I feel that the main point in establishing drainage in the abdomen is for the end of the drainage tube to be related intimately to the area needing drainage—e.g., the duodenal stump or the gall-bladder bed—so that a closed compartment results. I feel it is inviting pneumoperitoneum and other complications for a drainage tube merely to be placed in the general peritoneal cavity.

Dr. Edward Thomas's letter (p. 770) is a very salutary reminder of how difficult it is to establish numerical proof in a subject such as this. The series of patients reported took over 18 months to study and collect, and it would obviously take a lifetime's work to produce series strictly comparable in all their variables. As stated, the matter cannot be considered proved, but I feel that the possible complications due to a large post-operative pneumoperitoneum would be well worth confirmatory studies by others.—I am, etc.,

Dudley Road Hospital, Birmingham 18. P. Gilroy Bevan.

References

[1] Milnes Walker, R., in *British Surgical Practice (Surgical Progress)*, 1953, p 215. Butterworth, London.

Extraperitoneal Fibrosis

Sir,—I feel that Mr. Stephen Power's equation of the extraperitoneal fibrosis in his case (August 19, p. 498) with the idiopathic retroperitoneal fibrosis so ably described by Raper[1] should not be allowed to pass unchallenged. The essential features of the latter disease are: (1) Insidious onset, with general malaise and often an initial pulmonary lesion. (2) No obvious focus of infection. (3) The fibrous process envelops, but does not invade, contiguous structures. (4) The renal tract above the prostate is always involved. This may occur at any level from the kidney to the bladder, but the brunt of the disease falls on the ureter(s), with secondary hydronephrosis causing severe renal damage. Mr. Power's case, whose successful outcome is a tribute to his skill, does not fulfil any of these criteria. The condition found in his patient is easily explained by the inevitable infection of cellular planes.

The profusion of names applied to idiopathic retroperitoneal fibrosis (periureteritis plastica, periureteritis obliterans, Gerota's fasciitis, sclerosing lipogranuloma, etc.) is sufficient indication of the existing confusion about the aetiology and pathology of this condition. I feel that the issue will be clouded still more if conclusions are drawn from cases which should not be included in this classification.

In my own contribution[2] to the subject I suggested a partially controlled infection as the underlying cause. Similar views have been expressed by Vest and Barelare,[3] Hutch,[4] and Mulvaney.[5] I have therefore been surprised not to have encountered a case, as yet, in an African patient. At least 85% of these, in this region, are infested by *Schistosoma haematobium* and almost all of these have superadded secondary infection. Also, the later stages of bilharziasis produce marked fibrosis of the ureters and bladder, and this combination should provide an ideal basis for retroperitoneal fibrosis if infection is a major factor. In an excellent review of possible causes, Hoffman and Trippel[6] present interesting evidence to support their view that the process is really a hypersensitivity reaction, possibly triggered by infection, and similar to periarteritis nodosa. This concept would be in keeping with Raper's[7] original suggestion.—I am, etc.,

Bulawayo, S. Rhodesia. William Houston.

References

[1] Raper, F. P., in *Modern Trends in Urology*, 1960, 2nd series, edited by E. Riches. Butterworth, London.
[2] Houston, W., *Brit. J. Urol.*, 1957, **29**, 38.
[3] Vest, S. A., and Barelare, B., jun., *J. Urol. (Baltimore)*, 1953, **70**, 38.
[4] Hutch, J. A., Atkinson, R. C., and Loquvam, G. S., ibid., 1959, **81**, 76.
[5] Mulvaney, W. P., ibid., 1958, **79**, 410.
[6] Hoffman, W. W., and Trippel, O. H., ibid., 1961, **86**, 222.
[7] Raper, F. P., *Proc. roy. Soc. Med.*, 1955, **48**, 737.

Seasonal Incidence of Clinical Onset of Hodgkin's Disease

Sir,—I read with interest Dr. Marion D. Cridland's article (September 2, p. 621). It prompted me to review similar cases admitted to Guy's Hospital during the ten-year period 1950–9. The criteria for selection of cases were those of Dr. Cridland. During this time 98 cases of Hodgkin's disease were admitted. Of these, 48 were excluded from analysis because the time of onset was doubtful, and a further 20 cases because the disease was not localized. There remained 30 cases for analysis. The seasonal incidence of the clinical onset of these 30 cases, and of the 25 cases excluded because their disease was not localized, is shown in the table.

	30 Localized Cases with Definite Time of Onset		20 Cases Excluded because Disease not Localized	
	No.	%	No.	%
January	2	6·7	3	15
February	1	3·3	0	0
March	3	10	1	5
April	1	3·3	2	10
May	6	20	4	20
June	2	6·6	1	5
July	1	3·3	0	0
August	0	0	1	5
September	5	16·6	4	20
October	1	3·3	2	10
November	3	10	0	0
December	5	16·6	2	10

This study involves only a small number of cases, but it will be seen from these results that the incidence of clinical onset in May and September is high in both groups, but whether this indicates that there is a real seasonal incidence is debatable. The results certainly differ from those of Dr. Cridland.—I am, etc.,

Department of Medicine, Guy's Hospital Medical School, London S.E.1. R. D. Hill.

Sir,—I would like to congratulate Drs. James Innes and Joseph Newall (September 16, p. 765) for their promptness in analysing the seasonal incidence in their cases of Hodgkin's disease after the publication of my article (September 2, p. 621). It may interest them to know that in four instances in the London cases the time of onset of Hodgkin's disease was described as "early" in the particular year. These, of course, were not included in the series. It is possible that more specific information might have boosted the January incidence to 16%.

With regard to Dr. K. W. Beetham's implication of a festival incidence of Hodgkin's disease (September 30, p. 896), I must admit that I had also considered it and had, in fact, deleted a paragraph to this effect from the final article. In only one of the 23 cases was there specific mention of Christmas, five were recorded as "early in December" and three occurred in the last few days of the month. The remainder were recorded

as simply "December." If October proves to be the peak in Hull, we should expect news of a peak at Thanksgiving in America or one at the Jewish New Year in Israel.—I am, etc.,

Chester Beatty Research Institute, Institute of Cancer Research, London S.W.3. MARION D. CRIDLAND.

Isotope Studies of Portal Circulation

SIR,—The work of Drs. M. Salah Ibrahim and M. F. Abdel-Wahab (September 2, p. 623) has been received with great interest. At the University of Rochester School of Medicine and Dentistry we have continued our efforts directed toward isotopic evaluation of the portal circulation. Approximately 100 patients have been studied using the technique of percutaneous injection with an isotope into the spleen and simultaneous monitoring of radioactivity over the liver, heart, and oesophagus. Initially the technique was correlated with splenic-pulp manometry and splenoportography. Diagnostic patterns have been established for the normal portal circulation, patients with portal hypertension without varices, oesophagogastric varices, portal vein thrombosis, and portal-systemic shunts. Our initial investigations have been published in the *Journal of Nuclear Medicine* (1961, **2**, 85). The expanded work is to appear shortly in *Surgery*.

The apparatus is portable; thus the technique is particularly applicable to the emergency differential diagnosis of upper gastro-intestinal bleeding. Electively, it complements the splenoportogram in affording an evaluation of the dynamics of portal circulation and is particularly appropriate in the study of hepatic-portal encephalopathy.—I am, etc.,

University of Rochester School of Medicine and Dentistry, Rochester 20, New York, U.S.A. SEYMOUR I. SCHWARTZ.

Plantar Warts

SIR,—Dr. R. M. Clark's advocacy (September 30, p. 894) of radiotherapy for plantar warts is to be deplored. Even an alleged failure of other methods of treatment can be no justification for the employment of such a potentially hazardous form of therapy for a condition so exceedingly prevalent and so benign, though admittedly disabling.

Apart from the now widely recognized dangers of irradiation—and possible injury in children (by far the largest group of sufferers from plantar warts) to underlying epiphysial centres should not be forgotten—few dermatologists of experience have failed to become impressed by the notorious unpredictability of radiotherapy's capacity for cure even when employed in high dosage, and one has even seen a surviving and flourishing wart on a bed of radio-dermatitis.

The efficacy of any form of treatment in a condition so susceptible to suggestive influences is difficult to assess, and it is not rare for plantar warts to disappear spontaneously. Some investigators, moreover, have found that "*x* rays" work equally well when in fact they are not given, and the patient lies under the impressive apparatus in the mistaken belief that it has been switched on.

Though an absence of sequelae has been claimed by Dr. Clark, "long-term follow-up" may in fact not have been long enough, since it is known that such sequelae may not appear until an interval of very many years has elapsed. It is not surprising, therefore, that, as rightly pointed out by Dr. C. F. H. Vickers (September 16, p. 743), radiotherapy as a form of treatment for plantar warts has fallen into disrepute.—I am, etc.,

Wolverhampton, Staffs. H. W. CHADFIELD.

Lolly Rash?

SIR,—I have been following with great interest the correspondence on the above subject.

In reply to Dr. H. J. Kingsley's letter (September 30, p. 897), I would describe the rash in question as being mainly erythematous in nature, irregular in pattern, and confluent in parts. The distribution was mainly on the chest and abdomen, occasionally on the face and rarely on the limbs. It did not irritate very much, and cleared up completely in a few days. In all cases but one it was not raised, the exception being one case of a papular eruption.

It would seem that this rash differs in many important features from that described by Dr. Nevil Silverton (September 23, p. 831). Furthermore, I find it difficult to understand why Dr. Silverton describes erythematous macules as being one variant of papular urticaria, as by definition the former is not raised whilst the latter is. I should add that I am not a semantic, but appreciate the use of words which have a practical definition.—I am, etc.,

Plymouth, Devon. ALUN LLOYD-JAMES.

Aims of Criminology

SIR,—The holiday season interferes with one's reading, so I hope you will accept my apologies for bringing up at this late date your leading article on "Aims of Criminology" (August 12, p. 436). You remark that in criminology "methods of controlled experiment are not possible in this field." Ignoring the specific example you mention [flogging], since this is irrelevant, I would be grateful if you would inform me why controlled experiment is impossible, since it would appear that the problem of appropriate treatment for offenders is remarkably similar in its nature, from the point of view of research, to that of the treatment of patients.—I am, etc.,

Department of Psychiatry, Leeds University School of Medicine. MAX HAMILTON.

Health and the Commonwealth

SIR,—Now that the National Association for Prevention of Tuberculosis in the United Kingdom, having successfully dealt with the problem of tuberculosis, has changed its name to embrace the diseases of the chest, would it not be helpful if it took up the matter of the prevention of disease and disability as a whole and set itself up as a Commonwealth organization to create and guide similar bodies in the various countries of the Commonwealth? What I have in mind is a voluntary organization in every country whose task it would be to promote health in the widest sense. It would have to have representation from all sides of the nation's life if it was to perform its function properly.

We have at the moment in almost all countries of the Commonwealth a number of organizations against many types of disease and disability, such as associations for the prevention of malaria, venereal diseases, tuberculosis, leprosy, cancer, diabetes, trachoma, blindness, etc. Their numbers increase apace with the many specialties into which medicine is splitting. But