weakness in any other muscle groups. Two separate Tensilon tests (10 mg edrophonium chloride) with saline control were performed in a double-blind manner. After the first injection of edrophonium chloride the ptosis improved greatly, and two days later with the second test the improvement was less marked. After the Tensilon tests all therapy was stopped and the patient referred to the late Professor Andrew Wilson, who suggested that this myasthenic syndrome might be related to the practolol. Electromyography revealed no abnormality, nor did it six months later, when the patient had been off all therapy. Investigations including ESR, haemoglobin, blood urea and electrolytes, thyroid function tests, and x-rays of the mediastinum revealed no abnormality. The myasthenic symptoms have not recurred following the second dose of edrophonium chloride, but because the patient's blood pressure rose after stopping the practolol he was restarted on spirinolactone 100 mg daily and bendrofluazide 5 mg daily.

As remission may occur in myasthenia gravis perhaps a three-year follow-up period is too short to be sure that relapse will not occur. However, as the principal adverse effects associated with the use of practolol affect the eyes, skin, aural and nasal mucous membranes, and mesentery (14 June, p 577) and we have seen no mention of a muscular syndrome, we feel it worth alerting clinicians to the possibility of this syndrome being associated with practolol.

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An unnecessary risk to children

SIR,—While I have considerable sympathy with the general contention that children should remain in the back seat (leading article, 24 January, p 180), in the present state of the law on seat belt equipment this may serve actually to increase the incidence of death and injury rather than reduce it. This arises because less than 1% of cars have seat belts in the rear seat, since they are not a mandatory requirement, and children between the ages of 8 and 14 rarely use the child type of harness. In these circumstances it is quite conceivable that it is safer to be in the front seat belted up than in the back seat unbelted.

While the article quoted some statistics, these were not on a comparative basis. In particular, the extent to which the front seat risk is higher than that for the rear and the savings likely to be brought about by the wearing of seat belts in each location. It may be that an expansion of your analysis would indicate that mandatory fitting of belts to the rear seats is a more beneficial proposal.

It continues to be important that new legislation is reasonably likely to bring about an improvement just as the effectiveness of new medications should be proved. Otherwise the public is brought into increasing conflict with the police for no benefit.

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Dukes classification of carcinoma of the rectum

SIR,—In your leading article (13 December, p 605) entitled "Search for presymptomatic large bowel cancer" it is stated that "on the

Dukes classification stage A is a tumour limited to the submucosa, B is with invasion through the muscularis without nodal metastasis, and C with spread to the nodes." With regard to group A and to some extent also to group B this seems to be wrong.

In the original article¹ and later papers and monographs by Dukes^{2,3} the definitions given are: in group A cases the growth is limited to the rectal wall (also including cases infiltrating into but not outside the muscularis propria); in group B the growth has infiltrated into the perirectal tissue but has not reached the regional lymph nodes; and in group C there are metastases in the lymph nodes. These groups are well illustrated by Dukes in the original paper and later articles.

As the Dukes classification for cancer of the large bowel is used world-wide it seems most important that workers in this field, in stating that this classification has been used, should adhere to the definition given by Dukes himself to ensure as strict comparability of material and results as possible.

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- ¹ Dukes, C. E., *Journal of Pathology and Bacteriology*, 1932, **35**, 323.
- ² Dukes, C. E., *Journal of Pathology and Bacteriology*, 1940, **50**, 527.
- ³ Dukes, C. E., *Cancer of the Rectum*, p 66. Edinburgh and London, Livingstone, 1960.

* * * Dr Lindström is quite right; we quoted a widely used American version of the Dukes classification which, as he points out, is inaccurate. We agree that the definitions originally proposed by Dukes should be retained for international use.—ED, *BMJ*.

Folic acid deficiency during intensive therapy

SIR,—We have followed the recent papers on this subject^{1,2} and the ensuing correspondence³⁻⁵ with great interest. Ibbotson *et al*¹ point out that we did not state the exact type of intravenous nutrition in our paper⁶ and so we have now received our two cases. The first patient, who had a short illness following mitral valve replacement, received saline and dextrose only, while the second, who had septicaemia and renal failure, received Aminosol (without ethanol) for six days in his terminal illness. However, circulating megaloblasts were seen as early as 24 hours after commencing this treatment. There is no evidence that either patient received ethanol.

Although our two cases fit into the syndrome of rapidly developing folate deficiency during intensive therapy, they showed in addition extremely bizarre features (for example, giantoblasts, dyserythropoietic changes, frequent multinucleate cells, vacuolation) superimposed on the more usual megaloblastic changes. These additional changes may have been due to factors such as infection, drugs, uraemia, anoxia, etc, having a direct effect on erythropoiesis.

On an historical note, Ibbotson *et al*¹ inferred from our paper that the first description of this bizarre megaloblastic and dyserythropoietic anaemia of rapid onset occurring in seriously ill patients was that of Limarzi and Levinson.⁷ In fact we attributed this to an earlier paper by Harvier and Mallarmé published in 1938.⁸ Unfortunately this date was misprinted as 1968 in the list of references.

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- ¹ Wardrop, C A J, *et al*, *Lancet*, 1975, **2**, 640.
- ² Ibbotson, R M, Colvin, B T, and Colvin, M P, *British Medical Journal*, 1975, **4**, 145.
- ³ Wardrop, C A J, *et al*, *British Medical Journal*, 1975, **4**, 344.
- ⁴ Ibbotson, R M, Colvin, B T, and Colvin, M P, *British Medical Journal*, 1975, **4**, 522.
- ⁵ Colvin, B T, and Ibbotson, R M, *Journal of Clinical Pathology*, 1975, **28**, 1007.
- ⁶ Saary, M, *et al*, *Journal of Clinical Pathology*, 1975, **28**, 324.
- ⁷ Limarzi, L R, and Levinson, S A, *Archives of Pathology*, 1943, **36**, 127.
- ⁸ Harvier, P, and Mallarmé, J, *Sang*, 1938, **12**, 883.

Neonatal jaundice in association with operative delivery

SIR,—I read with interest Professor E A Friedman and Mr M R Sachtleben's paper (24 January, p 198) and their suggestion that clinically undetectable focal haemorrhage secondary to instrumental delivery might be a major contributory factor in the rising incidence of neonatal jaundice. I would like, however, to bring to their attention our findings published in August 1974.¹

On analysis of the full-term infants admitted to the special care unit of the Simpson Memorial Maternity Pavilion, Edinburgh, for hyperbilirubinaemia we similarly found no clear relationship with oxytocin administration, but the Kielland forceps delivery rate for the group was twice the mean for the hospital over the same period. Our conclusion was that the cumulative effects of induction plus operative vaginal delivery even near term probably produces a number of neonates not totally prepared for extrauterine life. In particular their hepatic conjugating mechanism might remain untriggered. We felt that focal haemorrhage too small to be clinically detected was unlikely to elevate the serum bilirubin concentration to such levels.

The morbid effects upon the fetus of modern obstetric practice must constantly be balanced against the undoubted rapid fall in mortality. With increasing vigilance of detection and improved treatment we have, as yet, no evidence that the "boom" of jaundiced babies has produced significant long-term effects on our population.

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- ¹ Eden, O B, Revolta, A D, and Adjei, S K, *British Medical Journal*, 1974, **3**, 573.

Computers and privacy

SIR,—Your leading article on this subject (24 January, p 178) is of particular interest to this practice. Since August 1975 we have been using a computer to maintain our medical records in total. We are particularly concerned with confidentiality and your last paragraph sums up our conclusions exactly.

Each doctor has a unique secret password into the system. We also have a "p p" password which we release to our medical secretaries so as to allow them access to the records.