to add a word of warning.

Knowing my interest in transfusion therapy during the war years, a friend in 1947 reported to me two fatal cases in babies due to cardiac failure caused by rapid transfusion therapy. In neither instance was anything found amiss with their hearts; it was a case of rather too much blood given too quickly. I well appreciate that marked apprehension may develop in young children from frequent transfusions, and the need to avoid interference with schooling where this applies, but I suggest the former is not necessarily reduced by frequent general anaesthetics, and that slower transfusion techniques need not incur a week's absence from school. Back in 1939 the French gave topping-up transfusions in the out-patient clinic, and I submit that 24 hours in hospital should provide ample time to do the job as safely and satisfactorily as any transfusion can be. Treatment of medical conditions by rapid infusions under general anaesthetics should, I submit, be reserved for very exceptional cases.—I am, etc.,

Oxford. HUGH ELLIS.

Sign of Wind in Infants

SIR,—After my fourth child I have again observed a sign which might be of some help if it were more generally known. This is a pallor of the area between the nose and upper lip in infants, which is present when the baby has "wind" and disappears immediately on eructation. When my first baby was born five years ago I observed this sign. I searched paediatric textbooks but failed to find any mention of it, although since then one eminent paediatrician[1] discusses in a recent textbook pallor of the complete face in infants with wind. I have never observed this, but I should be interested to hear of a physiological reason for the sign.—I am, etc.,

Glasgow, E.3. JEAN MCEWEN.

REFERENCE

[1] Illingworth, R. S., *The Normal Child*, 1953. Churchill, London.

Cervical Myelopathy

SIR,—Your annotation (*Journal*, January 12, p. 96) on cervical myelopathy ends by recommending that a means to arrest the vertebral disease should be sought. I agree. Prevention of a major displacement obviously consists in reducing it when it is minor. This should be undertaken at the outset of the disorder, years before there is any question of myelopathy.

When disk-protrusion begins at a cervical joint, it is the established practice to leave the displacement where it is. If, instead, logic were followed and the displacement were reduced at once by manipulation, the best possible would have been done to ensure that myelopathy never developed. When these displacements are small and recent they can nearly always be reduced by manipulation. When they press on the spinal cord enough to cause numbness and pins-and-needles in the upper and lower limbs without objective signs of interference with cord function, they may still prove reducible, sometimes with permanent result. By the time that a root-palsy or a spastic paresis has supervened, manipulation comes too late.

Is it not time that we took the possibility of myelopathy to heart and refused to subject patients with cervical displacements either to heat and massage at the resultant area of referred pain or to a collar applied with the displacement unreduced? These too frequent evasions must result in enhanced likelihood of crippledom later. This is best obviated by reduction carried out at the early stage. Provided anaesthesia is avoided and traction is applied during each manœuvre, there is neither risk nor difficulty.—I am, etc.,

London, N.W.1. JAMES CYRIAX.

Unusual Cause of Obstruction

SIR,—The following case report records an unusual cause of acute intestinal obstruction.

A man, aged 69 was admitted to hospital at 5.30 p.m. on November 29, 1956, moribund. He was vomiting faeculent material profusely, and he died very shortly after admission and before effective treatment could be instituted. At necropsy there was no relevant abnormality except in the alimentary tract. He was edentulous and had marked dilatation of the stomach and small intestine down to within 8 in. (20 cm.) of the ileo-caecal valve. At that level there was a ring of oedematous thickening encircling the gut for 1½ in. (3.7 cm.) of its length, and wedged across the proximal margin of that ring was a thin bone 1 in. (2.5 cm.) long which was beginning to soften at its ends. Firmly pressed against the bone was an unmasticated and undigested whole raw fig completely occluding the lumen of the bowel.

It appeared later that the patient had eaten rabbit on November 25 or 26 and figs on November 28. He was previously of good health, but complained of acute abdominal pain during the morning of November 29. He had dentures, but never used them.—We are, etc.,

B. J. STEPHENS.

Cardiff. J. N. BODGER.

Increase in Scabies

SIR,—Dr. Margaret S. M. McGregor has raised again the question of aetiology of papular urticaria (*Journal*, December 15, 1956, p. 1427). I am quite certain that there is no evidence of scabies or similar infestation in the vast majority of cases of papular urticaria. There is an urticarial response in some cases of scabies, but in these the scabies mite can be isolated. I do this in my scabies clinic by simple needling as advocated by Mellanby, and it is quite a simple procedure. A very credible explanation of the cause of papular urticaria has been put forward in an article by Drs. A. Rook and W. Frain-Bell.[1] They state that "there is strong evidence that most cases of papular urticaria are the result of an acquired sensitivity to the bites of certain insects, particularly fleas and bedbugs." This is a much more likely cause than food allergy.—I am, etc.,

Norwich. E. LISTER.

REFERENCE

[1] Rook, A., and Frain-Bell, W., *Arch. Dis. Childh.*, 1953, 28, 304.

Pregnancy Sickness

SIR,—I have been greatly interested in the correspondence on pregnancy sickness and would like to add my own personal experiences. I have four children. At no time did I have any sickness, but during the first three months of each pregnancy I had a type of nausea that would be more accurately described as acute hunger. It was relieved by small frequent quantities of easily assimilated carbohydrate. I concluded the immediate cause was a low blood sugar, probably due to a metabolic failure to adjust to supporting the foetus. My further experience supported this. I fed all four babies. The last two were difficult to wean and at six months were having little else than breast milk in very large quantities. At this time I experienced nausea exactly the same as that of the first few months of pregnancy and