Rovsing's Sign

SIR,—Mr. W. W. Davey (*Journal*, July 7, p. 28) has done well to dispose of the hypothesis that gas can be pushed from sigmoid to caecum and thus cause pressure on an inflamed appendix.

Both Rovsing's and Blumberg's signs cause pain in the iliac fossa by reason of creating general abdominal commotion which is felt painfully in the region of the inflamed appendix. I have found a more refined method of doing this, which I describe as the cough reflex. The patient producing a cough of requisite strength notices at once the circumscribed stab of pain in the right iliac region. I have found it a most delicate and reliable test, not forthcoming in renal colic, salpingitis, or diverticulitis.—I am, etc.,

London, W.1. A. DICKSON WRIGHT.

SIR,—Mr. W. W. Davey deserves thanks for focusing attention on this sign (*Journal*, July 7, p. 28) and for indicating how rarely it is positive in genuine acute appendicitis.

I have found the sign even more unreliable, however, since it has not infrequently been present in the absence of any inflammatory condition in the caecal area. In particular is this true in patients who are subject to attacks of colonic distension, in which the abdomen becomes distended and there is tenderness over the whole length of the colon, which itself is full of gas. I have myself suffered from several attacks of this condition in past years and have noticed a very definite positive Rovsing's sign on myself, although there has never, at any time, been evidence of inflammatory disease. Since noticing this I have frequently applied the test on patients with similar attacks of colonic distension, and a positive response is by no means infrequent. The mechanism in such cases is presumably a stretching of the caecal wall by the increased pressure of gas, and, as Mr. Davey points out, it can only apply where the whole colon is filled with gas.

A sign which is not only often absent in the condition for which it is supposed to be diagnostic but is not infrequently present in the absence of the disease should undoubtedly be discarded.—I am, etc.,

Manchester. HERBERT HAXTON.

Maladjusted Children

SIR,—There are certain aspects of the maladjusted schoolchild problem which modern society and psychiatry alike have failed to tackle properly. Special schools are provided for educationally subnormal children, but what about the educationally supernormal children? What provision does the Education Act, 1944, make for them?

The outstanding lesson of this century has been the bitter fruits of educational failure in this direction—failure to socialize the ability of supernormal children. Take the classical example. I quote a 14-year-old schoolboy who played truant from school frequently and disliked school because he received no recognition and no "marks" for his potential abilities. He was often away from school with vague illness and mollycoddled by his mother. His father had died, so he lacked paternal guidance and help. He had one outstanding gift, that of crowd genius. One could hardly blame his own teachers for not recognizing him.

Combine the three factors: a craving for recognition by the school group (the first crowd the developing child faces alone), an inadequate father figure, and crowd genius, and what was the result? The second world war. The child was Hitler, a school failure trying to convince the school group of his abilities at a time when his schoolmates had settled down to their ordinary careers and ordinary family life. It is important for us to recognize that many politicians with "crowd hatreds" are simply schoolboys or girls with "school hatreds."

The question that must be asked is this: "Is the school adequate for the developing child as a social structure?" The diagnosis of maladjustment among schoolchildren is obviously very important, as all school doctors realize, but the social deficiencies need correcting first. The overcrowded bedroom, the overcrowded living-room, the overcrowded classroom, and the overcrowded curriculum all contribute their quota to the sum total of maladjustments. —I am, etc.,

Wolverhampton. GARETH R. DAVIES.

Cancer Education

SIR,—Mr. Lawrence Abel in his contribution to the first plenary session at Brighton (*Journal*, July 21, p. 150) stressed the importance of "early diagnosis" in lowering the mortality from cancer. Nobody can doubt that when the disease is treated while still in an early stage the prognosis is markedly improved. If cancer is a progressive disease starting locally, how can it be diagnosed in an "early stage" if the patient through ignorance delays six months to a year or more after noticing symptoms before seeking advice?

Three years ago the Ministry of Health wrote to every local health authority urging them to start schemes for cancer education of the public, but so far it seems that there has been little response. Such a scheme need not be costly, and could be shared by several local authorities joining to run a common scheme. If approved by the Ministry, I understand that half the money will be returned. Surely this is a sound investment for the nation. The public undoubtedly is anxious to obtain such information, and as a small piece of evidence to this is the fact that since Christmas I have booked 47 lectures to Women's Institutes in this area, and hope to give about 100 per year.—I am, etc.,

Oxford. MALCOLM DONALDSON.

Jig for Inserting Radon Seeds into Bladder

SIR,—The use of a perspex jig for the implantation of radon seeds into the bladder, as described by Mr. A. I. L. Maitland and Dr. T. Martin Young (*Journal*, July 14, p. 102) has been tried, and usually discarded as unsatisfactory, by most radiotherapists and surgeons experienced in treating bladder neoplasms. The curvatures of the bladder walls vary considerably from patient to patient and in different regions of the same bladder—viz., A.P. and lateral cystograms. At operation the tumour-bearing area of the bladder wall can be readily made to fit the "slightly concave jig" described, but it will certainly not maintain this position in the post-operative period. In the bladder it is virtually impossible consistently to obtain accurate distributions using radon seeds. This difficulty can be surmounted by the implantation of radioactive tantalum wire (^{182}Ta), as described by Smithers, Wallace, and Trott,[1] and Wallace, Stapleton, and Turner.[2] Using this technique the bladder wall is to some extent "splinted" by the tantalum lying within the muscularis; implanted radon seeds usually lie in the submucosa. Moreover, ^{182}Ta, having a relatively long half-life (111 days) period, is removed per urethram, thus affording accurate control over dosage; on the other hand, a radon seed implant is permanent and nothing can be done to offset inaccuracies.—I am, etc.,

London, S.W.3. NORMAN MACKAY.

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1 Smithers, D. W., Wallace, D. M., and Trott, N. G., *Therapeutic Use of Artificial Radio-Isotopes*, 1956, edited by P. F. Hahn, chapter 15. Wiley.

2 Wallace, D. M., Stapleton, J. E., and Turner, R. C., *Brit. J. Radiol.*, 1952, **25**, 421.

Vaccination Complications

SIR,—I was very surprised to read in your leading article on the B.G.G. trials (*Journal*, February 25, p. 443) that the "complications of B.C.G. vaccinations appeared to be few *No special steps* were taken to discover them, but it was *presumed* that any serious complication would become known" (the italics are mine). It is extraordinary that the organizers should be so unscientific and deliberately ignore reactions following these new vaccines, at a time

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