"Priscol" and Acute Heart Failure

SIR,—In regard to the clinical note by Dr. David Wheatley (May 31, p. 1174) on relief of acute left ventricular failure by "priscol," is the author aware that the intravenous injection of morphine and aminophylline causes relief, within a very few minutes, of the acute dyspnoea and bubbling rales and a disappearance of the cold, clammy skin? If following this procedure a mercurial diuretic is slowly injected intravenously or given intramuscularly with a small amount of procaine solution, the patient usually experiences complete relief and no further therapy is needed.

Have Dr. Wheatley's patients been maintained on a very low salt diet?

It would be interesting and relevant to know what the experience of other English physicians with the use of a vasodilator has been.—I am, etc.,

Clarion, Iowa. R. L. GORRELL.

SIR,—Mortal conditions warrant the use of dangerous remedies; but the latter are only justified if they are certain in effect and there is no safe alternative. An intravenous mercurial diuretic may result in sudden death, and, although I have not tried intravenous morphine, it must be recalled that this drug is a powerful respiratory depressant. I would hesitate to say that intravenous injection would be entirely without danger, in a condition where pulmonary function is already seriously impaired. As I mentioned in my article, I have never seen any relief of acute pulmonary oedema follow the use of either intravenous mersalyl or aminophylline (0.5 g.), although I have employed both, before I thought of using "priscol." It would appear that Dr. Gorrell has been more fortunate in this respect; although the very multiplicity of his remedies may cast a suspicion of doubt in the minds of some upon their complete effectiveness.

In introducing priscol as a remedy for acute left ventricular failure, I have been actuated by a desire to find a rapid, safe, and effective drug the action of which is based upon physiological principles. As such, it is a remedy for sudden emergency, and my patients had not been previously maintained on a low sodium diet. In fact, the effects of such a diet upon cardiac failure are not relevant to the purposes of my article.—I am, etc.,

Twickenham, Middlesex. DAVID WHEATLEY.

Serum Culture of Erythroblasts

SIR,—I should like to comment on some points arising from the interesting article of Drs. Feinmann, Sharp, and Wilkinson (July 5, p. 14). I can confirm the authors' observation that no difference in effect can be shown between 40% and 60% *homologous* pernicious anaemia serum as culture medium on the ripening of megaloblasts. I had to compare 35% with 65% *heterologous* pernicious anaemia serum to demonstrate the presence of an inhibitory effect. Normal serum does not show a significant dilution effect. The importance of the use of heterologous serum—i.e., not the patient's own—has been pointed out in a detailed description of the technique (L. G. Lajtha, *J. clin. Path.*, 1952, **5**, 67), and E. E. Osgood and I. E. Brownlee (*J. Amer. med. Ass.*, 1937, **108**, 1793) also called attention to this point. No explanation has so far been found for the curious fact that the patient's own serum causes some ripening of megaloblasts to normoblasts and that the inhibitory effect is more pronounced when serum from another pernicious anaemia patient is used.

I cannot subscribe to the grouping together of proerythroblasts and megaloblasts in the differential counts. We have found it here necessary to define very strict criteria for the megaloblasts, including in this classification only those cells which are never seen in normal marrow. The recognition of megaloblasts in 72-hour cultures of normal marrows in 80–90% pernicious anaemia serum has been confirmed by R. B. Thompson in Newcastle (personal communication) and L. Bussi in Milan (personal communication). The Italian workers seem to have collected some evidence that certain metabolic products of tyrosine breakdown inhibit the ripening of megaloblasts into normoblasts *in vitro* (L. Bussi—to be published).—I am, etc.,

Oxford. L. G. LAJTHA.

Plastic Artificial Gullets

SIR,—Since the surgical treatment of cancer of the hypopharynx and the cervical segment of the oesophagus involves highly technical procedures, may I stress the importance of regarding each patient as an individual problem, so that a careful selection can be made of the best treatment to suit his special requirements, without any argument concerning the number of stages to be used? The surgeon must have at his disposal several techniques which he can use in certain eventualities. The primary consideration is that the disease must be eradicated, and we must not be hampered in this duty by thoughts of reconstruction which can be done satisfactorily later. Refinements of technique will come with the possibility of a satisfactory one-stage operation. For example, I have obtained primary closure by anastomosing the divided hypo-pharynx with the pharyngo-oesophageal junction; fibrous strictures do not follow this type of closure when perfect mucous membrane apposition is obtained. A procedure which leads to fibrous stenosis and dysphagia is useless.

I have used plastic artificial gullets as a temporary measure to enable the patient to swallow between the first and second stages of the planned procedure. In certain instances, as when the skin of the neck has been heavily irradiated, this interval may be prolonged but the patient can go home, and one patient went to work. The tube is removed when the reconstruction operation is performed.

I am strongly in favour, at present, of a procedure carried out in two stages for the majority of patients. It is possible for such a patient to go home fit, with perfect deglutition, in eight weeks and without the prospect of recurrent dysphagia from a fibrous stricture.—I am, etc.,

London, W.1. RONALD W. RAVEN.

Help for Tuberculous Students

SIR,—The British Student Tuberculosis Foundation was formed last year with the aim of opening in this country a 100-bed rehabilitation centre where students convalescing from tuberculosis can be fitted for return to college by courses of study including lectures, set reading and essay writing, tutorials, etc. In a little over 18 months students in Britain have collected some £20,000 towards it.

This April the N.W. Regional Hospital Board agreed to open a small experimental unit for men at Pinewood Hospital near Wokingham in Berkshire; this centre is expected to be ready in September. It will have accommodation for 16 student patients in one self-contained ward. This is to be divided into three parts: a dining-room where all meals will be taken, a lounge, and a bed-ward where students can read in silence during rest periods. The medical care and supervision of the patients will be the responsibility of the physician superintending the hospital. The academic side will be the responsibility of the Foundation. Those admitted will have to be recovering satisfactorily; they must be non-infectious in the sense of sputum negative. As only a minimum of nursing staff will be available, students must be fit enough to do a few light duties for themselves, such as making their beds. They must be able to take all meals up and stay up and dressed for at least four hours a day. Patients will be expected to abide by the rules of the sanatorium during their three to four months' stay there.

The Foundation is to be responsible for occupational treatment, and is now making arrangements for university teachers, principally from the University of London, to visit the centre regularly to give lectures and to supervise individual courses of study.

Entry is open to full-time male students from all parts of Great Britain, whatever their race, colour, or creed. It