followed by complete remission of signs and symptoms. Seventeen days after admission the infant was discharged cured, and since then her progress has been satisfactory.

Relatively few cases of naphthalene poisoning have been reported in the literature. It is only recently that reports have begun to appear of cases in which haemolytic anaemia has resulted from the ingestion of mothballs (W. W. Zuelzer and L. Apt, *J. Amer. med. Ass.*, 1949, **141**, 185); and one other case, with fatal outcome, occurred through skin absorption in an infant whose napkins had been stored in naphthalene mothballs (W. B. Schafer, *Pediatrics*, 1951, **7**, 172). In this case which I have recorded the presumption is that naphthalene was absorbed through the skin. This would be facilitated by the normal greasy condition of the skin immediately after birth, together with the fact that the child's skin was rubbed daily with olive oil. Here is a further example of cyanosis in infancy, associated with acute haemolytic anaemia, due to poisoning by a common household article, the diagnosis of which depended primarily on an accurate history.

I wish to express my thanks to Professor F. M. B. Allen for permission to record this case.—I am, etc.,

Belfast. N. A. F. JOHNSTON.

Appendicitis in the West Indies

SIR,—The article by Mr. Aubrey Leacock on this subject (June 21, p. 1347) raises an interesting point as regards the actual geographical world incidence of acute appendicitis.

Part of my war service (1942–7) as a surgical specialist was spent in West Africa, the Sudan, and Egypt. I was most impressed by the non-existence of acute appendicitis as a surgical emergency among the native troops and attached native civilians in our units, yet the disease remained as prevalent in relative proportion to its incidence in the United Kingdom among our own and captive European troops. Such contacts as I made with members of the Colonial Medical Service confirmed this view, yet I was surprised to find that acute appendicitis did affect the colonial troops when they were transferred to active theatres of war in Egypt, Italy, and Burma and were forced of necessity to consume European rations.

There are very few references in an extensive literature on appendicitis to its actual geographical incidence, and I feel that your columns at this juncture would prove an admirable place for those in far-distant parts of the world to give us information of their experiences of the actual incidence of this disease among non-European races.

I am convinced in my own mind that the disease is not a racial one, but rather has its origin in a disturbance of the habitual intestinal bacterial flora occasioned by a high carbohydrate, high protein, but low cellulose diet as adopted by the so-called civilized races of the world since about 1850, when flour was bleached and roller-ground, and meat subjected to mass refrigeration and exportation on a large scale. An era of rationing and starvation has been accompanied in this century by a marked fall in the incidence of acute appendicitis, acute cholecystitis, and constipation.—I am, etc.,

Dunedin, New Zealand. H. M. KARN.

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Scientific Exhibition

SIR,—Mr. Vernon Thompson's strictures on the Scientific Exhibition (August 23, p. 444) brought a flush of shame to my cheeks, because at the Winnipeg meeting in 1930 I conducted such a stall and stood there for three days endeavouring to catch the passing eye and distributing my reprints to the few who were interested. Fortunately the subject of my exhibition (chronic ulcers of the legs) inspired no jealousy or rivalry and I was left uncriticized in the *Journal*.

Unless the exhibitor is very good-looking I cannot for the life of me see the difference between an exhibition of this kind by a medical man for medical men and the writing of an article in this *Journal* on, say, 285 selected gastrectomies with 0.35% death rate, followed by the sending of reprints in the appropriate directions. Even the writing of monographic textbooks could be criticized on the same grounds. I can well remember one Christmas, when I was in general practice, receiving such a book from a surgeon who was showing monopolistic tendencies towards a certain organ. On the fly-leaf he wished me a happy Christmas. When the following year the same book arrived again, the fly-leaf this time wishing me a prosperous New Year, I still did not doubt the author's ethics, but lost some of my faith in his business ability.

Mr. Vernon Thompson's suggestion that if the exhibit was in the name of a hospital it would make the real sponsor anonymous does not hold water. The interested practitioner wants to send his patients to one man and not to a hospital or hospital department. The only two people in a hospital who could do the exhibit in a completely detached fashion are the house governor and the pathologist, and they are too busy, one with the Ministry and the other with his routine.

The Scientific Exhibition can only be run by individuals in the same spirit as they write articles for the *Journal* and read papers at the conference. They could be helped, it is true, by a specially trained official in the technique of display, as the Editor helps in the details of presentation. I cannot see the exhibition occurring again unless the stands are personally sponsored.—I am, etc.,

London, W.1. A. DICKSON WRIGHT.

POINTS FROM LETTERS

Oestrogens in Migraine

Dr. N. N. IOVETZ-TERESHCHENKO (Georgetown, British Guiana) writes: It appears from Dr. L. J. Moir's letter (June 28, p. 1408) that he is unaware that extensive trials of oestrogens, androgens, and other hormones in the treatment of migraine have proved that a *maximum* of only 7% of patients show any improvement. A full bibliography of this and other treatments is given in my symposium on migraine in the *Postgraduate Medical Journal* (December, 1950, **26**, 647).

Danger from Cuffed Endotracheal Tubes

Dr. C. A. G. ARMSTRONG (Co. Londonderry) writes: A risk that the inflated cuff of an endotracheal tube may override and obstruct the lower open end of the tube occurs commonly with old soft tubes and indicates that the cuff is over-inflated. Dr. C. F. J. Baron's method (August 16, p. 391) of overcoming the obstruction by pushing the tube farther into the trachea, while neat, is scarcely adequate and occasionally may actually aggravate the obstruction by pushing the tube down to the carina. It would seem safer to deflate the cuff and reinflate to a lesser extent. If it is found impossible to get an airtight fit of the cuff without obstruction, either the tube must be changed for a better one, or else the cuff must be left deflated and a pharyngeal pack substituted.

Antihistamines and Experimental Burns

Dr. S. SHUBSACHS (Manchester, 14) writes: Not only were Dr. S. Sevitt and his colleagues (July 12, p. 57) unfortunate in their choice of a comparatively weak antihistamine, but the illustrations of their article appear to show the very difference which I have noticed. Fig. 6 (on "antazoline") shows what looks like even epithelization from the base of the whole area. Fig. 7 shows a central part in the burnt area which looks less epithelized and gives the impression of epithelization from the periphery. Dr. Sevitt's explanation of the dark centre would be appreciated.

Colours of Gas Cylinders

Mr. NORMAN CAPENER (Exeter) writes: The new colours have obviously been designed to facilitate recognition by those who are colour blind. One such person to my knowledge finds this so and would have great difficulty if one of the colours selected had been green.