Lithopaedion in African Women

SIR,—Dr. F. Schwarz (July 19, p. 131) in reporting this case says he has not been able to find a single report of a lithopaedion in an African. It may therefore be worth noting that I found a lithopaedion at laparotomy in a Kenya African (Luo tribe) about three years ago. A note of the case was published in the *East African Medical Journal* (1951, **28**, 90) with references to other cases, at least one of which was also in an African woman.—I am, etc.,

Maseno, Kenya. R. B. LEECH.

Is Metallic Mercury Poisonous?

SIR,—I should like to comment on the article by Drs. Gilbert Forbes and James White (April 26, p. 899) and the letter of Mr. R. S. Handley (May 24, p. 1131) on the subject of metallic mercury poisoning. The frequency with which silver amalgam fillings are placed into excavated teeth should be sufficient to convince those who are interested that metallic mercury is not excessively poisonous. In the course of the insertion of the average silver amalgam dental filling a considerable portion of mercury which is uncombined with the alloy filling material is expressed prior to insertion into the cavity. Therefore quite an amount of relatively uncombined mercury remains in contact with the oral mucous membrane even following insertion of fillings. Also, the patient inadvertently, but very frequently, swallows small bits of silver amalgam which have been left in the mouth following carving. These bits of silver, which are swallowed, contain considerable amounts of uncombined mercury owing to the fact that they were the last carved-off portions of amalgam, in which the uncombined mercury content is extremely high. Although there have been some instances of sensitivity to silver fillings reported in the literature, these have been extremely rare considering the total number of dental fillings placed.—I am, etc.,

School of Dental and Oral Surgery, Columbia University, New York. AUSTIN H. KUTSCHER.

Chronic Lead Poisoning

SIR,—I have read with interest the contribution of Dr. Jane M. Fullerton (July 19, p. 117), in which she sets forth the haematological findings in a group of lead workers exposed to risk of lead absorption. Some minor points, however, call for comment.

It is stated that "under the present regulations cases without clinical symptoms cannot be notified as lead poisoning." But why not? As is stated, it is Section 66 of the 1937 Factory Act (not a regulation under the Act) which makes lead poisoning notifiable, but there is no direction, specific or implied, which makes it necessary for clinical symptoms to be present before a diagnosis, with subsequent notification, is made. The operative word is "believes," and, if any practitioner believes that punctate basophilia and/or a lowered haemoglobin percentage, etc., in the absence of symptoms or other signs is of a degree to indicate lead absorption in the circumstances prevailing, then it is evidence of "poisoning" and notification should be made. Only in this way can the purpose of notification be fulfilled—i.e., the direction of attention to processes where faulty techniques and practices are leading to lead poisoning. Notification as unfit is irrelevant in this context, but not so if certification is being made for purposes of industrial injury benefit under the National Insurance Act, which prescribes lead poisoning as qualifying for the payment of industrial disease benefit.

Toxic anaemia offers an alternative means of notification, although it is not defined in the regulation (S.R. & O. No. 196 of 1942) making it notifiable. The definition "any dyshaemopoietic disturbance" needs further qualification to take account of the necessary exogenous causative factor, be it lead, benzene, ionizing radiation, or other toxin.

Workers in Group A are stated to have been provided—by regulation—with an extra daily milk allowance. No such regulation now exists, as it was with the introduction of the Pottery (Health and Welfare) Regulations, 1950, that the only remaining regulation requiring the provision of milk was repealed (Pottery Regulations, 1913, S.R. & O. No. 2, 1913). Extra milk cannot be regarded as being effective in *preventing* gross lead absorption, but only possibly in lessening its effects. The provision of milk, indeed, may well lead to a sense of false security and the taking of risks which are not justified where the possibility of lead absorption exists.—I am, etc.,

London, N.W.11. A. W. GILKS.

Allergy and A.C.T.H.

SIR,—Professor G. W. Pickering (June 7, p. 1207) states that, although there is some evidence of altered tissue reactivity to certain specific antigens in acute nephritis, the evidence concerning the role of allergy in this disease is dangerously thin. Bell, in his book on nephritis, sums up the arguments on this issue, and concludes that acute nephritis is not associated with an allergic disturbance. The description of a case with a diagnosis of acute nephritis associated with painful swellings of the phalangeal joints of both hands, and a quick response to treatment with "antistin," may therefore be of interest.

A woman aged 30 attended the surgery complaining of puffiness of the face and swelling of the legs, and this had been noticed for about two days. Albuminuria was found on examination. She was examined in more detail at home the following day.

She now complained of headache, scanty urine, and painful swellings of the small joints of all the fingers, in addition to the swelling of the face and legs.

There was a swelling of the face, and a definite oedema of both legs. The B.P. was 140/95 mm. Hg, which was considered to be on the high side for this patient; the retinae showed no abnormalities; albuminuria was present but not heavy; granular casts were noted. In addition a swelling of the phalangeal joints of both hands was observed. The swelling of the face and legs was in no way indicative of urticaria or angioneurotic oedema and there was no pruritus. There was no recent history of an infective or other condition, and no past history of any kidney disease.

The treatment prescribed was rest, restricted fluid intake, a vegetarian diet, and an antistin tablet three times a day. In about four days the swelling of the face and legs, the albuminuria, and the joint disturbance had subsided. The B.P. was lower, and the patient stated she was quite fit again. The antistin was continued for a further week. It was considered that this patient had an acute nephritis associated with an allergic manifestation in the joints. In view of the quick response of the whole condition to the antihistamine, it is suggested that the kidney disturbance was of an allergic nature.

Professor Pickering in his article divides the allergic tissue responses into two broad types: the response that is immediate and associated with the release of histamine, and the delayed response which is of an inflammatory nature. It is possible that the case described may be of the type associated with the release of histamine, as shown by the quick response to the antihistamine, and that the typical case of type 1 nephritis is associated with a delayed tissue response of an inflammatory nature, and not amenable, as Professor Pickering points out, to antihistamine treatment. The suggestion is therefore made of two broad types of acute nephritis, and this may account for the divergent opinions as to the value of antihistamines in the treatment of acute nephritis.—I am, etc.,

Manchester. JACK CARR.

Trapping the Surgeon's Sweat

SIR,—In your issue of May 31 (p. 1197) I saw a picture of a cap for trapping surgeon's sweat. As a dental surgeon who works in a temperature varying between 75° F. (24° C.) and 90° F. (32° C.) I have had trouble with a sweating forehead and dewy glasses. I devised a headband which I find very useful, as well as being cheap and easy to make. A linen band about two to three inches (5–7.5 cm.) wide, and extending on each side just beyond the margin of the forehead, is used, and on the inner side two flaps are stitched which just overlap along the middle line. On the outer side

another piece of linen is stitched to provide a slot the whole length of the band for a piece of white garter elastic, which fastens at the back of the head with a press stud. The space between the flaps and the main band is occupied by two pieces of fine sponge rubber, sold at the drug stores for applying make-up. These sponge-pads are circular, and I cut one in half and use one over each eye. Before carrying the band to position it is immersed in a little ice water and squeezed out. This ensures a cool dry forehead for some time and the sponge will absorb any sweat. The elastic band and sponge can be easily transferred from one band to another.—I am, etc.,

Nassau, Bahamas. NORMAN STRATON.

Accidental Generalized Vaccinia

SIR,—After the article on "A Case of Accidental Generalized Vaccinia" by Drs. O. A. Finn, J. C. Dick, and J. S. Stevenson (May 17, p. 1067) and subsequent correspondence on the subject, perhaps the following case may be of interest.

The patient was a girl of 6 months who had suffered from a mild degree of eczema since the age of 6 weeks, when weaned on to the bottle: there was a strong familial history of eczema on the paternal side. On June 9 her mother was vaccinated for the first time, before leaving for the U.S.A., and one week later developed a blister on the site, which duly became pustular. Eleven days after this the baby developed a vesicular rash over the eczematous areas on the upper chest and arms. On admission three days later, July 1, the baby was febrile (temperature 103° F. (39.4° C.)) and had a profuse papulo-vesicular eruption smothering the face, neck, upper chest, and upper arms. There were scattered lesions on the limbs and lower trunk: the scalp was clear. She had been vomiting after feeds for two days, but did not appear dehydrated. No abnormality was detected in the other systems.

She was put on to three-hourly feeds of glucose saline, with "elixir benadryl" 1 dr. (3.5 ml.) four-hourly, phenobarbitone ½ gr. (8 mg.) thrice daily to minimize the risk of convulsions, and soluble penicillin 250,000 units b.d. Proflavine in pareolin 1:1,000 was applied locally to the lesions. The vomiting stopped immediately, and two days later feeds with half-cream National dried milk were recommenced. However, the lesions became very confluent, umbilicated, and pustular, and started to ulcerate in places: this was one week after the onset. In view of the history and character of the lesions, some convalescent vaccinial serum was obtained and two doses were given over a period of two days. The temperature remained at 103° to 104° F. (39.4° to 40° C.). On July 6 her condition deteriorated: she began to twitch, and became cyanosed. Oxygen was administered, and also syrup of chloral, and she improved considerably. However, the next day her temperature suddenly dropped to 95° F. (35° C.), and during the evening she died. Swabs taken on admission revealed on culture a growth of *Staphylococcus aureus*, β-haemolytic streptococci, proteus, and pyocyaneus.

I feel that this is worthy of note, and serves as a further warning against allowing eczematous children to come into contact with active vaccination sores. I am grateful to Dr. Warin for his help, and to Dr. Alice Carleton for her advice and permission to submit this.—I am, etc.,

Oxford. MARY L. ASSINDER.

Gall-stone Colic

SIR,—As mentioned in the factual article by Drs. T. R. Littler and G. Ronald Ellis (April 19, p. 842), gall-stone colic may occur only at night. Patients I have seen with this pain pattern have had stones which are single and the size and shape of a green pea. They have also been heavy, and though they were not analysed I guessed they contained a good deal of calcium.

When the patient is erect the fundus is the lowest part of the gall-bladder and the stone lies there quietly; when, however, the patient lies on her back, the stone after some time may gravitate into Hartmann's pouch, which is now the lowest part of the gall-bladder, and may thus cause biliary colic by blocking the entry of bile into the cystic duct.—I am, etc.,

Sydney. T. MAYNARD FURBER.

Obituary

Sir JACK DRUMMOND, D.Sc., F.R.S.

The civilized world has been shocked by the brutal murder of Sir Jack Drummond and his wife and daughter while on holiday in France on August 5. His death is a grievous loss to British medical science and to biochemistry.

Jack Cecil Drummond was born on January 12, 1891, and was educated in the University of London, first at Queen Mary College and then at King's College. Originally studying chemistry, he was quick to realize the growing importance of the new subject of biochemistry, and became a research assistant in biochemistry at King's College, London, in 1913, under Dr. Otto Rosenheim, F.R.S. Here he made his mark as an investigator, and in 1914 was appointed research assistant in the Biochemical Department of the Cancer Hospital Research Institute, London, of which institution he became Director of Biochemical Research in 1918. To his lasting regret he was considered unfit to serve in an active capacity in the war of 1914–18, but he threw his energies into nutritional research, a matter of clear relevance to the problems which faced the country in its war effort. At this time Casimir Funk was investigating the nature of the substance, present in rice polishings, which was capable of curing the polyneuritis developing in pigeons fed on a diet of polished rice, and Drummond entered with zest and vigour the field of vitamin biochemistry as assistant to Funk. The reputation he established as the result of his researches in the field of the vitamins led to his appointment as reader in physiological chemistry at University College, London, in 1919, under the late Professor E. H. Starling, F.R.S. Here he continued his researches on vitamins, and was made the first professor of biochemistry at University College, London, in 1922, at the early age of 31. At University College his investigations on vitaman-B deficiency and its relationship to inanition, and also on the nature of substances having vitamin-A and vitamin-D activity, quickly established him as an international authority on the subject of accessory food factors. He it was who advocated dropping the final "e" of "vitamine" (the name coined by Funk) so that the resulting word "vitamin" should be acceptable under the Chemical Society's standard scheme of nomenclature (*Biochemical Journal*, 1920, **14**, 660).

[*Walter Stoneman, London.*

His conspicuous ability to convey to lay audiences the significance of the technical aspects of nutrition and the role played by vitamins in health and disease led to his being called to advise many bodies concerned with problems of a practical nature in nutrition; for example, he visited Newfoundland in 1931 to report on the steps needed to alleviate the malnutrition which at that time was not uncommon in the island. In 1933 he was invited