think the explanation is that a large fraction of the adult population no longer has tonsils to get inflamed. The proportion with a gastric upset at some stage in the illness seems much nearer 30% than the 6% vomiting in Kuwait, but many, I think, suffer from nausea because of taking too many aspirins and various proprietary remedies in efforts to ward off influenza.

The real danger seems to me that a large part of the public now has in its keeping small amounts of various medicaments, from cough medicine to sulphonamides and oral penicillins, which have been given to patients with "bronchial" symptoms because of the publicity given in the press to deaths from bronchopneumonia and because of a medical officer of health being quoted as advising the calling of a doctor to all cases of influenza. As soon as the patients feel better many stop their drugs and give them to new "victims" of the influenza because doctors are no longer available quickly and the demand for visits goes up with headlines enumerating the number of "'flu deaths." This may lead to drug resistance in the ordinary throat germs—resistance which till now has plagued hospitals more than G.P.s—making the G.P.'s choice of sulphonamide or antibiotic harder this winter, making the use of the more expensive newer antibiotics essential, and sending the drug bill up even higher next year.—I am, etc.,

Manchester, 16. S. SHUBSACHS.

## Influenza Publicity

SIR,—My partners and I feel very strongly that it is time the B.M.A. took urgent steps to counteract the ridiculous and hysterical exaggerated publicity given in the daily press and magazines to the present epidemic of Asian 'flu. Although so far there have been no cases of Asian 'flu recognized as such in this neighbourhood, patients have already started sending urgently on most inadequate grounds. One woman in the best of health had obeyed instructions given her in a woman's magazine and had sent urgently because she felt hot. I gather that even television has been used to encourage patients to send for their doctor at once if they think they are starting 'flu. It is difficult to imagine any more efficient way of encouraging unnecessary calls.—I am, etc.,

West Malling, Kent. G. E. R. HAMILTON.

SIR,—I wish to protest against the highly sensational reports of the national press about the present influenza epidemic. Patients get worried unnecessarily and so do their doctors. A statement by the B.M.A. declaring that the influenza epidemic, whether Asian or 48-hour 'flu, is highly contagious but quite harmless, without evidence of serious complications, might help. Perhaps the press could instead devote their pages to the publication of names and addresses of victims of carcinoma of lung, with the average number of cigarettes smoked.—I am, etc.,

Nottingham. G. FIELDING.

## Caudal Analgesia

SIR,—Once again another article is published supporting the use of caudal analgesia in obstetrics (Dr. G. Trevor Johnson, *Journal*, August 17, p. 386), but surely it is time that the myth of its associated technical difficulties and complications was exploded.

The technique described by Hingson and Edwards[1] is well known, and most people familiar with extradural analgesia will acknowledge that in approximately 25% of subjects the sacral hiatus is difficult or impossible to locate. Why not, therefore, in such cases perform a lumbar extradural puncture with a Tuohy needle at the level of the first and second lumbar spines, and pass a vinyl plastic 442 T catheter into the extradural space? This method is easier to perform than that employing the sacral hiatus. In fact, anyone capable of making a lumbar puncture methodically should be able to give an extradural injection. This different site further away from the anal cleft should also help to rest the minds of those worried over the chance of the puncture site being soiled, if, indeed, they are not already consoled by the work of Hanley and Malone,[2] who had no case of infection in their series of 2,000 cases.—I am, etc.,

Jersey, C.I. M. BRIAN COMERFORD.

REFERENCES

1 Hingson, R. A., and Edwards, W. B., *J. Amer. med. Ass.*, 1943, **121**, 225.

2 Hanley, B. J., and Malone, C. M., *Amer. J. Obstet. Gynec.*, 1945, **50**, 306.

## Listerial Meningitis

SIR,—As the cases of Listerial meningitis mentioned in your article (*Journal*, July 27, p. 188) and subsequent correspondence were in infants, I feel that it might be of interest to draw attention to what I believe to have been a similar infection in a girl 10½ years of age. This girl was admitted to Waddon Hospital on May 30, 1957, as a suspected case of poliomyelitis. She had typical acute meningeal symptoms which had commenced on the previous day, with temperature of 102° F. (38.9° C.). She was an extremely thin child, had an irritable cough and cyanotic tinge, and looked more ill than is usual for non-paralytic poliomyelitis. The upper part of the left ear-drum was inflamed.

Lumbar puncture gave a turbid fluid containing 612 leucocytes per c.mm. (94% polymorphs and 6% lymphocytes), 90 mg. protein and 62 mg. sugar per 100 ml. No organisms were seen on the Gram or Z.N. stained deposit, but culture on a blood-agar plate produced a profuse growth of diphtheroid morphology. The organism was shown to be penicillin-sensitive, and the patient was successfully treated by daily intrathecal injections of penicillin for five days and oral phenoxymethyl penicillin for 12 days. Subsequent C.S.F. specimens, collected daily at the time of intrathecal injections, showed a continuous and rapid fall in both cell and protein content, thus further confirming that the meningitis was a septic rather than a poliovirus infection. Also, attempted culture of poliomyelitis virus from the faeces failed.

I had hoped to get the diphtheroid-like organism which grew from the C.S.F. further investigated, but the culture was unfortunately discarded after being sent to another laboratory. I have failed to find any record of meningitis due to a true diphtheroid, and therefore feel that the organism was most probably *Listeria monocytogenes*.—I am, etc.,

Croydon. J. J. LINEHAN.

## Toxic Effects of Meprobamate

SIR,—Dr. David L. Miller (*Journal*, August 3, p. 300) and Dr. Helen Wagstaff (*Journal*, August 17, p. 414) have each reported a case of a toxic rash due to meprobamate. I should like to describe a similar one.

A man of 58 was under treatment for a mild anxiety state associated with many organic disabilities. About two hours after taking the second dose of 400 mg. of meprobamate on September 7, 1956, he suddenly developed a rash associated with pruritus which was so intense that he had to leave an important religious service. At first the rash was a generalized, bright erythematous one, more severe on the trunk and pelvic regions. A few hours later large blisters appeared on the right elbow and thigh. The following morning antihistamine therapy was started with chlorpheniramine ("piriton") but without relief; later hydrocortisone ointment, applied locally, was effective in relieving the pruritus. Although no more meprobamate was taken after the onset the rash persisted for a fortnight. After three more weeks a patch skin test, done with pure meprobamate kindly supplied by I.C.I. (Pharmaceuticals) Ltd., was negative. A further two weeks later, after a dose of 200 mg., a similar rash appeared, persisting for about 10 days in the groins and genital area, where a little hyperkeratosis developed. He had not taken meprobamate before, but in the previous year he suffered the typical skin lesion associated with carbromal.