

grommet insertions" speaks for itself. What an admission of failure and advice of despair!—I am, etc.,

FRANCIS BAUER.

Liverpool 23.

REFERENCES

- 1 Senturia, B. H., *Proceedings of the Royal Society of Medicine*, 1963, 56, 687.
- 2 Sade, J., *Archives of Otolaryngology*, 1966, 84, 297.
- 3 Bauer, F., *Journal of Laryngology and Otology*, 1968, 82, 717.

** The consensus of expert otological opinion is strongly in favour of the use of grommets or similar devices for the relief of glue ear. This preference is based on the satisfactory results obtained in large published series—for example, Feuerstein, 191 patients;¹ Oppenheimer and Siegel, 300 patients;² which must be compared with Bauer's 18 patients (27 ears)³—both in the short term as judged by immediate improvement in hearing and in the long term by the relapse rate.

Success with the grommet, which acts not as a drain but as a pressure equalizer in the middle ear, points to Eustachian tube dysfunction as an aetiological factor, a view that has received support from such an eminent international authority as Professor Schuknecht, of Boston.⁴ It is known that air may be forced through the tube in these cases from either end, but that does not necessarily mean the tube is functional in a physiological sense. A cautious expression of view in this debatable subject still seems appropriate.—Ed., *B.M.J.*

REFERENCES

- 1 Feuerstein, S. S., *Laryngoscope*, 1966, 76, 686.
- 2 Oppenheimer, R. P., and Siegel, J. R., *GP*, 1967, 35, 105.
- 3 Bauer, F., *Journal of Laryngology and Otology*, 1968, 82, 717.
- 4 Schuknecht, H. F., *Clinical Pediatrics*, 1964, 3, 718.

Herpes Gestationis

SIR,—I read with interest your recent leading article on herpes gestationis (29 November, p. 516). The fact that you say no satisfactory explanation for the development of this dermatosis has been offered and that it closely resembles bullous pemphigoid of the elderly prompts me to report the following case of a patient recently admitted to our wards:

A lady of 82 years presented with a severe bullous eruption of six days' duration affecting mainly the limbs but also the centre of the abdomen. This was diagnosed as pemphigoid. She was also found to have gross abdominal distension of several years' duration. This was shown to be a benign ovarian cyst at operation, when 25 l. of fluid was removed. She died on the third postoperative day of left ventricular failure and bronchopneumonia.

Could abdominal distension be a possible factor in the causation of herpes gestationis?—I am, etc.,

B. B. SCOTT.

St. James's Hospital,
Leeds.

"Rebreathing Bag"

SIR,—Your leading article (15 November, p. 383) properly raises the question whether anaesthesia in a completely darkened room is ever required or indeed justified. This thoughtful article has great merit, and there-

fore it is the more distressing to note that the writer uses the antiquated and thoroughly misleading term "rebreathing bag."

This part of the anaesthesia machine is more properly called a "breathing or reservoir bag," since the one function it should not subserve is that of facilitating rebreathing unless proper precautions are taken for the disposal of carbon dioxide. Indeed, the misconception that rebreathing is one of the functions of this bag has led to fatalities. It is high time, therefore, that this misnomer be discarded.—I am, etc.,

GORDON M. WYANT.

Department of Anaesthesia,
University of Saskatchewan,
Saskatoon, Canada.

Peanut or Sweet?

SIR,—In the last few months we have come across several patients under the age of 2 years who had inhaled the kernels of peanuts. In each case there were some difficulties over the extraction of these vegetable foreign bodies, and in one no radiological changes.

Inhalation of peanuts leads to a local inflammatory response which may be severe, and the child may develop bronchospasm. If a history of inhalation is lacking the child could be misdiagnosed as having acute bronchiolitis, bronchitis, or another similar condition. Because of its shape and size, the peanut is easily inhaled and can readily travel down and obstruct a main bronchus. In children under the age of 2 years the difficulties of removal include induction of anaesthesia, passing of a bronchoscope of adequate size to allow instrumentation, and the ease with which the peanut can break when gripped with forceps. With care these difficulties can be overcome.

It has been suggested that children should be given items such as peanuts rather than sweets to prevent early dental troubles. However, we would urge that children in this age group should not be given, or encouraged to eat, peanuts because of the risks involved.—We are, etc.,

LEONARD SINCLAIR.
H. HOLDEN.

Metropolitan Ear, Nose, and
Throat Hospital,
London W.8.

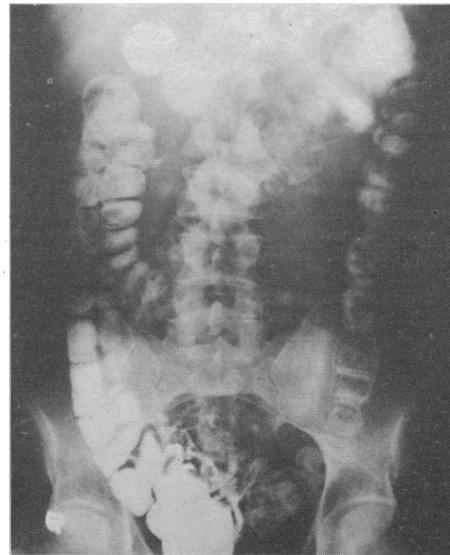
Possible Case of Ischaemic Colitis in a Young Man

SIR,—Radiological changes may occur in the colon following episodes of arterial insufficiency. These lesions—the most characteristic of which is known as "thumb printing"—tend to occur in the distal transverse and the proximal descending colon. In the majority of cases the colon returns to normal in a matter of weeks. As the condition is better known in elderly people, many of whom had overt arterial disease or suffered from diseases which predispose to arterial insufficiency, we think it is of interest to report the occurrence of possible ischaemic colitis in a previously healthy young man. In addition, the natural history of the patient's illness confirms the rapidity with which the radiological changes of ischaemic colitis can disappear.

The patient was a 26-year-old white male. He was perfectly well until the morning of 10

March, when he developed a watery diarrhoea, passing six stools that day. The stools did not contain blood. He had no abdominal pain, but did note a slight discomfort in both groins. Two days later he had abdominal cramps, which were not relieved by the passage of faeces. He now noted that the loose stools contained blood. He also experienced tenesmus and thought that he had passed mucus. The pain became more severe during the night of 13 March and he could not sleep. When seen the next day he did not appear ill. His temperature was 99° F. (37.5° C.) and his blood pressure 120/85 mm. Hg. No abnormality was detected on general examination and no bruits could be heard over any artery. There was tenderness on palpation of the left upper quadrant of the abdomen and along the line of the left side of the colon. Rectal examination, proctoscopy, and sigmoidoscopy to 25 cm. were normal. Rectal biopsy was normal. No pathogens were isolated from the stool. His haemoglobin, white cell count, blood urea, and urine were normal, but the E.S.R. was 29 mm.

Chest x-ray was normal. A straight film of abdomen revealed air in the transverse and upper part of the descending colon, with smooth rounded indentations protruding into the lumen of the descending colon. A barium enema done the same afternoon showed changes which have been described in ischaemic colitis—namely, thumb printing and saw-tooth appearance. (See Fig.)



Barium enema showing thumb printing and saw-tooth appearance.

He was given no specific treatment and the next day he was so well that he requested that he be allowed home because of pressing personal affairs.

It was felt that the diagnosis of Crohn's disease had to be excluded and a small-bowel enema was performed on 21 March, when the patient had no symptoms whatsoever and his E.S.R. was 10 mm. in the first hour (Westergren). The small-bowel enema was normal. The barium was followed through to the colon and no obvious abnormality could be seen. When the barium enema was repeated a week later the colon was normal.

The clinical presentation could have been due to an infective dysentery, Crohn's disease, or ulcerative colitis. However, the radiological features and the rapidity with which the patient's symptoms and radiographic appearances returned to normal, without any treatment, are possibly best attributed to ischaemic colitis.

We should like to thank Professor A. S. Johnstone and Drs. N. L. Hurst and E. Vosloo for their help in the management of the patient.

—We are, etc.,

O. A. A. BOCK.
T. LE ROUX.

Karl Bremer Hospital,
Bellville, Cape,
S. Africa.

Virus in Genital Warts

SIR,—A recent report compares the serological characteristics of the viruses obtained from human genital warts and common skin warts using immune electron-microscopy and complement fixation techniques.¹ The authors suggest the existence of a one-way antigenic cross between the two viruses on the basis of their finding that sera from patients with skin warts reacted with the viruses from both skin and genital warts, whereas sera from those with genital warts reacted with genital wart virus only.

This interesting problem regarding the antigenic identity of the virus in genital warts has also been studied in this department since it was demonstrated that genital warts contained virus particles morphologically identical to those in skin warts but present in very small numbers.² As insufficient amounts of genital wart virus were available here for use in standard precipitation and complement fixation tests, other methods for identifying the virus had to be pursued.

A rabbit inoculated with a suspension of genital wart material was found after the third inoculation to have developed precipitating antibody to virus from skin warts—in fact simple plantar warts. The precipitin line formed by this rabbit's serum gave a reaction of identity with precipitin lines formed against the same virus by serum from a patient with a simple plantar wart and serum from another rabbit immunized with virus from simple plantar warts. These lines are illustrated in the accompanying drawing made from the photographic record of this test (see Fig.).

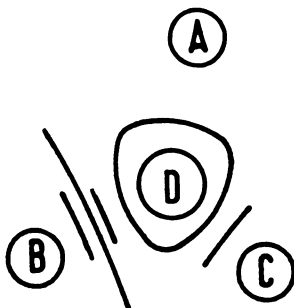


FIG.—(A) Serum from patient with plantar wart. (B) Serum from rabbit inoculated with genital wart suspension. (C) Serum from rabbit inoculated with plantar wart antigen. (D) Plantar wart virus antigen. The inner continuous line around well D shows the identity of the antibodies to wart virus in the three sera. The other lines represent antibody against other human antigens formed by the rabbits.

In addition sera from patients with genital warts were examined for antibody to the virus from plantar warts. Precipitation and complement fixation tests gave negative results with sera from 20 such patients. Recently, however, we have used a much more sensitive method for detecting antibody, particularly immunoglobulin M, to warts—a passive haemagglutination test. In this test tanned red cells sensitized with plantar wart virus are agglutinated by specific antibody in sera not only from people with plantar or other common warts but also from those with genital warts.³

These results show that human and rabbit antisera to genital warts do react in some circumstances with skin wart virus, though the genital wart sera of Mrs. Almeida and colleagues reacted only with genital wart virus in the test systems they employed. That wart viruses have more than one antigenic component has been suspected from the occasional observation of two parallel precipitin lines in some tests, but the position has not yet been clarified.

The genital wart material and sera for these investigations have been provided by Dr. D. H. H. Robertson, Royal Infirmary, Edinburgh.

The author holds a graduate research scholarship from the Medical Faculty of Edinburgh University.—I am, etc.,

MARIE M. OGILVIE.

Virus Laboratory,
Department of Bacteriology,
University of Edinburgh,
Edinburgh.

REFERENCES

- Almeida, J. D., Oriel, J. D., and Stannard, L. M., *Microbios*, 1969, 1, 225.
- Dunn, A. E. G., and Ogilvie, M. M., *Journal of Ultrastructure Research*, 1968, 22, 282.
- Hopkins, R., *An investigation into the immune response of people infected with the human papilloma (wart) virus, using the technique of passive haemagglutination*. (Dissertation presented for B.Sc., Edinburgh). 1969.

Medical Education and the State

SIR,—I enjoyed Professor R. V. Christie's stimulating article (15 November, p. 385) on "Medical Education and the State," but his Table showing the number of whole-time clinical teachers was misleading.

The figures he quotes of 120 in London and 419 in Great Britain are taken from p. 275 of the report of the Royal Commission on Medical Education¹ and exclude all lecturers except senior lecturers, pathologists, and those academic staff engaged in research or administration. They may well not be directly comparable with North American and Scandinavian figures. The approximate total number in Great Britain can be calculated from *The Statistics of Education 1967*.²

The correct figures appear to be three to five times as high as Professor Christie's, depending on whether pathologists are included.—I am, etc.,

R. D. LOWE.

Department of Medicine,
St. Thomas's Hospital Medical
School,
London S.E.1.

REFERENCES

- Royal Commission on Medical Education, Report 1965–68, 1968, Cmnd. 3569. London, H.M.S.O.
- The Statistics of Education 1967*, 1969, 6, pp. 104, 105, 108, 109, 142, and 143. London, H.M.S.O.

Consultant—by any Other Name

SIR,—I must apologise for trespassing again on your columns. However, there are two comments in the recent report on hospital medical staffing by the Central Committee for Hospital Medical Services (*Supplement*, 6 December, p. 53) that I feel should not go unchallenged, although in truth over 30 years' experience of the vagaries of our profession should have compelled me to ignore them.

In the never-ending discussion of the sub-consultant grade, Dr. I. McK. Thompson (*Supplement*, 27 December, p. 79) maintains that it should be classified as "Junior." It is said to be permanent. Would this still apply to an incumbent who has spent, say, 30 years in it? This naive and unrealistic approach is nothing compared to that of Mr. H. M. Bennett, who wants a grade "largely for drop-outs". What a future for a so-called learned profession, when a presumably responsible individual can use such language with all the undertones it represents. Would either of these worthy gentlemen accept such an appointment themselves or would they advise their own children to accept one? If not, why not?

Finally, in the interesting Personal View by Dr. R. J. M. Crawford (27 December, p. 802), he states that the larger Gilbert and Ellice Islands have doctors, but the smaller ones medical assistants or nurses. Need more be said?—I am, etc.,

I. M. LIBRACH.

Chadwell Heath Hospital
Romford, Essex

Publicity and the Pill

SIR,—Professor E. F. Scowen's "apologia" (27 December, p. 805) only confirms the naiveté of the Committee on Safety of Drugs in its dealings with the representatives of the pharmaceutical industry. The principle that medical colleagues should be informed first was sacrificed for doubtful recourse to expediency. But the second issue of principle may be of more importance to the profession—namely, the bald pronouncement by the Committee on the dangers of the particular drug or preparation without any accompanying supporting data and assessments of such dangers in the widest context of the use of the particular drug or preparation.

In our opinion, therefore, the Committee must be severely censured for not fulfilling such criteria, which members of a learned profession are entitled to expect.—We are, etc.,

D. RIVERS.
P. K. GHOSH.
K. T. FARN.

Coventry, Warwicks.