

be an expression of his and his committee's personal opinions and not the conclusions of their inquiry. A firm statement that legislation should be delayed till the committee has finally reported should again be made and should be addressed not only to political parties but private members of both Houses. In order to remove all taint of prejudice from the B.M.A. special committee, it may be desirable to convene a new committee under a different chairman, though those who encouraged this precipitate action by the Council are probably more to blame.—I am, etc.,

Birmingham 15.

MYRE SIM.

** The wording of the A.R.M. resolution was: "That, in view of the present agitation for reform in the law concerning abortion, (1) the Council of the B.M.A. should set up a special committee to evaluate the therapeutic indications; (2) the Government should be asked not to introduce any new legislation until this committee has reported."—Ed., *B.M.J.*

Diagnosis of Hysteria

SIR,—Having enjoyed Dr. Slater's Shorvon lecture (29 May, p. 1395) and the masterly defence of hysteria by Sir Francis Walshe (18 December, p. 1451), I am sure that many physicians must be grateful, as I am, to Sir Francis for his stand in defence of hysteria as a diagnostic label. His arguments are of course incontrovertible, but your own editorial, "Eclipse of Hysteria" (29 May, p. 1389), admits the findings of the General Practice Survey¹ that no less than 5.5% of cases examined by psychiatrists in over a million people surveyed were diagnosed as hysteria. This indicates that the diagnosis is by no means rarely made even by psychiatrists nowadays. Even though hysteria may not be common in the rarefied atmosphere of Queen's Square, even Dr. Slater had to admit this diagnosis in seven cases in his series, and he omitted to mention that many such cases never reach the psychiatrist or neurologist at all, as every doctor knows.

What is diagnosis but a label of identification of a disturbance of health requiring the advice of a doctor to patient or relatives? As long as such disturbances of health can be termed illnesses, as most doctors will agree, so long will the diagnosis of hysteria withstand the test of time, but it is nevertheless comforting to have the support of so distinguished a name as Sir Francis Walshe in reasoning along these lines.—I am, etc.,

Windsor.

PHILIP WILLCOX.

REFERENCE

- ¹ Watts, C. A. H., Cawte, E. C., and Kuenssberg, E. V., *Brit. med. J.*, 1964, 2, 1351.

Smallpox Vaccine in Plastic Tubing

SIR,—Dr. C. Kaplan in his letter (25 December, p. 1549) states that there have been complaints about the difficulty in manipulating the new type of plastic tube packed vaccine lymph. I have found the manipulation is much facilitated if the lymph tubing is taken off the card on which it is delivered

and wound on to a small adhesive plaster spool.

The type of spool found best is the small size metal spool which contains 1 yard of half-inch adhesive tape and which fits into an outer metal case. A small hole is made in the outer case. The plaster is removed, leaving only two rounds on the spool to be used for anchoring the end of the lymph tube. The lymph tube is wound on to the spool and the end two doses pushed through the small hole in the outer case. The spool is then pushed into its outer case. When vaccinating, the individual dose is not severed from the spool until the vaccination has been done.

While on the subject of vaccination, I have found that multiple-pressure vaccination with a disposable No. 1 intramuscular needle is much easier if a handle is made for the needle by cutting down a 5 ml. or 10 ml. disposable syringe. A stiff paste of Polyfilla or other suitable filler is placed in the barrel of the syringe, and the plunger after being wetted is used to pack the filler into the syringe and down the nozzle. The compressed filler should reach to about the 3 ml. mark. The syringe is then sawn through about a quarter-inch above the rubber washer. The stump of the plunger is withdrawn, reversed, and reinserted, and pushed home into the filled syringe stump so that the rubber washer is outwards and almost flush with the end of the syringe. The end of the nozzle can be sealed with a spot of plastic glue.—I am, etc.,

Milton,
Portsmouth, Hants.

E. D. B. WOLFE.

Diets for Peptic Ulcer

SIR,—One must agree with you (9 October, p. 834) fully that a reappraisal of the established practice of the traditional dietary regimens in the treatment of chronic duodenal ulcer is overdue. Where one would depart from you a little is your emphasis on liberal "antacid" treatment and rest combined with frequent small feeds in the active stages of ulceration as the treatment of choice.

I have been interested in the protective action of saliva in the causation of peptic ulcer for a number of years, and on the basis of epidemiological¹⁻³ and experimental evidence⁴⁻⁶ I had found that the pattern, not only of diet but also of eating, influenced certain properties of saliva—namely the quantity, buffer capacity, and the mucin content. In general, the total quantity, the buffer capacity, and the mucin content are increased in the saliva produced with diets requiring proper mastication but not so with foods which are bolted down. Ulcer is rare in populations habituated to "masticatory" diets rich in cellulose and vegetable fibres, but the reason for this is not clear.

Since peptic ulceration is the result of local breakdown of duodenal mucosal resistance in the face of what is usually an increased acid-pepsin aggression or diminished mucosal defence, I suggested that saliva of a higher buffer capacity and in larger total quantities swallowed with certain types of food might check that cause.¹⁻⁶

During the past few years patients with peptic ulcer, both gastric and duodenal, have been treated by me only on "masticatory" diet and on an ambulatory regimen, without antacids and anticholinergics. This showed that not only the immediate relief but also the long-term results were gratifying, provided the patient gave up "meal-scamping" and masticated his food well. The result of the chewing movements of

the jaws is an increase in the bicarbonate content of saliva,⁵⁻⁹ which enhances its buffer capacity.⁴ Orthodox medical treatment has little effect upon the long-term course of peptic ulcer. Controlled trials have shown the futility of Sippy diet, alkalis, continuous milk drip, and sedatives^{10,11} and anticholinergics.¹² This is to be expected if the patient goes back to his original sloppy diet. As your reference¹³ rightly states that food is both an antacid and a stimulus to acid secretion (and since the highest acidities of all are reached during the digestion of food and not when the stomach is empty¹⁴), frequent meals, especially of sloppy foods, which do not exploit the physiological device to counteract acid, in the form of salivary buffer, but depend only upon their own buffer action, would heal an active ulcer but are not likely to produce long-term results; in addition to being inconvenient.

Since infrequent masticatory meals (without antacids or anticholinergics even on an ambulatory regimen) have given good immediate as well as long-term results, I feel there are grounds to extend this concept for a critical study. In this the frequent sloppy feeds, rest, sedatives, and anticholinergics would be replaced by three main meals of foods which have to be masticated well—and would thus produce saliva of a higher buffer capacity and in larger total quantities. All that this may require is a change in the pattern of eating, or perhaps also in the methods of cooking, but not necessarily in habitual "normal" diets, with the possible exception of providing some cellulose and fibre content.

—I am, etc.,

Jagjivan Ram Hospital,
Bombay 8, India.

S. L. MALHOTRA.

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Death after Shipwreck

SIR,—It appears from the article on "Death after Shipwreck" by Dr. W. R. Keatinge (25 December, p. 1537) that it is accepted that swimming accelerates the onset of hypothermia.

Channel swimmers have often been in the water longer than 12 hours, swimming vigorously nearly all the time, and come out little the worse. The temperature is unlikely to be above 15° C., and they wear little clothing, though greasing the body is, I believe, usual. Is the use of grease likely to help survival, or is there some other explanation for the seeming paradox?—I am, etc.,

Loughton, Essex.

H. B. LEE.

SIR,—In his examination of the deaths following the shipwreck of the *Lakonia*, Dr. W. R. Keatinge (25 December, p. 1537) reaches the conclusion that the majority of lives were lost through hypothermia and shows that this can be retarded by entering

the water with sufficient clothing. This is presumably because the clothing retains the same water next to the body, thus holding a local volume of warmed water and reducing body heat lost. However, one fact that deserves closer examination is that many people died in the lifeboats of rescuing ships, after having survived long immersion, before a hot bath could be given to raise body temperature. This is presumably because of the increased cooling effect of evaporation from the body and wet clothing after removal from the sea, which will be greater than when the body was immersed in the water and had approached the equilibrium conditions described above. One obvious way of reducing the time between withdrawal of the body from the water and hot baths is to bring the rescuing ship very close to the stricken ship—the *Montcalm* was one or two

miles away from some of the lifeboats and this must have contributed to the loss of life. Also the time that the survivor is in the lifeboat could be used with advantage—clothes could be removed and the body rubbed vigorously. Another possibility worthy of experiment, perhaps, is not to remove the body from the sea, but to tow it slowly to the rescue ship.

The reduction in body cooling between being discovered and a hot bath is obviously vitally important in preventing death from hypothermia, and this is an area in which rescuing ships' crews should be instructed in the way that Dr. Keatinge calls for more instruction to passengers in standard passenger lifeboat drill.—We are, etc.,

SYBIL D. D. JONES.
L. BONVINI.

Tiverton, Devon.

New Apparatus for Chest Units

SIR,—Tracheostomy with positive-pressure respiration in the management of acute respiratory failure is now well-recognized practice. Although tracheostomy is a life-saving procedure, it is not without serious complications. Tracheal necrosis, tracheal stenosis, and aspiration bronchopneumonia are complications which follow the use of a single cuffed tube.

With this in mind, a double-cuffed tracheostomy tube has been devised (Fig. 1). In use each cuff is inflated alternately for a period of 30 minutes. This avoids prolonged localized pressure on the tracheal rings and maintains a constant block to the aspiration of pharyngeal secretions. It has been found very satisfactory in the management of crushed chests and multiple injuries. This tube is made for me by Portland Plastics Limited, Hythe, Kent.

In the management of crushed chest injuries the speedy and effective drainage of blood and air from pleural cavities is another essential step. This is achieved very effectively by using a self-tapping double-balloon catheter (Fig. 2). This catheter has a whistle tip, staggered eyes, and an initial length of 6 in. (15.2 cm.). The balloons afford stability and air seal, one being inside and the other outside the chest wall.

The catheter can easily be introduced through a stab wound in the chest wall, and

is usually inserted as far back as the mid-axillary line, preventing pooling of blood over the posterior thoracic wall. This catheter, which is available in a sterile pack, is made for me by J. G. Franklin & Sons Ltd.—I am, etc.,

Orthopaedic and Accident P. D. SALPEKAR.
Department,
Preston Royal Infirmary.

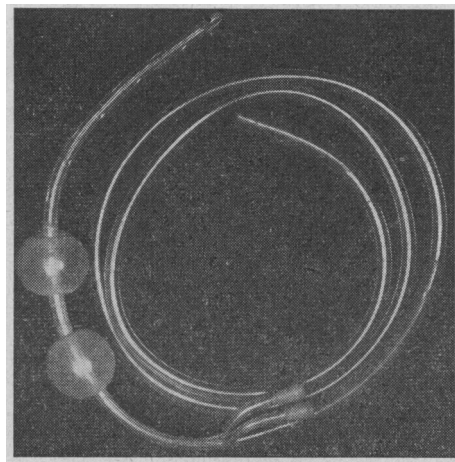


FIG. 2.—Self-tapping chest catheter with double balloon.

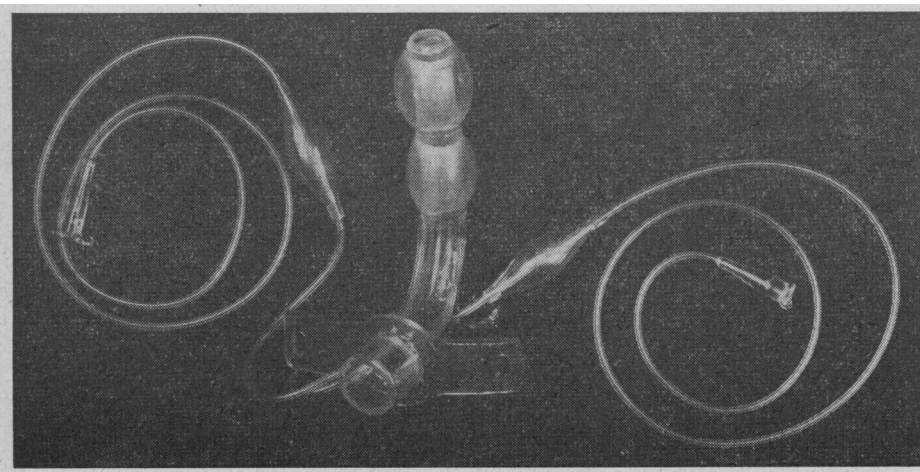


FIG. 1.—Double-cuffed tracheostomy tube.

Prevention of Heart Disease

SIR,—Although there has been published in recent years a huge mass of material on ischaemic heart disease, relatively little has been said about prevention. One obvious reason for the seeming neglect is that as long as we remain in the dark about causation we cannot deal satisfactorily with prevention.

The paper by Dr. M. F. Oliver and Professor C. H. Stuart-Harris (20 November, p. 1203) is a worthy attempt to stimulate interest and action. When a few years ago I was bold enough to make a similar attempt at the Royal College of Physicians there seemed little enthusiasm—and my effort hardly enhanced it. One distinguished cardiologist said it was too soon to talk of preventing coronary heart disease—we didn't yet know enough for that. Perhaps now the time is nearly ripe.

From the multitude of studies one thing at least seems clear: atherosclerosis arises from a combination of causes. The problem is to learn their nature and assess their relative strength. Statisticians and clinicians have taught us much, and they are unlikely to add significantly to our knowledge. The work of epidemiologists, biochemists, and nutritionists offers much promise.

Oliver and Stuart-Harris call for the establishment of an organization for regular physical examinations, and it does appear that the long-term studies of large groups of people are valuable. Framingham is teaching us that. Family doctors everywhere can provide valuable data, but their efforts need co-ordination through such bodies as the colleges of general physicians. That sort of thing is already in train.

Health education has an important place, but it presents many difficulties. Simple rules are best; there is danger in complexity. "Orderly living" is perhaps too concise a piece of advice—and too vague—but it covers about all we know. Just what is "orderly" needs elaboration. So far it appears that obesity and sloth are the main hazards. "Eat less and exercise more": those are two things health authorities can well publicize.—I am, etc.,

Adelaide.

A. R. SOUTHWOOD.

Insanity of King George III

SIR,—An impression one receives from Dr. Ida Macalpine and Dr. R. Hunter's learned and convincing reassessment of King George III's illness (8 January, p. 65) is that it is somehow more respectable to undergo a spell of hallucinations, delusions, and rambling over-talkativeness when such a mental state is caused by porphyria than when the cause is a manic-depressive disorder. Why should this be so? Undoubtedly we are considerably influenced in our attitudes by the absence or presence of an established physical aetiological factor and by the relative possibility of a cure—this explains, for example, why consumption has lost its erstwhile disgrace. If we are rational the factor of hereditary predisposition should not influence our attitude, because this is involved in every type of illness to a lesser or greater degree. In porphyria, according to Goldberg and Rimington's figures,¹ only about 50% of the cases developed mental symptoms, and