A child totally unconscious from whatever cause is a different problem, though again the anaesthetist may be of use in resuscitation and control of oxygenation during the operation.—I am, etc.,

Central Middlesex Hospital, London N.W.10. CONSTANCE C. M. HOWIE.

Bulbar Polio in Pregnancy

SIR,—Despite advances in treatment during the past decade, the outcome of a severe attack of poliomyelitis is always problematical and the mortality high. Nevertheless, there is general agreement on the value of the basic principles of postural drainage and tracheostomy with intermittent positive-pressure respiration when swallowing and breathing are affected. It is astonishing, therefore, that Mr. M. B. Wingate and Drs. H. K. Meller and G. Ormiston (February 11, p. 407) did not apply these well-established techniques when presented with a woman who could neither swallow nor breathe effectively. To prop up such a patient increases the danger of inhalation pneumonia and especially when there is a history of vomiting. Induction of labour merely adds to the demands already made on the failing respiration. Surely the belated advice offered by the authors, that "section is imperative when breathing becomes affected, and in this event tracheostomy and some form of mechanical aid to respiration are mandatory," is the only course to adopt in such cases.—We are, etc.,

Coppetts Wood Hospital, London N.W.10. R. T. D. EMOND.

Royal Free Hospital, London W.C.1. A. MELVIN RAMSAY.

Oral Treatment of Diabetes

SIR,—Two statements concerning diabetes mellitus in recent numbers of the *Journal* deserve comment, as they complicate what is a relatively simple matter. In a leading article (January 21, p. 188) you state that, when diabetes is controlled by diet and sulphonylureas, "diabetic control cannot be properly assessed if the only specimens of urine tested for glucose are those passed before breakfast; these merely reflect the lowest blood-glucose concentration." It is suggested that a specimen of urine passed two or three hours after a meal should also be tested.

Efficient simple control is important in many patients benefiting from this form of treatment, and the multiplication of tests does not contribute to this. The interpretation of the results by a patient (or even a doctor) of two tests, one negative and the other positive or negative, is not as simple as a single "all or nothing" test for glycosuria. Many of these patients will show a negative test for glucose in the second pre-breakfast specimen. What happens the rest of the day is immaterial, provided a test at the same time is negative the following morning. Efforts to render all the tests throughout the day clear of glucose invite the risk of hypoglycaemia.

That this approach is effective depends upon the fact that mild diabetics relapse very slowly, as is shown by the fact that a single injection of short-acting soluble insulin is very often effective in giving adequate control. If then it is accepted that it is sufficient to examine the second pre-breakfast urine specimen for the presence or absence of sugar, the second statement, in reply to an "Any Question ?" (January 7, p. 67), that "test papers should not be used by diabetics," becomes invalid. These test papers are not prescribable on an E.C.10, though they may be prescribed for hospital out-patients. Clearly they should be made available on prescription by general practitioners for the purpose described above.—I am, etc.,

Liverpool 1. EWAN F. B. CADMAN.

Over-stretching the Temporo-mandibular Joint

SIR,—Whilst the letter of Mr. J. M. Foreman (December 24, p. 1889) and the subsequent replies of Mr. R. R. Stephens (January 21, p. 207) and Mr. J. H. Sowray (January 21, p. 208) point out the danger to permanent incisors during tonsillectomy when a Boyle-Davis gag is in use, and stress the need for dental co-operation as soon as it can reasonably be obtained, they ignore a far more serious hazard to the patient. I refer to damage to the temporo-mandibular articulation, caused by over-opening with consequent pulling forward of the condylar head and rupture of the posterior attachment of the inter-articular disk.

The voluminous literature on arthrosis of this joint during the last twenty-five years underlines at once the frequency and difficulty in treating these cases. Hankey in his classical paper[1] reported that 20% of cases were due to extrinsic trauma; and forced opening under general anaesthesia will account for some half of these cases.

Dental surgeons are well aware of this danger and support the jaw whilst applying exodontic force. However, throat surgeons and anaesthetists do not show the same realistic approach. It would be well if the suggestion of Mr. Stephens for a round-table conference to improve gag design was implemented. There are few instruments which require greater care in their use. However, until such a conference can be held, it would be well if a dental surgeon could see all cases where forced opening of the mouth under general anaesthesia resulted in subluxation or post-operative pain in the temporo-mandibular joint, as well as those cases where there was actual dislocation or damage to teeth.—I am, etc.,

Dental School, University of St. Andrews. D. C. HALL.

REFERENCE

[1] Hankey, G. T., *Brit. dent. J.*, 1954, **97**, 249.

Tooth Reimplantation

SIR,—I have read the correspondence on the above subject with much interest, and I heartily endorse the plea made by Mr. R. R. Stephens (January 21, p. 207) for an improved design of anaesthetic gag. I disagree, however, with some of the dogmatic statements which he makes, and I feel that the medical profession should realize that the prognosis for such teeth is not invariably gloomy, nor is their loss easily compensated.

It is not my intention to enter into lengthy discussion on the detailed points in your columns, as I feel that these considerations fall more properly within the province of the dental surgeon, but I would disagree in particular with his advice "that if a central incisor is knocked out . . . the patient's interests will be best served by omitting to replace it." I believe the best course of action would be for the anaesthetist concerned to seek advice from a dental consultant, and, if this is

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