understood way utilising words already available to anyone educated to the literacy of "O"-level English. He calls upon foreign tongues—"angst" and "manqué"—when they are not only inappropriate but in any case have perfectly acceptable and more subtle English counterparts. He uses the words "apposite" and "sacerdotal" when he obviously does not understand what they mean. He makes arrogant statements regarding the social and intellectual behaviour of baboons, subjects which have recently been thoroughly and lucidly documented and found to be of a remarkably advanced kind. His references to "mental masturbation" and "corporate self-abuse," while extraordinarily offensive, are also entirely baffling in the context in which he uses them.

I can understand his attack only on the assumption that it was written after the author had been gazing into a mirror. Let us hope that the Personal View column will quickly recover from this sorry lapse and return to its established standards of discrimination, scholarship, and interest.

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Small thymus in anaemia

SIR,—I was most interested to read the article by Drs J Ellis and H G Kohler (20 March, p 694) in which they report low thymic weight in the human fetus following fetal transplacental blood loss. Dr Kohler has also found that the thymus weighs less than expected in many cases of perinatal death caused by various forms of anaemia.

During studies of the lymphoid organs in severely anaemic guinea-pigs¹ we found a 50% reduction in thymic weight. The histological structure was remarkable. The cortex was markedly reduced and in some specimens there appeared to be a massive migration of small lymphocytes into the interlobular septa and around the interlobular vessels, including the lymphatics, some of which were full of lymphocytes. There was no evidence of cellular pyknosis. In fact numerous mitoses and DNA-synthesising cells were present in the cortex. Accompanying these thymic changes there was a marked lymphocytosis in the peripheral blood and this was almost completely abolished by previous thymectomy.

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¹ Harris, P F, and Kugler, J H, *Journal of Anatomy*, 1970, 107, 389.

Observer error in blood pressure recording

SIR,—The article by Dr S Concerção and others on defects in sphygmomanometers (10 April, p 886) omits one important source of error—the user. The accompanying chart illustrates the readings given by 24 of our midwives from the film produced by Miss Jane Wilcox¹ showing a column of mercury slowly falling in a manometer tube accompanied by a recording of the Korotkoff sounds. Most of the readings give a systolic value of between 200 and 210 mm Hg but three read 260 mm Hg.

There is more agreement concerning diastolic values, which were mainly 100-110 mm Hg, but they vary between 80 and 190 mm Hg.

It is essential to discover whether personnel using sphygmomanometers are good or bad readers and this can be done by checking their performance with a double stethoscope.

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¹ Wilcox, J, *Nursing Research*, 1961, 10, 4.

Coeliac disease and farmers' lung

SIR,—We were interested in Dr T J Robinson's report of two cases of coeliac disease with farmers' lung (27 March, p 745). However, it is now generally accepted that the term "coeliac disease" should be used only when gluten withdrawal has resulted in a significant improvement in jejunal mucosal histology¹ and is not therefore necessarily appropriate to the two cases described.

There is, in fact, circumstantial evidence of gluten sensitivity in most of the cases of extrinsic allergic alveolitis with villous atrophy described, confirmed by repeat jejunal biopsy in one patient.² Also, an increased prevalence of the HLA-B8 antigen has been noted in both conditions.^{3 4} Nevertheless, we feel that future studies of this association should pay close attention to the effect of gluten withdrawal on the jejunal mucosa. The possibility of other antigens causing the intestinal lesion should also be considered, in particular the agent responsible for the alveolitis, and it was in view of this that we were careful to use the term "villous atrophy" rather than "coeliac disease" in our paper.

O E EADE
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¹ Booth, C C, *British Medical Journal*, 1970, 3, 725.

² Berrill, W T, et al, *Lancet*, 1975, 2, 1006.

³ Stokes, P J, et al, *Lancet*, 1972, 2, 162.

⁴ Flaherty, D K, et al, *Lancet*, 1975, 2, 507.

The bran-wagon

SIR,—A bran-wagon effect for the treatment of diverticular disease has been produced by a clever hypothesis,¹ suggestive epidemiological evidence,² and uncontrolled clinical trials.^{3 4} Now Mr A J M Brodribb and Dr Daphne M Humphreys (21 February, p 425) have given us another uncontrolled treatment trial. Granted they collected some objective data—transit times, colonic pressures—and granted

they sound a note of caution—"a positive placebo effect may have resulted." Nevertheless, they go on to conclude that a high-fibre diet does relieve symptoms of diverticular disease. They even state that "a low-residue diet . . . was accepted without any real proof of its therapeutic value," while they provide no proof that bran had anything to do with relief of 60% of symptoms in their patients. All parameters assessed were subjective and there were no control patients.

"It was not feasible to carry out a double-blind controlled trial," the authors state. If an uncontrolled trial with purely subjective end points is useless (as the authors seem to tacitly agree) why did they not just omit it? Or why did not the Editor of the *BMJ* winnow out the invalid parts of a good study? High-fibre diets may indeed benefit patients with diverticulitis. Let's see an article from the British bran-wagon that proves it.

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¹ Cleave, T L, Campbell, G D, and Painter, N S, *Diabetes, Coronary Thrombosis and the Saccharine Disease*, 2nd edn. Bristol, Wright, 1969.

² Painter, N S, and Burkitt, D P, *British Medical Journal*, 1971, 2, 450.

³ Painter, N S, Almeida, A Z, and Colebourne, K W, *British Medical Journal*, 1972, 2, 139.

⁴ Plumley, P F, and Frances, B, *Journal of the American Dietetic Association*, 1973, 63, 527.

Bacteraemia following rectal biopsy

SIR,—I was interested to read your leading article entitled "Bacteraemia from the bowel" (16 August 1975, p 396) and I wish to report an episode of significant bacteraemia which followed sigmoidoscopy and rectal biopsy.

A 69-year-old woman was admitted to hospital with a deep venous thrombosis, pulmonary embolus, and previously undiagnosed ulcerative colitis which had manifested itself by bloody diarrhoea for six months. Sigmoidoscopy was undertaken soon after admission, and an intensely hyperaemic and haemorrhagic mucosa was seen. A forceps biopsy was taken which showed the changes of severe proctitis. Treatment was started with an immediate dose of prednisolone 15 mg by mouth and intravenous heparin 10 000 units.

Four hours after the sigmoidoscopy and rectal biopsy the patient felt and looked less well. Her temperature had risen from 37.6°C to 38.7°C, but there were no other specific changes in her signs or symptoms. Blood, sputum, and urine cultures were taken. It was thought possible that her pulmonary infarct had become infected, and she was started on treatment with benzyl penicillin, one mega unit intramuscularly six hourly. The patient's temperature fell to normal within 12 hours and she made an uneventful recovery.

On the fifth day the blood culture grew anaerobic streptococci, and a rectal swab taken after the course of penicillin had been completed also yielded anaerobic streptococci. Transient bacteraemia has been shown to occur quite frequently after sigmoidoscopy¹ and barium enema.² However, in these studies the patients remained symptom-free and all positive blood cultures were obtained within 30 minutes of the examination and cultures thereafter were sterile.

This patient underwent a definite deterioration in clinical state four hours after sigmoidoscopy and rectal biopsy. A bacteraemia was demonstrated at this time, and anaerobic streptococci were isolated both in the blood and later from the rectum. In the reported