London, S.E.5. Information supplied would be regarded as confidential and passed on to the committee anonymously after correlation.—I am, etc.,

A. H. GALLEY.

Pancreatitis

SIR,—We would like to comment on the paper of Mr. M. A. Birnstingl (*Journal*, April 11, p. 938). Over the past few years we have had under our care about 40 patients with chronic pancreatic disease, 20 of whom have had a variety of surgical treatments.

We feel that Mr. Birnstingl pays insufficient attention to recent investigative techniques of value in the differential diagnosis of chronic pancreatic disorders. There is little justification for comparing as equally chronic two disorders so different in their time relations as the two compared in his paper. One should not call the disease described under the first heading "chronic" pancreatitis when the average length of symptoms was only 7.6 weeks. True chronic relapsing pancreatitis develops over many years and rarely comes to specialist investigation until symptoms have been present for some years. There is, therefore, little justification for the author's first category of "chronic" pancreatitis, except that derived from a histological report, which, as the outcome of this group of cases showed, was obviously incomplete. We were struck with the apparent assumption of Mr. Birnstingl that the obstructive factor is inconsiderable in chronic relapsing pancreatitis. This is against current general opinion. The obstruction may be at the ampulla, but it need not necessarily be in any major duct, and may be far back in the gland. The recognition of the site of an obstruction or localized disease may be difficult at times, and is a major difficulty in surgery of some cases.

Our experience confirms Mr. Birnstingl's observations that alcohol is an unimportant aetiological factor. Alcohol undoubtedly can cause pancreatic disturbance in chronic alcoholism, and we have seen this not infrequently. In contrast to American experience, our Irish cases are frequently teetotallers, and this is true of the major cases.

We feel that the diagnosis of chronic disease of the pancreas may require, and usually does, a full battery of tests based upon careful clinical appraisal of the case, and supplemented by radiology. These tests will include careful faecal examination, faecal fat determination, radioiodine tagged triolein and oleic acid absorption curves (if available), glucose tolerance curves, and, especially, some variety of the secretin/pancreozymin test. We use Howat's serum test and are most satisfied with it. Other tests, such as vitamin A acetate and alcohol absorption curves, may be of occasional value.

Chronic relapsing pancreatitis is, we feel, not at all so uncommon as is generally assumed. It does not, *at first*, necessarily manifest itself as a major disturbance, but it usually does so eventually. We feel that many patients who manifest the lesser symptoms are missed because the diagnosis is not considered. We are, however, satisfied that with proper tests this diagnosis can often be made with considerable confidence years before it may be confirmed at operation, or by the development of an acute episode of pancreatic disturbance with the well-known features of that disturbance. In addition we feel that sphincterotomy may be of great value if the case is diagnosed early, while the later case with the marked changes arising from chronic obstruction may require excisional surgery. Finally, on a point of nosology, we feel that to call the disease "chronic relapsing pancreatitis" is frequently incorrect, for these patients very often demonstrate persistent, though often slowly progressive, symptoms. In other words the chronicity is evident, the relapse is rarely so notable. There are examples of the relapsing types, but they are in our experience infrequent. It should be remembered that the disease has perhaps a different aetiology (*vide* alcohol) here and in America. We feel that the term chronic progressive pancreatitis may be more useful and more descriptive.—We are, etc.,

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Lumbar Puncture

SIR,—After reading your leading article on lumbar puncture (*Journal*, December 20, p. 1520) I consider it my duty to submit to you a little hint concerning the avoidance of headache after lumbar puncture. I read it some months ago in a German journal[1] and have tested it with satisfactory results up to now in a few cases. After the lumbar puncture (no matter whether for diagnostic or anaesthetic purposes) the needle should be withdrawn a little into the epidural space and 5–10 ml. of isotonic saline (0.9% NaCl) solution should be injected to prevent the leakage of C.S.F. by increasing the pressure in the epidural space. I hope that this simple procedure, if not yet known in Great Britain, may prove helpful.—I am, etc.,

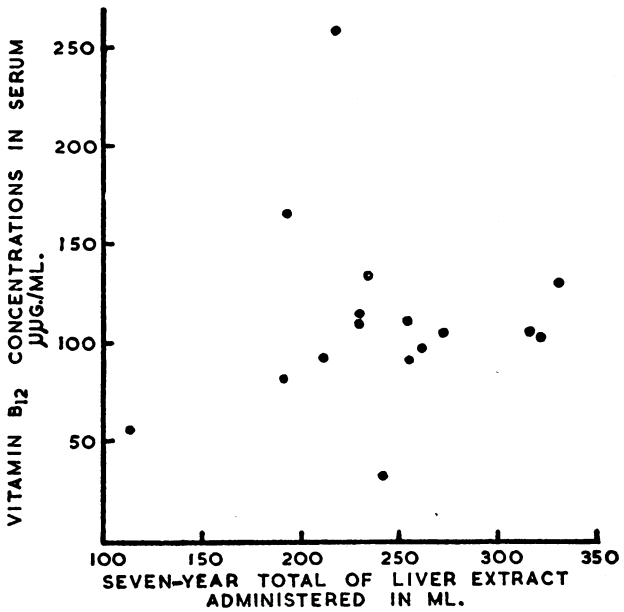
Berlin. J. E. ROLLENHAGEN.

REFERENCE
[1] Harrer, G., *Medizinische*, 1958, **29**, 1132.

Subacute Combined during Liver Therapy

SIR,—Drs. J. F. Adams and G. C. Timbury in their article (*Journal*, March 28, p. 833) illustrate the sad consequences resulting from the use of liver extracts of unknown potency. One cannot but agree with all the points they make.

We have recently been assaying (by the *Euglena* method) sera of patients who have been receiving injections of a "high potency" liver extract for a period of at least seven years. The total amount of liver extract administered over the last seven years corresponded roughly to the medium to maximum recommended by the manufacturers for maintenance therapy (2 to 4 ml. every four weeks = 182–364 ml. in seven years). In fact, during this period the patients received amounts varying from 112 to 328 ml. The



intervals between injections, however, were in some cases longer than 4 weeks (5, 6, or even 12 weeks).

From the Figure it can be seen that all but two of the 16 patients—randomly selected from a larger group of similarly treated individuals—had subnormal values of serum B_{12}. Six of the patients had serum concentrations less than 100 $\mu\mu$g./ml., and the one with the lowest level (36 $\mu\mu$g./ml.) had a relapse of megaloblastic erythropoiesis (Hb 8.6 g., P.C.V. 27%). Owing to an intercurrent illness, this latter patient had missed the last of her periodic injections before the blood count and assay.

The strength of this high potency liver extract was not stated by the manufacturers. An assay carried out by us gave an approximate B_{12}-content of 10 $\mu\mu$g./ml., making the seven-year total received by the patients 1,120 to 3,280 μg., which is well below the maintenance dose recommended by Mollin and Ross.[1]

From these observations it is obvious that it is highly important to know the vitamin-B_{12} content of any liver extract used, and to adjust the doses and intervals between the injections accordingly. Unless this is done, patients treated with liver extracts will find themselves earlier or later on the brink of a haematological relapse and/or of a neurological complication.—I am, etc.,

City General Hospital, Sheffield. S. VARADI.

REFERENCE

[1] Mollin, D. L., and Ross, G. I. M., *Brit. med. J.*, 1953, **2**, 640.

Children's Footwear

SIR,—A few years ago I was examining a 10-year-old girl at an orthopaedic school clinic. I noticed something most unusual about her feet; all her toes were perfectly straight! I am therefore not altogether surprised that Dr. Daphne Sasieni (*Journal*, March 14, p. 720) has failed to see a single child over 3 years old with ten straight toes.

No one doubts that badly fitting shoes can cause harm to schoolchildren's feet, and I would like to see shoe manufacturers make a real effort to vary their fittings, as at present they are quite inadequate, even in the most expensive footwear. Faulty shoes cause most damage to feet already affected by hallux valgus, hammer toes, and other deformities. I can never understand why it is difficult to believe that, just as the shape of the face and hands is inherited, so is the shape of the foot and toes. However, let us have a sense of proportion. Most deformities of the feet and toes are developmental, and it will be necessary to alter the genes rather than the child's footwear in order to prevent them.—I am, etc.,

Halifax. GEOFFREY HYMAN.

Early Diagnosis of Mental Defect

SIR,—In the correspondence between Dr. Brian H. Kirman (*Journal*, January 3, p. 50) and Professor R. S. Illingworth (*Journal*, November 29, p. 1355) on the subject of the early diagnosis of mental defect, Professor Illingworth has aptly made the points that a diagnosis of mental deficiency is not made on the basis of bad or abnormal behaviour but on the basis of a complete diagnostic evaluation, and that gross motor behaviour is not an adequate criterion of intellectual development. Although we feel it is inadvisable to make an unqualified diagnosis of mental deficiency to parents in the first year of life, there is one advantage to early evaluation of development with which Dr. Kirman would agree. It gives parents a reasonable guide for current expectations, so that the adverse environmental factors, either over-protection or pushing beyond the child's capabilities, will be minimized and the maximum potential of the infant more readily realized.

Beyond this, however, studies that we have done—the details of these examinations with a bibliography appear in the January, 1959, issue of *Pediatrics* in a letter to the Editor—indicate that when care is taken to eliminate bias and the infant examination is used as a clinical neurological tool by a physician adequately trained in its use, it is as satisfactory a predictor of later development as any psychological examination done at 3- to 7-year intervals. This approach of the Gesell Developmental Examination has not been employed by the psychologists who developed or used the tests which form the basis of the reports in the literature quoted by Dr. Kirman. They have been concerned rather with predicting precise I.Q.s in relatively homogeneous groups of infants. Ignoring the fact that infant behaviour as well as socially learned later behaviour both have their roots in the central nervous system, which operates throughout the life span of any individual, has led them to the erroneous conclusion that "infant testing" is invalid.

When the matter is approached from the medical viewpoint, correlations ranging between 0.5 and 0.75 between infant and later examinations have been found in four large groups of infants evaluated initially by the Gesell Developmental Examination and re-examined between 3 and 7 years of age. Gratifying as the predictability is, however, predicting school age I.Q. is not the major objective of the infant evaluation. Its two most important functions are, first, to make a diagnosis of the normality or abnormality of neurologic functioning, and, second, to detect those infants with a developmental potential that is below normal, usually on an organic basis. As clinicians we would feel that an examination which would allow us to make the following statement is an eminently acceptable and useful tool: "This infant has no neurologic impairment, and his potential is within the healthy range; depending on what his life experiences are between now and 6 years of age, he will at that time have a Stanford–Binet I.Q. above 90, unless qualitative changes in the central nervous system are caused by noxious agents, or gross changes in *milieu* alter major variables of function."—I am, etc.,

Clinic of Child Development, The Children's Hospital, Columbus, 5, Ohio. HILDA KNOBLOCH.

REFERENCE

[1] Knobloch, D., *Pediatrics*, 1959, **23**, 175.

Medicine on Television

SIR,—I feel I must comment on the unsuitability of recent television dramas on a medical theme. In the past few months we have witnessed such specialized procedures as corneal grafting, replacement transfusion in erythroblastosis, and a rather disrespectful necropsy, amongst other things.

Whilst a certain amount of education of the public is very salutary, such medical technicalities do *not* constitute an evening's entertainment, and I feel that the choice of such subjects only undermines the vital relationship between the patient and his doctor and also confuses the attitude of the patient to his illness. Let there be well-informed documentaries, by all means, for the discerning viewer, but surely there should be stricter