Primary Tuberculosis

SIR,—Your leading article (*Journal*, October 29, p. 1072) states: "To demonstrate and measure it [the effect of antituberculous drugs on the course of primary tuberculosis] therefore requires the usual carefully controlled trials, and none have so far been reported." Dr. R. McLaren Todd, working in this Department, has reported[1 2] two short series, the first concerning P.A.S. and the second isoniazid. Admittedly, each series was quite small, and no general conclusions were permissible. Dr. Todd himself stated, in the summary of his second paper, that a larger series would need to be studied. But at least a start has been made, and I feel that it is only fair to Dr. Todd to call attention to his painstaking work.

The subject is important, and might well be thought suitable for planned study in a number of centres.—I am, etc.,

Department of Child Health, University of Liverpool. NORMAN B. CAPON.

REFERENCES

1 Todd, R. McL., *British Medical Journal*, 1953, **1**, 1247.
2 —— *Lancet*, 1955, **1**, 794.

Anticoagulants and the Prothrombin Pattern

SIR,—We have read with great interest the paper by Dr. H. L. Matthews *et al.* (*Journal*, October 15, p. 947) on diurnal prothrombin variation during anticoagulant treatment.

The same problem had drawn our attention for a long time, and in a paper published in March, 1954,[1] we showed a graph with variations of prothrombin level during 24 hours in a patient treated with ethyl biscoumacetate. From our observations we have reached the conclusion that the maximum effect of ethyl biscoumacetate is reached after 8 to 12 hours, and we have therefore suggested that in order to maintain a steady level of decreased prothrombin activity the drug should be exhibited in small doses every 8 to 12 hours. Observations similar to ours have been published by Pulver and von Kaulla[2] and by Scardigli and Mininni.[3]—We are, etc.,

B. LEVI DELLA VIDA.
A. MORANDI.
Rome.

REFERENCES

1 Vida, B. L. D., and Morandi, A., *Clin. Ter.*, 1954, **6**, 245.
2 Pulver, R., and van Kaulla, K. N., *Schweiz. med. Wschr.*, 1948, **78**, 956.
3 Scardigli, G., and Mininni, G., *La Protrombina*, 1951. Salpietra, Firenze.

Treatment of Simple Rib Fractures

SIR,—I was interested to read the article by Mr. H. D. W. Powell on the treatment of simple rib fractures (*Journal*, October 1, p. 829).

Surprisingly, no mention was made of the great value of tomography in establishing the presence of a fracture not apparent on a P.A. radiograph. In these modern days simple radiographs alone must be regarded as rather a limited form of radiological investigation in such cases. If it is considered necessary or advisable to establish the presence of a fracture, and I feel that the Medical Defence Union would say it is, then all that is required is to localize the tender area(s) and have tomography carried out at the relevant cuts.

In conclusion, many will agree with Mr. Powell's criticisms of strapping in the treatment of such cases. They will also commend a form of treatment which removes pain and does not limit respiration, particularly in old people.—I am, etc.,

Kuala Lumpur, Malaya. JOHN MACKAY-DICK.

SIR,—May I reply briefly to Dr. M. S. Sanders (*Journal*, October 15, p. 970), who, because of the litigation risk, criticizes my suggestion (*Journal*, October 1, p. 829) that *x*-ray examination is unnecessary in simple rib fractures?

I believe that the accurate diagnosis of simple rib fractures is based on clinical and not on radiological evidence, that treatment should be so based, and that we should be prepared to stand by this belief in court should this be necessary. I am well aware of the insistence on *x*-ray examination of injuries of all kinds because of possible skeletal damage, including any suspected rib fracture. But to continue to *x*-ray every patient is to pay more respect to the beliefs of the law that it is essential than to the medical knowledge that it is inessential and very frequently misleading. Suppose the litigant appears in court and the *x*-rays show no fracture although this be evident clinically, which opinion has precedence, that of the clinician or that of the *x*-ray plate?

If some may raise the warning of the man with multiple rib fractures discharged from a central London hospital casualty department, who subsequently died in another hospital, may I cite a recent and not entirely dissimilar case? A man of 59 was admitted severely shocked with concussion, severe crush injury of the lumbar spine, with paraplegia and gross injuries to one knee. Not until 48 hours after the accident did further clinical examination reveal six rib fractures on one side; these were found clinically, not seen on *x*-ray plates, treated by injection, and caused him no subsequent pain.

I doubt, Sir, if these arguments will prove acceptable to many, but meanwhile money and time will continue, in my opinion, to be mis-spent.—I am, etc.,

London, S.W.19. H. D. W. POWELL.

Acute Pancreatitis

SIR,—In the recent discussion on acute pancreatitis and serum amylase levels, it has been a surprise to me that no distinction has been made between the two entirely different diseases, both of which go by the name of "acute pancreatitis."

The first, which used to be called "acute haemorrhagic pancreatitis," is fortunately rare, but is a truly terrible disease and is almost invariably fatal, regardless of the type of treatment instituted. The pancreas is black or plum-coloured, presumably as a result of a massive haemorrhage or infarct, and there is no concomitant biliary disease. The patient is intensely shocked, with excruciating pain and copious vomiting. In contradistinction, however, to the rigid supine attitude of the perforated peptic ulcer, this patient insists on support for his back and is afraid to lie down. The serum amylase level is grossly raised, and despite all methods of resuscitation operative mortality is high. My last case survived operation, but finally died several weeks later, and at necropsy the whole pancreas was replaced by a huge abscess cavity, which had tracked in all directions in the retro-peritoneal space.

The second disease is the common form of acute pancreatitis, believed to be always associated with some form of duct obstruction. The pancreas is swollen and there is variable fat necrosis. The mild case may pass almost unnoticed, while the severe case may at first sight be mistaken for a perforated peptic ulcer. Careful clinical examination, however, reveals that although the pain may be severe there is no real collapse, and an unnecessary operation may be avoided. Treatment should always be conservative, as these cases are very liable to recur, and biliary drainage is no insurance against recurrence. This disease is a not infrequent late sequela of cholecystectomy. The prognosis is extremely favourable. The serum amylase level naturally varies with the degree of fat necrosis.

Failure to distinguish between these two entirely separate entities has led to much confusion regarding treatment, and from a wide experience of emergency surgery I have come to the rather depressing conclusion that the prognosis in either type is probably quite independent of the treatment received.—I am, etc.,

Slough. ROBIN BURKITT.

Gorleston Holiday Camp for the Handicapped

SIR,—Again I should like to thank all doctors who kindly filled up the medical certificates for their handicapped patients attending the above camp in response to my appeal in the *Journal* of June 18 (p. 1478). Many of those forms contained not only most useful clinical information, but social details about the patient's attitude to his, or her,