diazepam. The description of the procedure and of the cases makes it clear that in all cases of hypotension the drug was given intravenously. The patients were nursed in an intensive care ward where observations of physiological functions were made regularly at 15 minutes, or less if necessary. Why Drs. Taylor and Ounsted should not know "how an adequately representative blood pressure was recorded from a patient in . . . grand mal status" is difficult to understand. Naturally one does not aspire to recording during the actual seizure, but the traditional techniques serve quite well between convulsions. Drs. Taylor and Ounsted believe that the "title may serve by itself to alarm practitioners into avoiding this . . . drug as their treatment of first choice." This may be a fair comment upon the reading habits of physicians or may reflect the view that Drs. Taylor and Ounsted have of their fellow practitioners. For those who read more than the title, the summary and the rest of the paper made it obvious that diazepam is a highly successful drug in the treatment of status epilepticus. The fact that combined treatment with other drugs in seriously ill subjects may lead to an undesirable or potentially fatal hypotension should not deter practitioners from its use, but should lead to greater caution.

Obviously combined treatment cannot be wholly avoided. Some cases of status epilepticus do not respond to treatment with diazepam, given early or late, even in the best-regulated of circles. The use of phenobarbitone or phenytoin in patients who have been receiving these drugs for years is not necessarily illogical and is sometimes essential; the deliberate or inadvertent withdrawal of anticonvulsant medication is a common cause of status epilepticus, and in cases of prolonged status the regular medication should be continued without interruption. Furthermore, when cases of intractable status arrive at a special treatment unit some will have received treatment, not necessarily the wisest, and probably with more than one drug. Consequently the dangers of treatment with diazepam in conjunction with other drugs should be adequately advertised. —I am, etc.,

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Unsuspected Military Tuberculosis

SIR,—I read with interest the letter by Dr. R. Milton and others (1 February, p. 315) on the above subject.

In 1965 a colleague and I drew attention to unsuspected tuberculosis in the aged, of which two cases were diagnosed after death.¹ Recently I reviewed all post mortem material since publication of that paper to the end of 1968 (1,500 cases), and found 6 cases of military tuberculosis out of a total of 14 cases of active tuberculosis, two of the former being aged 80 and 90 respectively.

I would like to emphasize the importance of being aware of this hidden seed bed of tuberculosis, and it is practice in this laboratory to culture all sputa routinely for tubercle bacilli. Furthermore, in the nine cases of military tuberculosis in my two series all had

miliary tubercles in the marrow—on this evidence I now recommend that we culture some of the marrow aspirate in all cases of pyrexia of unknown origin in liquid tuberculous culture medium.—I am, etc.,

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Guy's Hospital Group,
London S.E.16.

REFERENCE

- ¹ Fullerton, J. M., and Dyer, L., *Tubercle (Lond.)*, 1965, 46, 193.

Awareness during Anaesthesia

SIR,—With regard to the article by Drs. J. Wilson and D. J. Turner (1 February, p. 280), may I make one very simple point? It is well known that sensory input during operations performed under light general anaesthesia plus muscle relaxation is an important factor in producing awareness. It has been my practice to apply tight-fitting plugs of moistened gauze to both external auditory meati on all patients undergoing caesarean section as soon as intubation has been performed.

There are clearly several factors operative in the cases described by Drs. Wilson and Turner, but the routine use of ear plugging, with consequent blocking of auditory stimuli, may well be an important factor in reducing the number of patients who complain of awareness during caesarean section.—I am, etc.,

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Torsion of Testis

SIR,—Following Mr. K. Mohay-ud-Din's letter (15 February, p. 445), without detracting from his statements I should like to remind him of the condition of idiopathic scrotal oedema of children¹ as a differential diagnosis. A few operations have been needlessly performed because of a mistaken diagnosis of torsion of the testis.

The distinguishing features are absent or minor pain, normal scrotal contents, and the distribution of the oedema, with some irritation of the scrotum or perineum.—I am, etc.,

BARRIE HANSTEAD.

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REFERENCE

- ¹ Hanstead, B., and John, H. T., *Brit. J. Urol.*, 1964, 36, 110.

Bilateral Tension Pneumothorax in Newborn

SIR,—I was interested to read the letter by Mr. I. V. Lishman and Dr. F. Mansfield (11 January, p. 121). The authors mention the difficulty in diagnosis they might have experienced had their patient not had surgical emphysema as well as tension pneumothorax. I have observed in several cases of pneumothorax in newborn and older infants that abdominal distension may be a prominent clinical finding. The explanation is presumably that the pressure of the air pushes the diaphragm downwards, thus compressing the

abdominal contents. The following case histories may help to demonstrate the point.

A newborn infant delivered by caesarean section failed to breathe. The child was cyanosed and limp, and the abdomen was soft and not distended. Heart rate was 96 but quite strong. An experienced anaesthetist passed an endotracheal tube and oxygen was administered at a rate of 2 l./min. through a Sampson respirator. Immediately the oxygen was started marked abdominal distension developed. The anaesthetist was certain the tube had entered the trachea but none the less removed it. Surgical emphysema developed in the neck. Resuscitative measures failed, and the infant died before an x-ray could be obtained. At necropsy the infant showed areas of pinkness contrasting with the generalized cyanosis.

Bilateral tension pneumothorax was present with ballooning of the diaphragm into the abdomen. No obvious area of trauma was found in the respiratory tract.

An infant of 3 months being treated for acute gastroenteritis developed marked abdominal distension. The child was a little dyspnoeic, and the air entry on the right side of the chest was poor. X-ray revealed tension pneumothorax on the right side and no intra-abdominal lesion. The pneumothorax was relieved by a catheter and underwater drainage, and following this the abdominal distension disappeared. Recovery from staphylococcal pneumonia and gastroenteritis was complete.

I wonder if any other readers would agree that abdominal distension may be a sign to turn one's thoughts to a possible diagnosis of tension pneumothorax in an infant with respiratory difficulty.—I am, etc.,

JOAN WAGNER.

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SIR,—The correspondence (11 January, p. 121 and 22 February, p. 514) on the emergency treatment of tension pneumothorax in the newborn prompts us to relate our own solution to this problem when faced with it recently.

A child delivered by caesarean section after some hours of intermittent foetal distress attempted to breathe before the air passages could be cleared of thick meconium. Respiratory efforts ceased while the pharyngeal contents were being removed by suction, and as there was no improvement after gentle inflation with oxygen from a face mask an endotracheal tube was passed. Ventilation with oxygen then produced a rapid improvement in colour, and spontaneous respiration started, but when the endotracheal tube was withdrawn it was clear that something was wrong; respiratory efforts were excessive, and there was a violent seesaw movement of the thorax and abdomen. The child rapidly became cyanosed again, so the tube was replaced and artificial ventilation recommenced. Auscultation revealed very little air entry on either side of the chest, and an x-ray showed a right tension pneumothorax with marked displacement of the mediastinum to the left.

An underwater drainage apparatus was improvised, using a disposable infusion set (which, when taken to pieces, provides a number of useful parts, including several male/female Luer connectors), a 16-gauge disposable intravenous cannula, a wide-bore 6-inch 15 cm. aspirating needle, and a rubber-capped 100 ml. bottle containing 50% dextrose. The aspirating needle was inserted through the rubber cap, and the dextrose was removed and replaced by sterile saline and chlorhexidine solution to a depth of 4 cm. The delivery tube of the infusion set was divided just below the drip chamber, and