

## Changing Sex Ratios in Diabetes

SIR,—Dr. W. A. Nicholson (20 November, p. 465) reports an increase in the proportion of male diabetics aged 50 years and over in the second of two consecutive decades ending in 1967. We have completed a similar survey of patients attending the diabetic clinic at the Mater Misericordiae Hospital, Dublin.

Patients were classified in groups according to age at onset of diabetes—namely, at 15 years of age or less; between 15 and 45 years; and at 45 years or over. The Table

50 years or over in his clinic increased from 60 in the first decade to 165 in the second, an increase of 175%, while in our clinic male cases diagnosed at 45 years or over increased from 117 in the first decade to 377 in the second—an increase of 219.6%. In both surveys the increase in the number of women was much less. At the Hartlepool Clinic female diabetics increased from 172 to 262, an increase of 52.3%, and in Dublin from 239 to 522—an increase of 118.4%.

The marked increase in the proportion of

Age at Diagnosis of Diabetes	1951-60		1961-70	
	Men	Women	Men	Women
45 years or over . . . . .	117 (32.8%)	239 (67.2%)	377 (41.9%)	522 (58.1%)

illustrates the sex distribution among diabetics diagnosed at 45 years of age or older in the two decades 1951 to 1960 and 1961 to 1970. The proportion of men diagnosed at 45 years or over rose from 32.8% in the first decade to 41.9% in the second—an increase of 9.1%. The figures (allowing for differences in method) are similar to Dr. Nicholson's figures of 25.9% for men at 50 years and over in the first decade and 38.2% in the second—an increase of 12.3%. The number of men diagnosed at

men in the older age group in both surveys, together with the less sharp increase in the number of women, supports the view<sup>1</sup> that a change in the sex ratio has occurred among maturity-onset diabetics.—We are, etc.,

M. I. DRURY  
F. J. TIMONEY

Mater Misericordiae Hospital,  
Dublin 7

<sup>1</sup> Malins, J. M., Fitzgerald, M. G., and Wall, M., *Diabetologia*, 1965, 1, 121.

## Specimens from Female Genital Tract

SIR,—We note with interest the microbiological findings in the female genito-urinary tract described by Dr. W. H. Hughes and Mr. J. M. Davies (13 November 1971, p. 424). We have been carrying out a similar but more restricted investigation in Malawi on groups of African women who are: (1) pregnant or immediately postpartum; (2) healthy and of menstrual age; (3) attending a sterility clinic. Some of our results are summarized and compared in the Table with selected results from the Hughes and Davies's London survey.

able to assess the incidence of *N. gonorrhoeae* found in fresh swabs only from a Gram film: probably therefore we have underestimated it. Nevertheless, our clinical impression of the incidence of gonorrhoea is such that even if it were practicable to mount a routine screening programme here it would not be worthwhile. The effort and money put into such a programme would be prohibitively costly for any country. A much smaller sum spent in tracing contacts of established cases more vigorously than at present would have a much greater return.—We are, etc.,

Organism	London Survey	Malawi Survey
<i>Trichomonas vaginalis</i> . . . . .	35 (3.5%)	53 (28%)
<i>Candida albicans</i> . . . . .	152 (15.2%)	52 (27%)
<i>Neisseria gonorrhoeae</i> . . . . .	3 (0.3%)	0

Total patients examined: London 1,000; Malawi 191.

Whatever the causes, and there are probably many, the incidence of *Trichomonas vaginalis* and *Candida albicans* is much higher in the Malawian women. We were

MARY MCCALLUM  
R. A. TOZER

Central Pathological Laboratory,  
Queen Elizabeth Central Hospital,  
Blantyre, Malawi

## Neurological Disease and Folate Deficiency

SIR,—I should like to record a case of folate deficiency anaemia causing myelopathy.

A woman, aged 63, was admitted with a history of depression with anxiety of about four years' duration. She was known to be anaemic, and her anaemia had been treated with iron by her own doctor but with only limited success. Recently she had been getting weak in her legs, stayed in bed a great deal, and was complaining of numbness in her feet and legs. Her appetite was poor but her weight loss was negligible.

On examination she was sensible but depressed, anxious, and pale. She had some weakness in the hands and forearms but quite marked weakness in the legs. Tactile and pain sensation were intact but vibration and position sensations were lost in the lower limbs. Romberg's sign was positive. All the tendon jerks were brisk and the plantars were upgoing on both sides. Fundi, cranial nerves, and systemic examination revealed no other abnormalities. A clinical diagnosis of subacute combined degeneration of the

spinal cord due to pernicious anaemia was made.

Investigations showed: Haemoglobin 8.2 g/100 ml; R.B.C. 2,300,000/mm<sup>3</sup>; W.B.C. 5,600/mm<sup>3</sup>; P.C.V. 28%; M.C.H.C. 31%; M.C.V. 117 μ<sup>3</sup>; serum iron 156 μg/100 ml; saturation of iron 91%; total iron binding capacity 171 μg/100 ml; platelets 264,000/mm<sup>3</sup>; serum B<sub>12</sub> 300 pg/ml; and serum folate 0.6 ng/ml.

The bone marrow was mildly megaloblastic with hyperactive erythropoiesis and increased iron storage. Myelopoiesis was active with giant metamyelocytes and hypersegmented polymorphs.

Treatment was started with hydroxocobalamin, but there was no improvement haematologically or neurologically within 10 days. Reticulocyte response was 2%. After receiving the results of B<sub>12</sub> and folate, treatment was started with folic acid 10 mg t.d.s. and hydroxocobalamin was stopped. Her haemoglobin went up to 10 g/100 ml in 15 days, reticulocyte response was 12%, and physically her improvement was remarkable. Her legs became stronger, the numbness disappeared, no sensory sign was detected but tendon jerks remained brisk and the plantars were upgoing.

It is generally accepted that folate deficiency does not cause neurological disease.<sup>1,2</sup> But Grant, Hoffbrand, and Wells<sup>3</sup> showed that there was a definite association between folate deficiency and neurological disorders. Anand described a case of folate deficiency causing peripheral neuropathy.<sup>4</sup> Hansen *et al.*<sup>5</sup> reported a 50-year-old epileptic man who had been treated with anticonvulsants and developed atrophy of muscles and loss of cutaneous sensibility. He died four months later from pneumonia and at necropsy lesions were found in cerebellum, spinal cord, and peripheral nerves. Thus there is some definite evidence to suggest that folate deficiency causes not only depression, anxiety, and irritability, but also neurological manifestations.

I would like to thank Dr. B. K. Samtani for his permission and suggestion to report this case.

—I am, etc.,

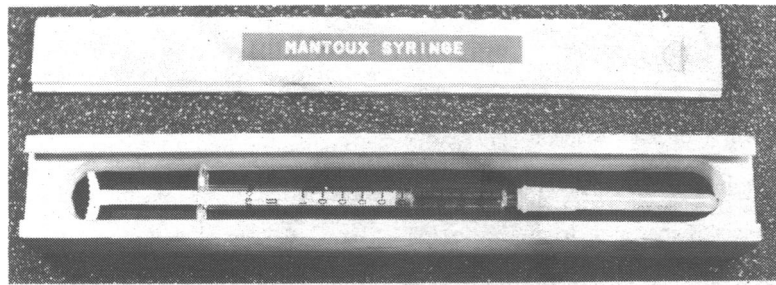
M. AHMED

Department of Geriatric Medicine,  
St. Mary's Hospital,  
Kettering, Northants

- <sup>1</sup> Cecil-Loeb, *Textbook of Medicine*, ed. P. B. Beeson, and W. McDermott, 13th edn., p. 1472. Philadelphia, Saunders, 1971.
- <sup>2</sup> De Gruy, G. C., *Clinical Haematology in Medical Practice*, 3rd edn., p. 138. Edinburgh, Blackwell, 1970.
- <sup>3</sup> Grant, H. C., Hoffbrand, A. V., and Wells, D. G., *Lancet*, 1965, 2, 763.
- <sup>4</sup> Anand, M. P., *Scottish Medical Journal*, 1964, 9, 388.
- <sup>5</sup> Hansen, H. A., Nordqvist, P., and Sourander, P., *Acta Medica Scandinavica*, 1964, 176, 243.

## Collecting Vesicle Fluid

SIR,—Some two years ago expediency led us to employ a disposable Mantoux syringe, fitted with an appropriately fine needle, to collect vesicle fluid from a case of atypical varicella in which virological studies were felt necessary to exclude any possibility of variola. We were impressed both by the painless ease with which the vesicles could be punctured and by the good harvest of fluid. Prompted by this early success we have continued to use Mantoux syringes for this purpose and feel it is probably a



superior technique compared to the established practise of employing glass capillary tubes.<sup>1</sup>

Among immediate advantages we see are the ready availability of disposable Mantoux syringes and their needles, their acceptably low cost, and their sterility. Used with care, puncturing vesicles causes no discomfort and less fluid oozes out around the fine shaft of the needle than around the thicker, blunter capillary tube. Furthermore, reasonably delicate and controllable suction is afforded by this fine bore syringe which permits more complete evacuation of fluid from the vesicle—a factor of some importance when vesicles are scanty and poorly filled.

Once evacuation of the vesicles is complete certain potential difficulties arise in transporting the filled syringe to the laboratory. Firstly, the needle, which should not be removed as it usually contains useful additional fluid, has the potential to cause accidental trauma. This can be overcome by replacing the original plastic sheath over the needle and affixing it to the nozzle end of the syringe by binding with adhesive tape—an action which also prevents leakage. Secondly, the withdrawn piston can be inadvertently pushed back into the syringe barrel; here again, adhesive tape can bind the piston to the barrel thereby preventing this possibility. A useful tip is to leave a free inch or so of the adhesive tape at both sites of application as this aids removal of the tape and affords a site for labelling the specimen. Finally, a suitable container for transportation is desirable. This initially proved difficult but we fortuitously found a box with sliding lid (rather like an old-fashioned pencil box in miniature) which proved ideal.

In the virology laboratory our technicians have found the Mantoux syringe/needle assembly easy to handle and prefer it to capillary tubes both for routine and electron-microscopic examinations. We also have a strong suspicion that a higher yield of virus particles is obtained by the syringe, and our best electron-microscopy results have occurred when this technique has been employed.

We feel this method can be recommended to others involved in similar work. It can, at least, provide a practical method of collecting vesicle fluid if a traditional collection kit is unavailable. Furthermore, anyone inexperienced in using capillary tubes for this purpose will probably obtain a greater amount of vesicle fluid using the disposable Mantoux syringe.

Finally, the method described does not do away with the desirability of collecting smears on glass slides or scabs from patients with suspected variola and, should the Mantoux syringe/needle assembly require to be sent by post, the packing would of course

have to meet the statutory regulations.—We are, etc.,

J. STEVENSON

Department of Infectious Diseases,  
Seacroft Hospital,  
Leeds, Yorks

M. H. HAMBLING

Department of Virology,  
Public Health Laboratory,  
Leeds

D. B. BRADSHAW

Department of Preventative Medicine  
and Public Health,  
University of Leeds

1 Department of Health and Social Security,  
Scottish Home and Health Department.  
*Diagnosis of Smallpox: Medical Memorandum*,  
London, H.M.S.O., 1969.

the presenting part at the introitus, the left foot was also in the pelvis, but the buttocks were held up above the pelvic brim. The pelvis was obviously contracted and once the left foot had been brought down, so that the thigh filled the pelvic brim, the patient was sedated by intravenous cyclo-morphine, and transferred by ambulance the 12 miles to the main unit where a live male infant weighing 2915 grammes was delivered by lower segment caesarean section. The second stage of labour had been three hours by this time. Postoperatively the patient was pyrexial, though a high vaginal swab was sterile, and the pyrexia responded to a course of ampicillin. Subsequent lateral radiographic pelvimetry showed the antero-posterior diameter of the pelvic inlet to be nine centimetres.—I am, etc.,

EDWARD DAW

Department of Obstetrics,  
University of Dundee

1 Baird, D., ed., *Combined Textbook of Obstetrics and Gynaecology*, 8th edn., pp. 435 and 466. London, Livingstone, 1969.

2 Chassar Moir, J., ed., *Munro Kerr's Operative Obstetrics*, 6th edn., p. 169, London, Bailliere, Tindall and Cox, 1956.

3 Clyne, D. G. W., *A Textbook of Gynaecology and Obstetrics*, p. 660, London, Longmans, 1963.

### Irritable Hip in the Adult

SIR,—Transient arthritis in the hip is an established clinical entity in the child. Otherwise known as observation hip, transitory synovitis, fugitative or ephemeral coxitis, the diagnosis is made by exclusion of other painful joint conditions.<sup>1</sup>

The condition was initially described in 1912<sup>2</sup> and has been repeatedly described with a variety of suggestions as to its aetiology.<sup>3,4</sup> Whether the cause is in fact traumatic, infective, allergic, or toxic it is a constant feature that haematological and serum investigations, with the exception of an occasionally raised E.S.R., are unrevealing and radiology in the acute stage shows no abnormalities. Furthermore, the condition is always short-lived, presenting as pain in the hip exacerbated by movement in any direction and after settling with a few days' bed rest there is no short-term residual defect. Initially, bacterial arthritis of the hip was considered a disease limited to childhood<sup>5,6</sup> but it is now generally accepted that adults are similarly affected,<sup>7</sup> the diagnosis being made by prolonged symptoms and signs affecting one or more joints and with a positive bacterial culture.

From our observations of two cases we suggest that transitory arthritis in the hip, like bacterial arthritis, is not limited to childhood. A search of the English language literature has not revealed a similar suggestion.

Two women who presented with similar features, were admitted at different times to the accident and trauma unit of the University Hospital of Wales.

The first was a woman aged 55 years with no previous history of major illnesses and no chronic medical condition. She was admitted complaining of severe discomfort in the right hip exacerbated by movement. She pointed to an area 1 in (2.5 cm) proximal to the greater trochanter as the site of maximum pain, and described its gradual onset over twelve hours. General examination revealed no underlying defect. The hip was flexed to 30°, in 0° abduction/adduction and 0° rotation. In-

### Ortho-Novin

SIR,—The article by Dr. L. Poller and others (11 December 1971, p. 648), entitled "Oestrogen/Progesterone Oral Contraception and Blood Clotting: A Long-term Follow-up," refers to Ortho-Novin. I would like to draw your attention to the fact that this was Ortho-Novin 2 mg and not the currently available Ortho-Novin 1/50. Ortho-Novin 2 mg contains 2 mg norethisterone and 100 µg of mestranol.—I am, etc.,

NEVILLE SHEPARD

Medical Director,  
Ortho Pharmaceutical Limited

High Wycombe,  
Bucks

### Knee Presentation

SIR,—Knee is a rare variety of breech presentation<sup>1</sup> associated with pelvic malformation<sup>2</sup> and extension of the other thigh.<sup>3</sup> In view of pelvic malformation it is not always possible to pull a foot down and allow a spontaneous breech delivery as advised by Baird.<sup>1</sup> I wish to report a case so that the management may help others who encounter this condition.

The patient was a 22-year-old primigravida, 5 ft (1.5 m) in height. She had been booked for confinement in a general practitioner maternity unit. The pregnancy was uneventful and the patient went into labour spontaneously 14 days past her expected date of confinement. At this time it was thought that the fetal head was engaged in the pelvis and vaginal examination was not performed until the patient had been in labour 14 hours.

This examination found the cervix to be fully dilated and a buttock almost at the introitus. As the unit was not equipped for this type of case, the help of the obstetric flying squad was sought. The patient had been in the second stage of labour for two hours when the squad arrived and she was reassessed. The left knee was found to be