tion of cases of mitral stenosis should provide the proof, however.

An additional slight corrective may be worth while in case nihilistic conclusions be drawn on the therapeutic value of cardioversion. As it is emphasized in the title, at least, the evidence presented only refers to right ventricular output. If true, my alternative explanation of reduced benefit in patients with symptoms implies there could still be full benefit for left ventricular output.—I am, etc.,

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Newcastle upon Tyne.

Infectious Diseases as a Specialty

SIR,—Your leading article (7 January, p. 2) has stimulated a brisk response, and sound points were made by your correspondents (21 January, pp. 170 and 171). The specific infections diphtheria, smallpox, and meningococcal meningitis were mentioned. I now present poliomyelitis as another illustration of the problem.

Paralytic poliomyelitis appears to have become an epidemic threat because of improvements in our living conditions; developing countries share this danger as their conditions improve, as can be seen by the emergence of epidemic poliomyelitis in several countries of Africa. Disease due to poliovirus is controllable, perhaps ultimately eradicable, by general and sustained immunization programmes. Decline of the disease as a result of immunization is followed by loss of interest by the public (and potentially by medical profession and administrators). Within sight of victory, inadequate immunization of a new generation results in the accumulation of pockets of susceptibles in which brush-fire outbreaks can occur (and have done so on several occasions in Britain).

Each case, sporadic or associated with others, paralytic or otherwise, presents a diagnostic problem requiring both clinical skill and virological assistance. Is the illness compatible with poliomyelitis? Is the patient infected with poliovirus? If so, of what type, and is it a "wild," "vaccine," or variant strain? If not, is there some other infection—for example, Coxsackie virus A7? In any case, do the findings suggest that the virus is the cause of illness or merely coincidental? What was the source of infection? What is the status of and what are the possible implications for the contacts and wider community? Is this a sporadic case or the forerunner of an outbreak or epidemic? Is there evidence to suggest that vaccine was ineffective or unsafe? How may all of this be most effectively and rapidly investigated and evaluated, and what control measures may be necessary or possible?

Clinical management of the patient requires the normal medical and possibly surgical skills—perhaps involving a short or permanent period of mechanical respiration—together with such special measures as are necessitated by the infectivity of the patient.

If the above train of thought and pattern of action are unfamiliar to others then there is a need for infectious disease specialists to whom they are not.—I am, etc.,

N. R. GRIST.
University of Glasgow.

Economics of Cosmetic Surgery

SIR,—After reading "What Price Anaesthesia?" (12 November 1966, p. 1190) I am tempted to ask, "What Price Plastic Surgery in Prison?" Lord Stonham, Parliamentary Under-Secretary at the Home Office, recently gave details of cosmetic surgery being carried out at three British prisons to remove obscene and particularly prominent tattoo marks on prisoners. This was in reply to a Labour M.P., one of whose constituents had complained that the operations could be done in prison but not under the National Health Service.

Apart from the undesirability of removing identity marks, has the question of cost been considered? In an investigation recently the cost of a simple appendicectomy was nearly £10, but I do not know if this includes medical personnel. Inclusion of this might double the cost. The long-suffering British taxpayer has to foot the bill for this psychiatric experiment and is entitled to ask if the money and time are being profitably spent.—I am, etc.,

E. F. WILSON.
Plymouth,
Devon.

Casualty Management

SIR,—Problems of management[1] culminate in the casualty department, where diagnosis and treatment of a large number of patients on first attendance is carried out. In doing so it has to co-ordinate all the specialized services of the hospital. Also the requirements of many civilian authorities have to be considered. "The emergency situation" is not confined to the community and similarly the casualty department often has to do work arising in the hospital which cannot be otherwise departmentalized. The department is in every way an integrating body within the hospital and between the hospital and the community. There is hardly any aspect which is not dominated by immediate problems of management.

The casualty officer is continually estimating the order of importance of social and administrative demands. To do this, diagnosis must be made with certainty, and a regular and orderly mobilization of the resources for treatment and disposal must follow; he should know their potential and disposition. This involves an alteration in orientation from "everything for this patient now" to "what is best for the most," and the casualty officer must ensure this latter by keeping one eye on the department as a whole as well as one on the patient. The requirements of the essentially individual approach of "clinical consultants," "specialist assistants," and "general practitioners" advocated for the staffing of casualty departments by the Sir Harry Platt and Robert Platt reports are necessarily uncompromising and merely embarrass the equable management of the mass situation.[2]

Surely in every way the paper on management functions[1] supports the contention of the senior casualty officers that "top management" in the department can only be achieved by establishing a career structure to the level of "consultant in charge of a medical service department."

It is pleasing to see that this same paper finds anxiety in patient and staff distinguishes hospital management from that of other concerns, and this certainly accords with the circumstances of casualty work,[3] but it is surprising that having done so no mention is made of personnel selection. It is in context to quote a combatant Service officer: "Under fire there are three mutually incompatible and mutually indispensable types, those who 'go it alone,' those who 'take over the organization,' and those who 'take over the management.'" Whether or not there is any psychological foundation to this classification it certainly has relevance to the present administration of casualty departments.

Personnel selection should take precedence over academic ability, but, whatever the outcome of the casualty problem, I must say (as a "go it alone") that anxious and rigid management—the attitude that nothing must happen without my personal "say so"—is crippling to any organization. In medicine anxiety is born of inexperience, and it becomes necessary for the administrative authority in casualty to participate in the emergency work.—I am, etc.,

E. P. ABSON,
Secretary,
Senior Casualty Officers' Committee.
County Hospital,
Ryde, Isle of Wight.

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1 *Management Functions of Hospital Doctors*, Ministry of Health, 1966, H.M.S.O.
2 Abson, E. P., and Caro, D. B., *Lancet*, 1965, 1, 1158.
3 —— ibid., 1961, 2, 1256.

Leucine-sensitive Hypoglycaemia

SIR,—We were interested to read the article of Dr. D. B. Grant *et al.* (17 December 1966, p. 1494) reporting the abolition of leucine-induced insulin secretion in a child with leucine-sensitive hypoglycaemia treated with a combination of diazoxide and chlorthiazide.

We have treated two such patients with diazoxide alone and have shown a similar failure of the blood insulin to rise following leucine loading. Treatment in one patient had a satisfactory hyperglycaemic effect, but had to be abandoned after six months because of generalized hirsutism which caused parental distress. In the second patient a satisfactory hyperglycaemic effect has been achieved over a period of 12 months, and there have been no side-effects, apart from mild hirsutism. A full account of these two cases is to be published.[1]—We are, etc.,

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P. H. W. RAYNER.
Children's Hospital, Birmingham.
L. STIMMLER.
Guy's Hospital, London S.E.1.

REFERENCE
1 *Arch. Dis. Childh.*, in press.

Cervical Cytology

SIR,—We were interested to read the report from Darbishire House Health Centre (10 December, p. 1454) describing the poor response of women when invited to attend for a cervical smear examination.

We have had a similar experience in Oxford.[1] Some months after a programme of population screening for carcinoma-in-situ of the cervix had been introduced a pilot study in two repre-

sentative city practices was undertaken in order to determine the possible demand for screening. A list of women patients in these practices was compiled with the help of a clerk from the health department. A letter was sent to these women informing them that, if they completed the enclosed application card, arrangements would be made for them to have a cervical smear examination by their own doctor. In one practice 196 parous women in the 35–44 age group were approached and a 50% response was obtained. In the second practice all the 263 women between the ages of 25 and 59 were contacted, with a response of 31.6%. Three months after this initial effort the 180 non-responders from the second practice were again invited to apply for examination. They were given the opportunity of choosing between attending a clinic taken by their own doctor and one taken by a woman doctor on the staff of the health department. A 20% response was obtained to this second approach, half of the women wishing to be examined by their own doctor. The total response to these approaches was 43.3%, 114 out of the 263 women finally requesting a cervical smear examination.

We would agree that there is considerable "consumer resistance" to this service. We estimate that only 43% of the annual target towards a five-yearly screening programme of all Oxford women over the age of 20 years is now being achieved. This figure includes not only women attending cytology clinics but also those who are examined at gynaecological and postnatal clinics, as hospital in-patients, at Family Planning Clinics, and by their own doctors. There is therefore much to be learned regarding the most practical and economic method of reaching women at special risk of developing carcinoma of the cervix.

One of the disadvantages of the "do-it-yourself" vaginal pipette technique, quite apart from its reported poor specificity and absence of visual inspection of the cervix, is that other gynaecological abnormalities remain thereby undetected. Among the 5,217 women examined to date at our local authority clinics, 345 other abnormalities requiring treatment have been discovered. It has also been our experience that many women seek reassurance and advice through the cytology clinics for symptoms about which they have previously felt unable to consult a doctor.—We are, etc.,

CATHERINE E. HALL.
J. F. WARIN.

Health Department,
Oxford.

REFERENCE

1 Hall, C. E., and Warin, J. F., *Med. Offr*, 1966, **116**, 181.

Charming of Warts

SIR,—As Dr. A. Lyell (24 December 1966, p. 1576) cannot exclude, while Dr. R. P. Goulden (7 January, p. 50) seems definitely to include, emotion as a factor in the process, the matter should be carried further, for the custom has had its pragmatic sanction professionally recognized. Nearly 50 years ago the late Professor Millais Culpin—the best clinician I have ever known—told me that in his early days at the London Hospital warty patients were regularly referred to a certain nursing-sister, who successfully charmed the warts away.[1]

Tradition, like intuition, is based upon forgotten experience, and should not be ignored by the scientist.

Since people can produce these little growths with or without a virus, and can shed or withdraw them spontaneously or apparently under emotional direction, why and how does it all happen? What mechanisms are involved? Might not a better understanding of them throw light upon the problems of less innocent growths?—I am, etc.,

Southsea, Portsmouth. W. S. INMAN.

REFERENCE

1 Inman, W. S., *Brit. J. med. Psychol.*, 1951, **24**, 267.

Morbilliform Rashes

SIR,—Reporting two instances of a morbilliform rash following a course of ampicillin in my practice to the Committee on Safety of Drugs, I learn that out of 200 reports to them of adverse reactions associated with the use of ampicillin "175 have been of a skin reaction, and of these 22 were described as being morbilliform."

For general practitioners like myself labouring under a measles epidemic this news may be topical.—I am, etc.,

Blackpool, Lancs. ARCHIE MUIR.

Volvulus of the Sigmoid Colon in Pathans

SIR,—I was very interested to read the article by Mr. I. Ahsan and Mr. H. Rahman about volvulus of the sigmoid colon among Pathans (7 January, p. 29). I had a somewhat similar series of 40 cases from the Deccan area of India.[1]

Aetiology: I note that the series were in the Pathans in the Peshawar district, and that one of the doctors had worked at three other centres in Pakistan, where he found these cases were rare among non-Pathans. They suggest that among the Aryan races the high incidence is peculiar to Pathans. The extensive series from Norway reported by Bruusgaard[2] and Frimann-Dahl[3] indicate that while the incidence in the early part of the present century was fairly high in Norway it fell to a low level before and between the two world wars, but *rose at the end of each.* These findings were confirmed in my more recent survey[4] of 10 Norwegian hospitals, which also showed a gradual fall since the last war. This suggests that the incidence is affected by changes of diet, and suggestion has been made that this operates through a "high residue" diet. This is normally used in countries where the disease is prevalent, and occurred under abnormal wartime conditions in Norway. I would be interested to know whether any major differences in diet between Pathans and other major groups in Pakistan have been observed.

Incidence: The incidence in the Ahmednagar series[1] was 24% of 168 cases in a five-year period, compared with 30% of 127 cases in a three-year period in Peshawar, which is of a similar order. However, included in the Ahmednagar series of 40 cases were 14 of the small intestine and 2 of the caecum.

Treatment: The excellent results obtained by Ahsan and Rahman by primary resection and anastomosis establish this as the method of choice whenever the condition is good and there is no gangrene. I would like to confirm their observation that the general condition of the great majority of cases with volvulus of the pelvic colon is good except where gangrene has intervened. The method of reduction under sigmoidoscopic control with a flatus tube was first established by Schilling at Ulleval Hospital, Oslo, about 1918, and it became the routine method of treatment at that hospital in the absence of symptoms or signs suggesting gangrene. Bruusgaard reported a series of 134 attacks treated conservatively, with only 3% mortality.[2] External perforation occurred once in the cases treated conservatively, 0.7%. In the Ahmednagar series 13 out of 14 cases in which sigmoidoscopic reduction was attempted were successful. All these cases were advised to have resection after an interval, but only one case agreed to have it, after his third attack. This confirms strongly the recommendation made by Ahsan and Rahman in their paper to proceed immediately to do a primary resection and anastomosis wherever adequate facilities exist, but there remains a valuable place for conservative treatment by Schilling's method where such facilities are not available.—I am, etc.,

Institute of Urology, London W.C.2. D. A. ANDERSEN.

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2 Bruusgaard, C., *Surgery*, 1947, **22**, 466.
3 Frimann-Dahl, J., *Roentgen Examination in Acute Abdominal Conditions*, 2nd ed. Charles C. Thomas, Springfield, Ill., U.S.A.
4 Andersen, D. A., *J. Oslo City Hosps.*, 1966, **16**, 101.

Accident and Emergency Services

SIR,—It was with interest that I read the provisional programme for the B.M.A. Scientific Meeting, to take place in Bristol in July (*Supplement*, 21 January, p. 13), and noticed that there is to be a Symposium on the Problems of Accident and Emergency Services.

As the B.M.A. well knows, the senior casualty officers are interested in these problems and are anxious to take part in scientific meetings, but no contact was made with them before this programme was arranged, and only one of the opening speakers is in fact directly concerned with the running of an accident and emergency department.

There is a difference of opinion between senior casualty officers and the orthopaedic surgeons over the organization of an accident and emergency service, but this difference should not be allowed to separate them when scientific meetings are being arranged, and it would seem to me that it would have been courteous for an approach to be made to the senior casualty officers before this programme was arranged.—I am, etc.,

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Post-hemiplegic Epilepsy

SIR,—"Post-hemiplegic Epilepsy in the Elderly," by Dr. Wilfred Fine (28 January, p. 199), wins my appreciation and gratitude. One patient whose problem has been buzzing at the back of my mind for some weeks I think falls exactly into this category.

She is not, however, elderly, only post-hemiplegic, and has been so since the age of