formation of anticoagulant fibrinogen degradation products aggravates the haematologic defect. Moreover, to control the replacement of fibrinogen, as is suggested, is difficult, since the laboratory tests commonly employed in acute fibrinolytic conditions (thrombin time, Fibrindex, etc.) are at best semi-quantitative. Even if a rapid method of fibrinogen estimation is used⁶ the findings can be misleading, for the blood level of fibrinogen may be higher than that indicated by the test owing to the presence of anticoagulant fibrinogen degradation products.⁷ In our experience in obstetrical patients^{4,5} the clinical condition of the patient may be a better guide to therapy than the fibrinogen level determined in the laboratory, and fresh whole blood is a better substitute than fibrinogen alone.

Lastly, the risk of E.A.C.A. causing intravascular thrombosis (apart from that presented by the original stimulus for defibrination) when it is given for a relatively short period (as in acute obstetrical conditions) is negligible. This is because the drug is excreted through the kidneys very rapidly.—I am, etc.,

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Polycythaemia and Chorea

SIR,—Your leading article (23 December 1967, p. 696) referring to Gautier-Smith and Pranker's two cases of progressive chorea due to polycythaemia rubra vera prompts me to summarize a similar case.

An old lady of 77 was referred to me at Barnet General Hospital in October with a six-months history of fidgety movements. Examination revealed that she was very arteriosclerotic, and the blood pressure was 190/100 mm. Hg. She showed grimacing movements of the face and writhing movements of the tongue, and had a moderately severe dysarthria. There were marked choreic movements to the trunk, leading to a lurching gait, and typical choreiform movements of the fingers and toes. Apart from extensor plantar responses the rest of the neurological examination was normal.

Regarding her as a probable case of senile chorea due to cerebral atheroma, treatment was started with thiopropazate (Dartalan) 10 mg. three times a day. At her next attendance one month later she was remarkably improved, and her daughter, an excellent witness, stated that the movements had ceased completely two days after the drug was commenced. However, the blood taken at the first attendance showed that the haemoglobin was 18.5 g./100 ml. and packed cell volume was 66%. A full blood count was

therefore ordered, and revealed: R.B.Cs 8,000,000/cu. mm., haematocrit 64%, M.C.H.C. 29%, M.C.V. 80 cu. mm., platelets 320,000/cu. mm., white blood count 8,800/cu. mm., neutrophils 58%, eosinophils 3%, basophils 2%, lymphocytes 36%, and monocytes 1%.

Re-examination at this time showed no enlargement of spleen, and this, together with a normal white cell count and platelet count, suggested that the polycythaemia was probably of secondary type, perhaps due to chronic bronchitis. It was thought advisable to withdraw 1 pint (0.6 l.) of blood, but this had no noticeable effect on the patient. Because of the side-effect of drowsiness the thiopropazate was progressively withdrawn, but at a dose of 10 mg. daily the choreiform movements returned, although not so severe as when she was first seen. She is now well controlled on thiopropazate 20 mg. daily together with orphenadrine 100 mg. daily.—I am, etc.,

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Transplant Lung

SIR,—We feel that the authors of the article on transplant lung (13 January, p. 80) are premature in describing this as a new syndrome. Previous reports by Rifkind¹ and Hamburger² have referred to "transplant pneumonia." The discussion by Mr. Slapak and others, however, on the pathogenesis of this syndrome in terms of alveolar-capillary block is extremely speculative for two reasons. Firstly, they produce no histological evidence of a thickened alveolar membrane; in the literature they have cited there is one illustration¹ showing hypertrophied alveolar cells in a case which also shows the alveoli filled with a fluid containing many cysts of *Pneumocystis carinii*. Secondly, their evidence that the dysfunction in lung physiology is a decrease in oxygen diffusion is weak because they do not report the effect of breathing 100% oxygen, a procedure which should overcome a diffusion block.³ In addition, it has been recognized for some time that the commonest cause of hypoxaemia, hypocapnia, and a low CO₂ diffusing capacity is imbalance of pulmonary ventilation and perfusion.⁴

The sentence "Our patient's vital capacity was 100% of the predicted value but his F.E.V.₁/V.C. was 78%, showing a mild degree of restriction," appears contradictory to us. Restrictive lung disease can only be diagnosed when the vital capacity is reduced. The F.E.V.₁/V.C. ratio is a measure of airways obstruction; the value quoted is normal.

We do not feel the authors have fully assessed the role of alveolar and interstitial oedema, especially since the chest x-rays of their cases are similar to those found in pulmonary oedema. The evidence for an immunological basis for this syndrome is extremely circumstantial. The decline in lung function was not accompanied by any deterioration in renal function, as might be expected if cross-reacting antibodies are involved. It is also surprising that investigators have so far been unable to reproduce this condition experimentally in the dog (and in our experience we have not encountered it either), since in many other respects the dog, after renal transplantation, has shown similar changes to those described in man.

There is little evidence for the conclusions these authors have reached or the hypotheses they have proposed.—We are, etc.,

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Rinsing the Dialyser

SIR,—I read with interest the paper by Dr. D. B. Evans and others (16 December 1967, p. 651) on different techniques of washing-back the blood from the two-layer Kiil dialyser at the end of dialysis. Evidence is presented that a rinse with 1 l. of normal saline (after tipping the dialyser vertically during half an hour) yields best results. However, with this technique the patient receives 500–700 ml. of 0.9% saline at the end of each dialysis. In patients on twice-weekly haemodialysis this equals an extra weekly sodium load of approximately 150–214 mEq. This seems to be highly undesirable in chronically dialysed patients who need rigorous dietary sodium restriction, which is (together with appropriate ultra-filtration during dialysis) the cornerstone in correction of hypertension.

I refer therefore to a recently published air-rinse technique¹ which yields equally excellent results without flushing extra water and sodium chloride into the patient. Results (approximately 5 ml. residual blood loss in the dialyser) were confirmed in our unit. Dangers of air embolism are virtually zero in nurse-supervised hospital dialysis and might be eliminated in home dialysis procedures by a rather simple device which blocks automatically the outflow bloodline immediately before the venous cannula when the first air bubble passes a photocell.—I am, etc.,

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REFERENCE

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Elastic Band Injuries

SIR,—I was interested to read the series of letters following the description of artifact ulcers produced by elastic bands by Mr. I. D. Kitchin and others (22 April 1967, p. 218). Dr. L. Cohen (6 May, p. 376) described the result of allowing an elastic band to slip over a tooth, and Dr. J. G. B. Thurston (same page) reminded us of his previous description of ulcers produced around fingers by elastic bands. Mr. J. P. Turney (13 May, p. 445) described an ulcer in the upper arm produced by a group of three elastic bands, and Dr. K. Dawson-Butterworth (20 May, p. 510) described skin ulceration with a deeply buried elastic band in the lower third of the

leg. Lastly, Dr. G. Glew (25 November, p. 488) described another ulcer in the lower third of the leg produced after an elastic band had accidentally slipped from a dressing over a varicose ulcer.

To this remarkable anatomical catalogue of legs, teeth, fingers, and arm may I add the neck?

A 6-month-old girl was brought to the casualty department of Poplar Hospital because her mother reported a foul smell which seemed to be coming from the girl's neck. The presence of a powerful smell was immediately confirmed, and a linear ulcer running deeply in the skin folds of the neck was found to be completely encircling the child's neck, as seen in the photograph. The casualty officer removed two thin elastic bands from the depths of the wound, which then healed up normally.

We thought that the bands may have been slipped over the girl's head accidentally, as the mother used such bands to give the girl a pony-tail. There was no evidence to suggest that the bands had been put round the girl's neck deliberately. We thought it odd that the girl's mother had not noticed the bands at bath time. It is conceivable that if these bands had been left in place the process of ulceration would have continued, perhaps into the superficial jugular veins at first, and later possibly into deeper structures.—I am, etc.,

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Real Reasons for Emigration

SIR,—Publishing the report of the Ministry of Health Interview Board on the emigration of British doctors to the United States of America and Canada (6 January, p. 45) is a tremendous free advertisement for North American medicine. We already knew that things were better in many respects on the other side of the Atlantic, but surely many of us were unaware quite how freely the milk and honey were flowing. The report paints a far rosier picture of life over there than at least the Canadian Department of Immigration (Canada House) seems to be able to do.

I qualified 18 months ago, and after registration there seemed to be two main channels open. General practice I had always regarded as the ideal form of medical practice, but it

appeared (and recent experience only confirms this) that if one was to be a general practitioner of integrity with decent premises and facilities, refusing to sign "sick lines" or give prescriptions except when strictly indicated, one was going to lose both money and patients. One was also going to lose most of one's seriously ill patients to the hospital service—a dichotomy that was going to make it difficult to keep up with advances in therapeutics—and one's surgeries would be full of patients with trivial illnesses, just because with a completely "free" service they will not give Nature a chance to try her hand first.

Hospital practice looked more stimulating, but the M.R.C.P. and the F.R.C.S. clubs are very reluctant to admit new members. The quality of medical graduates must surely be very bad if only about one-quarter of candidates manage to pass these specialist examinations. And in what other profession is it necessary to tour the country passing the equivalent examinations three times before one can be sure of getting on? One might suspect that the Colleges themselves have some interest in these affairs, for the examination fees, and the fees for the courses which it is necessary to take at each College if one is to have a reasonable chance of success in its examinations, must provide a useful income.

This left only the minor channels open, and I am quite happy in one of them. But if the Interview Board's report had come out 18 months earlier I might at this moment be doing a ward round in my lavishly equipped hospital at £5,000 per year. If we are going to freely admit that the other side is so much better in most respects then we really must start making some of the medical changes we talk about.—I am, etc.,

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Are Our Priorities Right?

SIR,—Lord Platt has placed us all in his debt for his timely warnings on "Medical Science: Master or Servant?" in his Harveian Oration, and you have put us in your debt for making it available to a much wider audience (25 November, p. 439). While agreeing with all he has to say about the whole man in health and disease being the fit subject for study by medical science, I would have liked him to extend his reasoning to cover the patient in society.

For most of the world's people hospitals are still a last resort, their facilities, woefully inadequate as they frequently are, inaccessible because of distance and/or cost. The majority of the medical schools in developing countries, especially those in former colonial territories, are patterned on those of the West, which they try, and indeed are encouraged, to emulate. The possibilities for the abuses of which Lord Platt speaks are even greater there. With the frequent failure of the Governments of these countries to provide the bases for reasonable practice in the community it is hardly to be wondered at that the capable young graduate feels forced into the brain-drain or seeks the security and lucrative private practice to be found only in the cities.

The task of bringing the benefits of present-day medical science to the people who need them appears truly Sisyphean. A

first step is for the relevance and respectability of community medicine to be taught from the outset in the undergraduate curriculum, and attractive opportunities to practise it later provided. I would draw the attention of your readers to an account¹ of the programme of the new Hacettepe Medical Center, Ankara, Turkey, where this is being done. Perhaps there is something wrong with our sense of values when a technically brilliant novelty, such as heart transplantation, can retain front-page publicity for weeks, while achievements in health practice affecting whole communities go virtually unsung.—I am, etc.,

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REFERENCE

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Foot-and-mouth Disease in Man

SIR,—The present epizootic of foot-and-mouth disease should draw attention to the occurrence of foot-and-mouth disease in man. This is considered to be very rare, but as I had two such cases in my practice¹ I wonder whether in fact this is so. Foot-and-mouth disease in man is as a rule a mild illness, so that the patient does not see his doctor, or the condition is not diagnosed. It is important that it should be, as man can spread the disease among animals. I thought it might be interesting to give here a short history of my first patient, observed in 1938 in Poland,² the diagnosis being confirmed by positive results in inoculated guinea-pigs.

While inspecting a slaughterhouse seven days before the present illness started, the veterinary inspector had some recent minor injuries on the dorsal side of his right hand. Six days later he noticed a marked suppuration of the injuries, right axillary lymphadenitis, and slow healing of injury, though previously similar injuries had healed quickly. Seven days after inspection of the slaughterhouse, besides general weakness, considered by the patient to be due to overwork, he developed rigors and a temperature of 39° C., and complained of a burning sensation of palms and soles. Next day he had a burning sensation of the mouth. On the fourth day there were red spots on lips, face, trunk, palms, and soles. On the fifth day the burning sensation of the mouth increased. Temperature remained at 39° C. for six days.

On the sixth day he was admitted to the university hospital with suspected acute leukaemia. Examination revealed temperature 38.1° C., pulse 88, blood pressure 142/98, extensive aphthous stomatitis, and superficial ulcers. There were red spots on lips, face, and trunk, as in herpes zoster, also on palms and soles around nails. There were some vesicles around the mouth. A small similar to that present in animals with foot-and-mouth disease was noted around the patient.

Laboratory investigations: W.B.C. 5,100/cu. mm., R.B.C. 4,900,000/cu. mm., Hb 96%. Differential count: polymorphs 49, eosinophils 3, lymphocytes 43, monocytes 5, platelets 156,000, E.S.R. 6 mm./hr. Tests for W.R., *Salmonella typhi*, *S. paratyphi B*, Weil-Felix reaction, and *Brucella abortus* were all negative.

On the seventh day there was marked improvement of his general condition, more vesicles around mouth, and blisters on palms and soles were bigger. Guinea-pigs were inoculated with fluid from blisters on palms and soles. They developed foot-and-mouth disease 12 to 14 days after inoculation. On the ninth day his mouth was healing rapidly and so were the