those relieved by transplantation or colpocleisis. The cases refusing relief operations should not be included. Thus, of 54 cases, 4 refused either a second vaginal operation, or a relief operation, leaving 50 cases. Of these, 43 were repaired, 3 underwent successful transplantation, and 1 colpocleisis, giving a total of 47 cured or relieved, or 94%.

3. Percentage of cases relieved only, out of the total of those relieved and cured:

$$\frac{\text{cases only relieved} \times 100}{\text{cases cured and relieved}} = \frac{4 \times 100}{47} = 8.5\%$$

4. Cases complicated by the presence of other fistulae should be recorded as it may give some idea of the severity of the condition. Three cases had an associated uretero-vaginal fistula: in each the V.V.F. was repaired; in one a nephrectomy was necessary; and in the other two the offending ureter was transplanted into the sigmoid. The three cases were complicated by a recto-vaginal fistula: one had both fistulae repaired, another had the R.V.F. repaired, and both ureters transplanted (V.V.F. inoperable), and the third had an inoperable V.V.F. in which several attempts to cure the R.V.F. failed.

5. One's criterion of inoperability and how many the series included (3 cases).

6. Number of cases treated previously operated upon elsewhere and how often: 11—9 once, 1 twice, and 1 four times. These include two of my failures and nine repairs.

7. Successful cases which required more than one attempt: one in this series had two vaginal operations; all the other successes healing at my first attempt.

Would not records on these lines do much to enable workers to avoid avoidable misunderstanding? It is doubtful if further information could usefully be offered, short of supplying full case notes.—I am, etc.,

Bournemouth. G. BENION THOMAS.

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Lice in Hospital

SIR,—After six years spent with a relatively non-verminous military population it is depressing to realize that one's own people can be indifferent to the louse. This realization focused attention on the prevalence of lice, and the noting of verminous patients on admission to hospital during the past two years makes it possible to deal with true figures. Patients examined have all suffered from notifiable disease and may be considered a fair cross-section of the Lanarkshire population, since all grades of society find themselves at times in an isolation hospital. No distinction was drawn between head and body lice, since it is reasonable to regard these as the same insect. Nits have been taken as evidence of lousiness.

Tabulation of the available figures show:

TABLE A.—*Gross Figures: Louse Infestation*

Year	Total Admissions	Verminous	Clean	% Verminous
1944	1,983	566	1,417	29%
1945	1,895	670	1,225	35%
1946 (Jan. and Feb.) ..	394	119	275	30%
Total	4,272	1,355	2,917	32%

It would appear that approximately 1 in 3 of the patients admitted were lousy on leaving their homes.

TABLE B.—*Age and Sex Incidence* (1944, 1945, 1946, *Jan. and Feb.*)

Sex	Age Group	Verminous	Clean	% Verminous
Males	0- 4·9	130	413	24%
	5-13·9	253	559	31%
	14-17·9	22	104	18%
	18+	21	529	4%
Females	0- 4·9	142	303	32%
	5-13·9	494	375	57%
	14-17·9	63	54	54%
	18+	230	580	28%
Total		1,355	2,917	32%

The relatively high incidence in children of both sexes in the pre-school age group suggests neglect on the part of parents, and the incidence among adult women indicates a lack of personal cleanliness which cannot but be reflected on their children. The female figures are all bad, and it is depressing to note the condition of school-age children (males 31%, females 57%). These figures seem to demonstrate a certain futility in the present methods of eradicating lice in schools. They indicate, too, the chance a clean child has of acquiring lice. Lousiness among adolescent girls at as high a rate as 54% is an ill augury for the mothers of the future. The reasonable figures for adult males cannot be due to lack of available infection, but undoubtedly short cropping of male hair creates an uncomfortable environment for the louse just as the apparently untouchable and unwashable "perm" provides a secure retreat. When the problem is considered honestly there is no real reason why anybody in this country should harbour lice, and it seems apparent that apathy, indifference, and laziness are the real reasons why British lice still flourish.

In the County Hospital, Motherwell, dichlordiphenyltrichlorethane (D.D.T.) as a 5% dust in talc has been used to control these vermin. A simple dusting with the powder on admission suffices to kill the lice, and as nits hatch out the still effective powder destroys the nymphs. No toxic effects have been observed, and in these days of nursing shortage D.D.T. saves much time and obviates embarrassing scenes with female patients. The good uses of D.D.T. have been seen on a large scale abroad, and there seems no reason why the 5% dust, applied perhaps once a month to school-children, should not reduce the present verminous condition to infinitesimal proportions. D.D.T., being stable and effective for several weeks, should take care of renewed infestation in the home. In schools the dust could be applied rapidly, economically, and without offence, by the use of a dust-gun.—I am, etc.,

Weston-super-Mare. JAMES MACRAE.

Rheumatic Fever

SIR,—When Dr. H. S. Barber reads Dr. K. Douglas Wilkinson's letter (Aug. 3, p. 174) I hope he will not feel too crushed and discouraged. Nearly 20 years ago, when I was doing some work on allergy, the late Dr. Oriel, whose work on the biochemical aspect of allergy was well known, told me that he had evidence which convinced him that the articular symptoms of acute rheumatism were an allergic response.

Dr. Wilkinson wants Dr. Barber to explain the response of acute rheumatism to the salicylates. Asthma, which I prefer to regard as a syndrome rather than a disease, is distinguished chiefly by bronchospasm. There are various causes of bronchospasm, and I and many others have observed the response of the allergic variety to acetyl-salicylic acid. Some patients have even made the discovery for themselves.

I have no doubt that Dr. Barber will probably answer Dr. Wilkinson in detail.—I am, etc.,

Brookwood. H. M. STANLEY TURNER.

Achromotrichia in Tropical Malnutrition

SIR,—I was interested in Dr. William Hughes's article on achromotrichia in African children (July 20, p. 85) as I have recently seen similar types of depigmentation of hair and skin in Europe. I should explain that I am an Army M.O. with administrative charge of a Civilian Internment Camp. The internees are here pending investigation of their part in the Nazi régime, etc. Many of them are considerably undernourished, and recently I have seen four cases with the following points of similarity:

(1) All were males over 55 years of age and had been in a poor state of nourishment previous to arrest.

(2) On the backs of the hands, the wrists, and front of the neck the skin was thickened, brown, and there was a flaky desquamation. Two of the men showed snow-white patches in these brown areas.

(3) The tongue was rather red and quite smooth. There was no pain or burning taste.

I wondered if this might be a pre-pellagra stage, although there were no signs of C.N.S. involvement or diarrhoea, etc. Large doses of vitamin B_1 and increased diet had no effect. Unfortunately vitamin B_2 is not available.

I have noticed several cases of depigmentation of a patchy type in the hair. It cannot be pulled out painlessly though. The German doctors here consider this to be a symptom of anxiety rather than malnutrition.—I am, etc.,

E. ROEBUCK,
B.A.O.R. Capt., R.A.M.C.