addition he was receiving regular doses of hydrocortisone and "aramine" intravenously in an attempt to raise his blood-pressure, which was persistently below 70 mm. Hg. The following day, although rectal loss was still severe, the toxaemia was diminishing. The pulse fell to the normal range, but the blood-pressure still did not rise above 80 mm. Hg. However, on the fourth day there was a dramatic improvement, the patient was cheerful, the diarrhoea had almost ceased, and the blood-pressure rose to his normal value (130 mm. Hg systolic). One week later the patient was discharged feeling well, and with normal bowel actions; stool cultures were negative. Since then he has remained in good health, but complains of slight constipation.

We should like to draw attention to the following points: (1) The occurrence of this condition following gastric operations; (2) that stool cultures, only available when the patient was past the acute stage, grew two strains of staphylococci both of which were resistant to penicillin G and one to erythromycin, thus stressing the importance of using a drug to which all staphylococci are sensitive, such as methicillin, as early as possible in this, often rapidly fatal, disease.—We are, etc.,

The Churchill Hospital, Headington, Oxford.

N. C. KEDDIE.
H. N. MAGNANI.

Oedema and Rubella

SIR,—During a recent epidemic of German measles three patients were seen by me with oedema of the hands and face. All these patients were female, the youngest being 10 years old. The oedema appeared two days after the appearance of the rash and cervical adenopathy, and persisted for about five days. Attention was drawn to this oedema in two cases involving young married women by the tightness of their wedding rings. One of these had paraesthesiae similar to Dr. K. W. G. Heathfield's cases and also complained of mild arthralgia of the wrists, shoulders, and knees. Blood-pressure and urine examination was performed in each case and revealed no abnormality. Hess's test for capillary fragility was performed in two cases and was negative. The oedema, which was transient, did not involve the feet or legs. I have the impression that oedema of the hands and face was more common in this part of the country than arthralgia.—I am, etc.,

Worthing, Sussex. R. H. DAVISON.

Complications of Rubella

SIR,—Dr. M. J. F. Courtenay's letter (June 16, p. 1698) prompts me to record similar complications of rubella seen during the recent outbreak.

One patient developed a rubella rash, but no glandular enlargement, 21 days after the appearance of typical rubella in her son. Four days after the rash she had red, swollen, and very painful joints in all her fingers and toes, which improved in a few days. Two other patients have reported precisely similar attacks which were not seen by me. One of these, in addition to the arthritis, had tenosynovitis of the extensor pollicis longus, and yet another patient, a boy of 8, developed painful hamstring tendons without arthritic symptoms.

One other feature of this outbreak has been the occurrence of two cases of severe conjunctivitis simultaneously with the rash. One of these was infected by a brother with typical rubella, and the incubation period was 19 days.—I am, etc.,

R.A.F. Lyneham, Wilts. I. N. L. JOHNSTON.

Tubeless Gastric Surgery

SIR,—The object of the surgeon is to perform any necessary operative procedure with the maximum of safety and with the minimum of discomfort for the patient. When these interests conflict safety must clearly be the prime consideration, but surely the degree of risk must be interpreted with common sense?

I support strongly the contention of Mr. W. Garden Hendry (June 23, p. 1736) that to use a naso-gastric tube and an intravenous infusion for every gastrectomy is to condemn a large number of patients unnecessarily to considerable discomfort, disturbed rest, and risk from the infusion. For the past four years my routine has been substantially the same as his, though my patients reach unlimited fluid on the third and light diet on the fourth day, and I, too, have found that convalescence is smoother, quicker, and happier than when tubes are used.

A number of patients, of the order of one in 20, become uncomfortable and need temporary restriction of oral intake; an occasional one, as Mr. H. W. Gallagher (July 21, p. 193) points out, suffers from a non-functioning stoma for many days or weeks, a condition which I believe is due to inadvertent total vagotomy when dividing the left gastric vessels, and these patients do need gastric aspiration. However, to intubate 99 patients unnecessarily for the needs of one is, in my opinion, unjustifiable, for there is no difficulty post-operatively in detecting the patient with a non-functioning stoma, efferent loop obstruction, etc., who requires aspiration.

Moreover, a naso-gastric tube may sometimes mislead the surgeon. I have seen several gastrectomy patients, intubated routinely, in whom the volume of aspirations consistently exceeds oral intake but who were otherwise perfectly well. Removal of the tube was at once followed by a normal convalescence.—I am, etc.,

Folkestone, Kent. A. STANDEVEN.

Prevention of Wound Infection

SIR,—I wonder if the St. Thomas's Hospital team (July 21, p. 151) realize that the compulsory initial bathing is the chief source of skin contamination in hospital patients.

I learned this nearly nine years ago when I was admitted to the private wing of one of our large city hospitals. There were three dingy grey "tidemarks" on that bath which I did my best to remove—a futile enough effort, as several stitch abscesses and a plaster sore taking five long weeks to heal bore witness. I have avoided hospital baths since and am convinced that they should be replaced by showers.

I should place the much maligned blanket contamination a very long way behind the cleansing bath, and the former could be completely eliminated by passing the blankets (dry) through the calender. Contrary to accepted ideas, dry heat causes little deterioration in woollen materials (every nurse knows this who has used woollen hot-water-bottle covers over the years—or has used a woollen ironing "board"). Any real effort to allow a ward patient to contend with his own skin and mucous-membrane bacteria *only* should include sterilization of all washing-bowls before marking and keeping for each patient's own use—and for bed bathing a pair of well-scrubbed hands on the nurse.