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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F. W. WEBB.

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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J. WOMERSLEY.

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

¹ Dogramaci, I., *J. med. Educ.*, 1966, 41, 1063.

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

vesicles on the body. In the next few days there was further improvement. From thirteen days on, palms and soles desquamated in large flakes. On the sixteenth day the mouth had healed, with residual brown spots on lips. Skin of soles peeled off like sandals, in one piece.

The patient was admitted to a general ward and treatment was symptomatic. On discharge the patient was warned that for some time he might spread foot-and-mouth disease among animals, and that therefore he should avoid contact with susceptible animals. Veterinary authorities were notified about this patient and carried out inspections in the district in which the slaughterhouse was situated. Foot-and-mouth disease was found among animals, although previously this district was declared free from disease.

In conclusion I would like to emphasize that the health authorities would be well advised to pay close attention to the possibility of the disease in man as a potential factor in the spread of foot-and-mouth disease.—I am, etc.,

London W.13.

HENRYK DLUGOSZ.

REFERENCES

- ¹ Dlugosz, H., *Brit. med. J.*, 1943, 1, 189.
- ² ——— *Pol. Gaz. lek.*, 1938, 17, 501.

Budd-Chiari Syndrome after Oral Contraceptives

SIR,—I have read with interest the two recent case reports (16 December, p. 660, and 6 January, p. 53) of hepatic-vein thrombosis (Budd-Chiari syndrome) in young women taking the contraceptive pill. A similar case was admitted to St. Bartholomew's Hospital in November 1965.

A 24-year-old housewife was transferred to the care of Mr. A. H. Hunt. Four weeks previously she had been admitted to another hospital for investigation of peripheral oedema, ascites, and hepatosplenomegaly. She had noted increasing abdominal distension for five months, and for four months before the onset of these symptoms she had been on Anovlar (norethisterone acetate and ethinyloestradiol). After paracentesis of nearly 5 l. an exploratory laparotomy was done. An enlarged, firm, and congested liver was noted and the spleen was considerably enlarged. Liver biopsy showed appearances suggestive of Budd-Chiari syndrome.

On examination she was ill, with gross peripheral oedema and reaccumulation of ascites, but with no stigmata of liver disease, and liver-function tests were only slightly impaired. Shortly after admission the abdominal incision disrupted. While this was being resutured she had a cardiac arrest. The heart was restarted after one and a half hours of cardiac massage, and on recovery of consciousness several days later her mental state was impaired. During this time she developed an ischaemic right foot, which subsequently required a below-knee amputation. The tibial vessels were thrombosed. With the collaboration of Dr. A. M. Dawson, an unsuccessful attempt was made to control the oedema and ascites with large doses of steroids and diuretics. Her condition gradually deteriorated and she died 10 weeks after admission.

Necropsy confirmed the diagnosis of Budd-Chiari syndrome. The hepatic veins were almost completely obliterated, with only a pinhole opening left. Histological sections showed widespread occlusion of these veins and their small divisions by organized thrombus. The liver showed patchy congestion and haemorrhage, with areas of liver-cell atrophy and early interstitial fibrosis. Thrombosis causing partial occlusion of the

vessel lumen was also noted in the hepatic segment of the inferior vena cava, the left common iliac vein, and the superior mesenteric, splenic, and main portal veins. The bifurcation of the right common femoral artery was occluded by a recent saddle embolus, and infarcts were noted in both lungs, both kidneys, and the left ventricle. The extent of the thrombotic process in this patient strongly suggested a generalized condition affecting the intima of the blood vessels.

It is interesting to note that three oral contraceptives have now been reported as being associated with hepatic-vein thrombosis. The first reported case had been on mestranol for only 14 days before the onset of symptoms¹; the second case had been on lyn-oestrenol for 12 to 18 months (16 December, p. 660); and the third case (6 January, p. 54) had been on Anovlar for a year or more and was fortunate to have recovered. The present case had been on this latter drug for four months. The usual prognosis with Budd-Chiari syndrome is a progressive deterioration with a fatal termination, as occurred with this and two of the other reported cases.

I am grateful to Mr. A. H. Hunt for permission to publish details of this case.

—I am, etc.,

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REFERENCE

- ¹ Ecker, J. A., McKittrick, J. E., and Failing, R. M., *Amer. J. Gastroent.*, 1966, 45, 429.

SIR,—Following recent reports in your columns (16 December, p. 660, and 6 January, p. 53) of two cases of the Budd-Chiari syndrome in women who had been taking oral contraceptives, we are able to add a further case, resembling in many respects that of Drs. K. Sterup and J. Mosbech.

A 40-year-old woman sought medical advice on account of increasing abdominal distension, stress incontinence, flatulence, and anorexia. She was the mother of four children, aged from 12 to 21 years, and had been taking an oral contraceptive, megestrol acetate and ethinyl oestradiol, for two years. Examination revealed a mass in the pelvis and hepatic enlargement. Laparotomy was performed nine days later and showed a fibroid uterus, the size of a 16-week pregnancy, ascites, and a large liver which appeared to be cirrhotic. Abdominal hysterectomy was performed, which was followed by paralytic ileus and rapidly increasing ascites. Fluid leaked through the abdominal wound and on the eleventh postoperative day led to a rupture of the abdominal scar. Her condition deteriorated steadily from then onwards. She became comatose and died 14 days after operation.

Necropsy Findings.—The liver weighed 1,440 g. and presented a striking appearance: its surface was slightly lobulated and the colour was dark red with coarse golden-yellow mottling throughout the parenchyma. Histological examination revealed widespread centrilobular necrosis with gross distension of the central veins, most of which were occluded by thrombus. The portal tracts contained a lymphocytic infiltrate and increased amounts of fibrous tissue. In addition, both femoral veins were distended with recent thrombi which extended through the iliac veins into the inferior vena cava. Small old infarcts were also found in the left cerebral hemisphere, but no recent thrombi were found in the cerebral vessels.

The cause of death was recorded as "hepatic necrosis following hepatic-vein

thrombosis." In view of the reported association between the taking of oral contraceptives and a tendency to thrombosis in comparatively young women, this case was reported to H.M. Coroner and to the Safety of Drugs Committee.—We are, etc.,

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C. GILES.

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Length of Menstrual Cycle

SIR,—It is well known that the administration of oestrogens with synthetic progestogens in combination or used sequentially over 20, 21, or 22 days of the month not infrequently leads to some change in the menstrual cycle. Usually the cycle becomes more regular and pain previously associated with the menses often disappears. Some women, however, experience shortened cycles and in others the cycle length may be prolonged. With the introduction of low-dosage preparations and sequential regimen the incidence of breakthrough bleeding and amenorrhoea has fallen. It is also quite clear that with combination preparations those containing a 19-norprogestogen (norethisterone, ethynodiol diacetate, lyn-oestrenol, etc.) give rise to a much lower incidence of shortened cycles than those containing a progestogen of the 17-acetoxy series (megestrol acetate, chlormadinone, etc.).

Since the introduction of these preparations for use in conception control women of reproductive age have necessarily come under much closer observation than hitherto, although it has long been known that the effects of organic disease, shock, change of domicile, different occupation, or illicit relationships, etc., may lead to shortening of the cycle or, more commonly, lengthening of the cycle and amenorrhoea. The precise mechanisms for these changes in the non-medicated woman is not known, but presumably alterations along the corticohypothalamic pathways may affect secretion of gonadotrophin releasing factors with its sequelae. The late Dr. Gregory Pincus frequently cited the data collected by Haman¹ and observed that some 10% of menstrual cycles in apparently normal women are less than 24 days in length. Pincus² pointed out that following the administration of ovulation-inhibiting steroids the incidence of shortened cycles often falls below 10%, the medication producing a better than normal control of cycle length. I have previously drawn attention to the variation in cycle length from that usually accepted as normal.³ This information obtained from 11 studies is tabulated below.

Cycle Length in Normal Non-medicated Women

Source of Data	Percentage Cycle Length		
	24 days or less	25-30 days	31 days or more
Issmer (1889)	9.2	78.3	12.5
King (1926)	13.8	73.7	12.5
Allen (1933)	14.4	61.5	24.1
Pratt <i>et al.</i> (1929) ..	22.8	66.5	10.7
King (1933)	14.3	64.0	21.7
Fluhmann (1934) ..	18.5	46.9	34.6
Engle and Shelesnyak (1934)	24.0	35.9	40.1
Latz and Reiner (1935) ..	7.2	71.0	21.8
Scipiadis (1935)	5.5	55.2	39.3
Latz and Reiner (1937) ..	11.8	75.3	12.9
Haman (1942)	9.6	71.4	19.0
Mean	13.7%	63.6%	22.6%