girth, but without signs of obstruction. Paracentesis revealed the above-mentioned findings. Laparotomy was undertaken and a gangrenous appendix was removed. It had obviously perforated a considerable time before operation. The total duration of symptoms was three weeks. Complete recovery ensued.

Case 3.—A 28-year-old Bantu male was admitted with a complaint of generalized weakness and increasing abdominal girth. Paracentesis produced a fluid of similar character to that obtained in the other two cases. At laparotomy a perforation of ileum was found approximately 4 ft. (1.2 m.) from the ileocaecal valve, the perforation being partially walled off by descending colon and the resulting abscess cavity extending into the retroperitoneal space in the left flank. Resection and end-to-end anastomosis was performed. The clinical appearances suggested and pathological report confirmed that the condition was due to Crohn's disease. The patient died within 24 hours of operation.

Thus of five cases presenting with ascites all were infective in origin, two being due to tuberculosis and three to peritonitis secondary to perforation of bowel. One tuberculous patient was submitted to laparotomy and the diagnosis made only after pathological report on a biopsy, the appearances suggesting carcinomatosis, and the other diagnosed as a result of a previous history of tuberculosis. Facilities for biochemical examinations are not available at this hospital.—We are, etc.,

HECTOR S. LIVINGSTON.

ALEX. STEWART.

Nessie Knight Hospital,
Qumbu,
Cape Province, S. Africa.

Foetus—or Fetus?

SIR,—Professors J. D. Boyd and W. J. Hamilton touch on one point in the confusion of medical language (18 February, p. 425).

This language has developed haphazardly over the course of many centuries, and now comprises a jumble of word roots which are often misspelt, used incorrectly, have more than one meaning, and are multiplied beyond necessity. These roots are strung together to make words whose meaning is defined more by general usage than by strict convention.

Has not the time come for a critical revision of medical language, if only for the sake of medical students and epidemiologists?—I am, etc.,

Belmont Hall,
Queen's College,
Dundee.

D. M. SMITH.

SIR,—If it must be foetus let it be fetus, but why not embryo all the way? After all most textbooks are on "Embryology" not "Fetology" (or "Foetology").—I am, etc.,

Department of Anatomy,
Queen's University,
Belfast.

JAMES SCOTT.

SIR,—Since Professor D. B. Stewart first drew my attention in 1953 to the etymological facts behind the persistent British and Continental use of the ugly diphthong in "foetus" I have campaigned constantly but so far unsuccessfully for the alternative and more correct "fetus." Secretaries and editors quietly ignore one's own spelling and substitute "foetus" for "fetus," and a letter

on this subject to the *Lancet* in 1962 brought no response. I have therefore read with great pleasure the elegant and convincing arguments adduced by Professors J. D. Boyd and W. J. Hamilton in your pages (18 February, p. 425) in favour of the earlier spelling. I hope they will have the courage of their convictions and insist on "fetus" in their writings from now on.—I am, etc.,

J. H. M. PINKERTON.

Department of Gynaecology,
Queen's University,
Belfast.

Inflatable Splints

SIR,—I have read with interest the article by Dr. Heather Ashton (10 December, p. 1427) and the recent correspondence on this subject. I have used these splints in mining accidents, road accidents, and mountain rescue for some years and more recently in the accident unit at this hospital, and been very pleased with the splints in all situations. I feel that some of my findings may be of general interest.

Firstly, I was interested in the pressures to which these splints are usually inflated. Sixteen ambulance drivers were asked to inflate a splint applied to a limb. First, they inflated the splint as tightly as they thought necessary in a patient. This pressure ranged from 32 mm. mercury to 50 mm., mostly approximating closely to the average of 41 mm. They then inflated the splints as tightly as they could. The pressures recorded ranged from 62 to 135 mm., averaging 76 mm.

Secondly, I was interested in how the splints kept their pressure. A dozen splints of all sorts were inflated to exactly 40 mm. on a limb and pressures taken every 5 minutes for 20 minutes. In all cases the pressure had fallen to below 30 mm. in the first 10 minutes and seemed to level out at 20 to 25 mm.

The chief use of these splints in the accident unit is in preparing patients for open reduction of limb fractures. The limb is prepared normally and then immobilized by a plastic splint over the sterile dressings for several hours and sometimes overnight. Data were recorded on the last five patients treated in this way. In each case, the injury being to the lower limb, a full leg-splint was applied. The ages of the patients ranged from 19 to 52. In two cases the splint was applied at exactly 40 mm. mercury and in the other three at approximately the same pressure. In all cases the patient felt more comfortable with the plastic splint applied than with the conventional splinting applied previously. The splint was left in situ for between three and six hours. At subsequent surgery there was no evidence of impairment to the circulation. There was no subsequent albuminuria in any of these cases, lending no support to a theory that these splints cause serious kidney damage from a crush syndrome effect.

Finally, I would like to draw attention again to the findings of Dr. W. J. Gardner,¹ where an inflatable splint was applied to the foreleg of a dog. A pressure of 170 to 200 mm. Hg for five hours produced no detectable damage to the limb, and a pressure of 300 mm. continuously for ten hours no permanent damage. To summarize my findings, it appears that the splints are applied at a somewhat higher pressure than is generally appreciated. The pressure, however, appears to fall away to some extent. In practice the

splints appear to cause absolutely no ill effects, and experiments on dogs would make it appear that far greater pressures than can be applied to these splints by mouth do not produce the damage that one might expect in theory.—I am, etc.,

I. W. JONES.

Caernarvonshire and
Anglesey General Hospital,
Bangor.

REFERENCE

- Gardner, W. J., *J. Amer. med. Ass.*, 1966, **196**, 491.

Drug "Addiction"

SIR,—The following observation on this time-wasting problem may be of some general interest.

While participating recently in a group therapy session, a middle-aged man complained bitterly that his doctors persisted in giving him up to 100 Tuinal (quinalbarbitone sodium and amylobarbitone sodium) gr. 3 by prescription just as often as he needed them. Following some rather feeble and vague explanatory remarks on my part he continued to complain, and went on to say that when he was on holiday in Dublin he called in a doctor who gave him Tuinal gr. 3 × 8 on prescription. On taking the prescription to a chemist he found that he was expected to pay 12s. 6d., with the result that his addiction was temporarily relieved, and he found that he was enabled to spend the remaining period of his holiday in an unusually alert and active condition. On his return to this country his resolve failed him and he began to visit his doctors again, and he became supplied with drugs as freely as before.

It would seem that at present doctors are inadequately protected against the drug addict's demands. It would also seem that some of the very many millions of pounds spent on drugs so liberally may be a mixed blessing.—I am, etc.,

High Royds Hospital, DOROTHY COLLINS.
Ilkley, Yorks.

Dependence on Dextromoramide

SIR,—Following the letters by Drs. J. J. C. Cormack and Dr. B. A. Juby (11 February, p. 362), it would probably be of interest to relate the subsequent history of the two cases that were described in the paper on dependence on dextromoramide (14 January, p. 88). Both patients were stabilized on the optimum dose of dextromoramide required to prevent the appearance of withdrawal symptoms, and these were given regularly—Case 1 15 mg. six-hourly (doses 1–5), none being taken when asleep; and similarly Case 2 20 mg. 12-hourly (doses 1–9). The tablets were given in opaque gelatin capsules, which the patients were observed to swallow. The capsules prevented the tablets from being tasted, the only method of distinguishing the drug from placebo. Substitution with placebo was by reduction of 5 mg. of dextromoramide each day, Case 1 progressively first in dose 5 then 2, 4, 1, and 3 respectively. A similar process was applied to Case 2.

Case 1.—Dextromoramide was completely withdrawn from the patient over a period of 12 days by reduction of the dose by 5 mg. each day. To cover this it was necessary to give doses of trifluoperazine 1 mg. by intramuscular injection

eight-hourly, and then orally increasing from 5 to 15 mg. eight-hourly. His restlessness, vomiting, and abdominal discomfort progressively increased. When his six-hourly dose had been reduced to 5 mg. he stole a tin labelled "Palfium" (dextromoramide) from the ward trolley and was abusive when he found it empty. At this time he began to refuse the dummy tablets, which he described as useless. It was of interest, however, that when his symptoms became severe he would still accept them and they produced a slight and temporary effect in that they appeared to reduce his restlessness at night and enabled him to go to sleep for short periods. He eventually reacted to treatment by leaving hospital twice for periods of 24 hours, and on one of these occasions managed to obtain 30 mg. of dextromoramide from another Mersey-side hospital. He was finally detained in the addiction unit on an order. No further dextromoramide was given, and he was treated with chlorpromazine, 150 mg. t.d.s., and sodium phenobarbitone, 600 mg. six-hourly. On the fifth day of this regimen abdominal discomfort disappeared, and apart from some yawning and slight restlessness symptoms of the abstinence syndrome entirely disappeared. The patient became cheerful and was obviously relieved that he was no longer addicted to the drug. On discharge he was symptom-free and was not receiving any medication.

Case 2.—This patient did not like being in hospital and was less willing than Case 1 to undergo the treatment. Even when he had been established on 20 mg. of dextromoramide every hour he appeared to suffer from the abstinence syndrome, and would always demand his next dose a few minutes before it was due.

Ten days after admission he left the hospital in the morning, and when he finally returned to the hospital in the evening he was elated, refused to go to bed, and threatened to leave permanently. He had four tablets of dextromoramide in his possession and admitted that he had been taking the tablets at home. On the following day he said he would try to reduce his dose of dextromoramide voluntarily. Substitution of one tablet of dextromoramide by a dummy tablet was followed by a great increase in restlessness and an emotional outburst in which the patient said he wanted to leave hospital; it was clear that the dummy tablets were having no placebo action at all. On the next day he received 15 mg. dextromoramide every hour, except on four occasions when he received 20 mg. Like Case 1 this patient left hospital during the withdrawal regimen and similarly on one occasion he obtained 40 mg. of dextromoramide at another hospital. He also claimed that he could buy the drug in Liverpool. He was finally detained on an order. His withdrawal regimen carried out by substitution of dummy tablets was continued under cover of trifluoperazine, 2 mg. intramuscularly eight-hourly. On the eighth day after intensive treatment had been started he refused the dummy tablets, because he said they were no longer necessary. At this time he had slight abdominal discomfort, and was yawning and had some tremor of the hands. He was cheerful and co-operative in the ward and welcomed visits from his wife and children. He was discharged from hospital 19 days after intensive withdrawal therapy had been started. On discharge he was symptom-free and was receiving no drugs.

Attempts were made to follow up both patients through the psychiatric clinic and visits of the psychiatric social worker. Case 1 was seen on one occasion six weeks after discharge. At this time he was not having any dextromoramide and his craving for the drug had disappeared. Physically he was much improved and had gained in weight. Further attempts to follow him up failed because he had moved from the area.

Case 2 was referred by his general practitioner to a surgical clinic six weeks after

his discharge with complaints of epigastric pain, which did not respond to alkali, and of vague chest pain. After a series of negative investigations he underwent a laparotomy, and only a very small healed anterior duodenal ulcer was found. He discharged himself against advice 12 days after operation. He was seen in the psychiatric clinic five months after discharge from the addiction unit and he stated that, although he had had a craving for dextromoramide on about four occasions between discharge from the addiction unit and his admission for surgery, he had not been taking dextromoramide at any time during the past five months. Following his discharge from the surgical ward his doctor prescribed ethchlorvynol as a sedative, and at one time he was taking about 1,000 mg. daily.—I am, etc.,

Clifton Hospital,
York. R. SEYMOUR-SHOVE.

Infective Eczema

SIR.—Dr. Alan B. Shrank (11 February, p. 349) writes lucidly about that ill-defined and difficult group of diseases which are included under the label infective eczema, and his practical advice on treatment will be endorsed by most of his dermatological colleagues.

For me, however, there was a notable omission in his failure to mention magenta paint *B.P.C.* as a treatment for intertrigo of submammary folds, groins, and natal and toe clefts. Magenta paint, at one time better known as Castellani's paint, can be diluted with an equal quantity of water if too strong on a first application. Its staining properties are a disadvantage, but this is outweighed by its quick effectiveness in clearing cases of moist intertrigo which, with the increasing use of topical corticosteroids and antibiotics, are so frequently complicated by infection with *C. albicans*.—I am, etc.,

PATRICK HALL-SMITH.

Brighton and Lewes
Group of Hospitals,
Sussex.

Trigeminal Neuralgia

SIR.—Further to the letter of Mr. J. Campbell (18 February, p. 429), it may be of interest to our medical colleagues to remind them that in the elderly edentulous patient with gross resorption of the mandible the mental foramen comes to lie on the summit of the alveolar ridge. In these cases the emerging mental nerve is traumatized by the lower denture—there being no bone above it. The nerve can easily be palpated by the finger, and this manoeuvre will frequently produce the pain complained of—it does, in fact, stimulate the trigger point. X-rays confirm the clinical diagnosis.

Two forms of treatment are available. The first, easier and usually successful, is to relieve the denture in the appropriate area; the second is to reposition the mental nerve lower down by making a new foramen with a burr, provided there is sufficient depth available.

I feel this clinical entity should be excluded before undertaking Mr. Campbell's operation and producing permanent anaesthesia.—I am, etc.,

Hove, Sussex.

PAUL F. B. GILLET.

Mercurial Poisoning

SIR.—I read with interest the article by Mr. H. Brendan Devlin and Dr. M. Sudlow (11 February, p. 347) on mercurial poisoning and peripheral mercurial embolization. I note that in their case there was a marked thrombocytopenia and leucopenia which responded to elimination of the mercury. The patient I have described (17 December 1966, p. 1534) had been ingesting mercurials for 33 years, resulting in death from aplastic anaemia.

Your contributors accept that acute mercurial intoxication can be associated with thrombocytopenia and leucopenia. Nevertheless, it seems that the effects of mercury upon the haemopoietic system are only just becoming apparent, and this element should take its place with the other heavy metals as a possible marrow depressant.—I am, etc.,

D. R. WILSON.

Pinderfields General Hospital,
Wakefield, Yorks.

Photographing Jejunal Biopsy Specimens

SIR.—I would like to suggest to anyone pursuing this photographic problem (28 January, p. 237) the following advantages of using an Exakta Varex camera. Firstly, the ability to be able to remove and process three or four frames before removing the specimen from the microscope; secondly, Exaktas have many types of removable screens and hairline cross giving a clear aerial image, which is essential at high magnification; thirdly, the Magnear attachment allows the fully corrected existing camera lens, or a special additional lens, to be used.

I feel that perhaps the lighting system could be improved. Two "glancing lights" and filters are essential to get a modelling and stereoscopic effect.

I should like to thank Dr. O'Brien, consultant pathologist to the Warrington and Croydon Hospital Group, for advice and allowing me to use his laboratory and equipment.

—I am, etc.,

Croydon.

W. O. WHITTAKER.

Termination of Pregnancy Bill

SIR.—May I request the courtesy of your correspondence column to reply to some points raised by the letters of Dr. D. M. Potts (14 January, p. 113) and Dr. Evelyn Fisher (28 January, p. 236) in answer to my letter (17 December 1966, p. 1531)? Dr. Potts is puzzled that I should express reservations regarding the Bill at present before Parliament, and welcomes it "because it removes the only outside pressure that can ever override a doctor's decision—namely, a restrictive law." Dr. Fisher also makes the same point when she asks, "Why not free the doctor to consider these questions dispassionately instead of permitting policemen to breathe down the necks of the medical profession?"

The Royal College of Obstetricians and Gynaecologists in their recent report¹ on legalized abortion confirmed that they are unaware of any case in which a gynaecologist has refused to terminate pregnancy,