immediately treated. The Denis Browne splint offers an easy and entirely acceptable approach to the problem of keeping the child in the corrected position. It is light; easily manageable by the mother; the child can be picked up and carried as in a portable crib; the child seemingly enjoys his position and placement in this splint; and there is no problem such is found in placing these children into a cast or even a Milwaukee brace.

Our approach, therefore, to the management of the child with idiopathic or other forms of scoliosis is to use our best judgment and avail ourselves of all the modalities of treatment which have been found to be useful. I place the Denis Browne splint in this category, and I would further say that if there is any form of treatment that should be carried out routinely on any infant with postural or structural curvature of the spine the Denis Browne splint offers the only logical means of handling this problem. While in many cases the treatment may be superfluous and unnecessary it certainly does no harm either to the emotions of the mother, the child, or to anyone else. In scoliosis I have the strong feeling that it is better to overtreat rather than to undertreat. I therefore agree with Sir Denis Browne's concepts of proper management of the infantile scoliotic, even though in many instances it might be postural and spontaneously resolving.—I am, etc.,

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Minneapolis, U.S.A.

Prevention of Heart Disease

SIR,—May I comment on the paper by Dr. M. F. Oliver and Professor C. H. Stuart-Harris (20 November, p. 1203) with regard to rapid gain in weight and hypercholesterolaemia as risk factors in ischaemic heart disease.

In April this year four members of a Dublin cricket club, all males between the ages of 29 and 37, expressed their desire to lose weight by way of a "crash diet." A diet providing 500 Cal./day had been devised for them for a period of 10 days. Although the importance of exercise was pointed out, they could not make themselves free for more than two occasions during the 10 days, when it was decided to "jog" around the club grounds eight times (total distance about two miles—3.2 kilometres).

Only two of the four were able to go through with the programme of diet and exercise as planned; subject No. 1, a 29-year-old man who put on 18 lb. (8.1 kg.) during the previous winter, and subject No. 2, a 34-year-old man who gained 15 lb. (6.8 kg.) in the same time. Both were moderately overweight according to the Metropolitan Life Insurance Company standard weights and height classification.

Serum-cholesterol levels were estimated before the start of the diet and thereafter every other day for the whole 10 days. The first subject lost 9 lb. (4.1 kg.) and the second 9.5 lb. (4.3 kg.). The series of cholesterol levels (mg./100 ml.) were as follows:

Subject No. 1: 195, 193, 218, 247, 286, 289.
Subject No. 2: 180, 182, 215, 264, 278, 273.

Two weeks later, when they were proceeding with a normal but still somewhat carbohydrate-reduced diet, the readings were as follows: No. 1—190; No. 2—187.

Without trying to draw generalized conclusions from such a limited study, could it be possible that a rapid weight loss by way of fat mobilization might supply even more lipids for arterial deposition than gain in weight?—I am, etc.,

Meath Hospital,
Dublin 8. STEPHEN SZANTO.

Heart Failure in Old Age

SIR,—I read with interest Dr. A. K. Thould's paper on "Coronary Thrombosis in the Aged" (6 November, p. 1089) and also your editorial "Heart Failure in Old Age" (p. 1076) of the same issue.

The following figures from a survey of 1,713 post-mortems in patients aged 70 and over during the years 1950–63 show that cardiovascular disease accounted for 543 deaths, of which 138 were caused by coronary thrombosis (females 63, males 75). Ruptured heart occurred in 12 cases, the oldest being a male aged 93, and one was syphilitic in origin. Seventeen patients in this total of 138 were diabetics, and 22 had carcinomata of various sites.

Haematemesis and melaena from gastric and duodenal ulcer was probably the precipitating cause in 5 cases, while 71 other major pathological findings were recorded amongst the remainder. Pomerance[1] draws attention to the multiplicity of pathological heart conditions in the aged, and among a variety of lesions found in my group there were 14 cases of subacute bacterial endocarditis.

With reference to Dr. Thould's remarks on the frequency of coronary thrombosis in relation to cerebrovascular accidents as a reason for admission, when it comes to post-mortem this series shows 152 cases of cerebrovascular accidents (male 45, female 107), which agree closely with those of Howell,[2] and Howell and Piggot,[3] and Stewart Smith.[4]

May I suggest that when considering diseases of old age post-mortem findings perhaps give more consistently accurate statistical estimates than clinical impressions.—I am, etc.,

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London S.E.16. J. M. FULLERTON.

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Cardiac Arrest in Myocardial Infarction

SIR,—We read with interest your editorial on cardiac arrest following acute myocardial infarction (13 November, p. 1135). Since the introduction of an intensive-therapy unit at this hospital we have been attempting to classify the severity of each case of myocardial infarction on admission. Each case had been assessed according to the prognostic index of Peel *et al.*,[1] and also had an arterialized venous sample of blood estimated for biochemical estimation of base deficit.[2] In a series submitted for publication 50 consecutive cases were analysed. Of these 20 cases had a prognostic index of less than 13 with six deaths, and the remaining 30 cases had a prognostic index of greater than 13 with seven deaths. No case with a prognostic index of less than eight died.

When we analysed the arterial sample for base deficit 33 cases had a significant base deficit in which there were 12 deaths. Only one case who failed to show a significant base deficit died (this is significant to 5%).

It would appear, therefore, that by the estimation of base deficit we have a rapid, easy, and accurate method of ascertaining the severity of cases suffering from myocardial infarction and, therefore, those which are more likely to benefit from intensive therapy.—We are, etc.,

G. R. ROYSTON.
M. A. NEAVERSON.

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Barnet, Herts.

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Evanescent Parotitis in Diabetes

SIR,—A temporary condition of painful parotitis has occurred in some 20 of my diabetics. As I see only diabetics I do not know if this also occurs in non-diabetics, but I have noted no reference to such a condition in the general medical literature nor is there mention of it in the 10th edition of Joslin's book.[1]

The patients usually complain of earache, sometimes unilateral but usually bilateral, with an obvious swollen and tender parotid gland. In those who develop the condition it is usually brought on by some stimulating taste, such as sucking a lemon, and exacerbated by strong-tasting food. I remember a public-school boy who had his holidays spoiled by the better-tasting food at home, which kept his parotid painful. He has now grown out of the condition, as do all the sufferers ultimately. There has been no apparent sepsis in the mouths of these patients nor in the juice extracted from the duct of the parotid gland. I cannot explain the condition. Frequently, in my absence, the patients have been referred to an ear surgeon with supposed ear trouble.—I am, etc.,

London W.1. R. D. LAWRENCE.

REFERENCE

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Hypoglycaemia Due to Isolated Corticotrophin-deficiency

SIR,—We were interested in Dr. J. Gordon Sprunt's comments (30 October, p. 1064) on the use of methopyrapone in the assessment of pituitary-corticotrophin reserve. Unfortunately, plasma cortisol was not measured in our patient during the administration of methopyrapone. However, in common with the 17-ketogenic steroids, urinary total 17-hydroxycorticosteroids failed to increase either during or after the administration of methopyrapone.

Dr. Sprunt states that many would consider inadequate the dose of methopyrapone administered to our patient. We would then refer them to the paper by Buus *et al.*,[1] in which it was recommended that methopyrapone be administered two-hourly owing to its short biologic half-life; 3 g. of methopyrapone given as 250 μg. two-hourly beginning at noon was shown to produce

maximum suppression of plasma cortisol. We have found this dosage of methopyrapone satisfactory in the evaluation of pituitary-corticotrophin reserve.

Finally, the diagnosis of isolated corticotrophin deficiency in our patient does not rest solely on the lack of response to methopyrapone. We feel sure that Dr. Sprunt will agree that both the correction of insulin-induced hypoglycaemia-unresponsiveness with exogenous corticotrophin and the low-normal plasma cortisol during fever further support the presence of a hypothalamic-pituitary defect affecting the secretion of corticotrophin.—We are, etc.,

K. A. WOEBER.
R. ARKY.

Department of Medicine,
Harvard Medical School,
Boston, Massachusetts, U.S.A.

REFERENCE

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Systemic Reaction to Bromsulphthalein

SIR,—Dr. M. J. Phillips in his letter (4 September, p. 595) asks if our patient who developed a systemic reaction to bromsulphthalein had ever been in the habit of using laxatives containing phenolphthalein. The patient has never had any difficulty with his bowels and denies taking laxatives of any type; the general practitioner confirms that he has not prescribed any therapy of this kind.

Phenolphthalein would seem to have few toxic side-effects.

Blatt *et al.*[1] reported that up to 8 g. were ingested by children without untoward effects. Skin rashes are known to occur sometimes, and severe non-fatal reactions with collapse have been reported but are rare; they appear to occur with an excessive purgative effect in hypersensitive individuals and might be explained by water and electrolyte changes.

The molecules of these two substances do appear to be similar; however, I have not seen a report of a systemic reaction to bromsulphthalein in which a preceding history of phenolphthalein ingestion has been given. The association would seem, therefore, to remain hypothetical, but inquiries in any future case might reveal some connexion.

As Dr. Phillips suggests, more cases of systemic reactions to bromsulphthalein may be described, and it might be of interest if the incidence could be determined. The reaction has been reported to the Committee on Safety of Drugs.—I am, etc.,

T. W. ASTIN.

The Royal Hospital,
Sheffield 1.

REFERENCE

1 Blatt, M. L., Steigmann, F., and Dynewicz, J. M., *J. Pediat.*, 1943, **22**, 719.

Failure of Oral Contraceptives

SIR,—Dr. Kenneth Heber (16 October, p. 943) described the rare combination of contraceptive failure and ectopic pregnancy, and he suggested that his patient's gastro-intestinal upset just before the apparent time of conception might have interfered with the absorption of the contraceptive pill (Volidan). A similar case is now recorded, except that this patient had no gastro-intestinal or any other upset at the time of conception.

The patient was a 33-year-old white woman, gravida-10, para-9, with seven living children. When she first consulted me on 16 September she had had a daily loss since her last period on 20 August 1965. Her other complaints were menorrhagia and dyspareunia for several months, and lower abdominal pains with the last period. She had been taking Lyndiol (mestranol and lynoestrenol) for the past seven months. The uterus was slightly enlarged and tender, and tenderness was elicited in the left fornix, but no mass was felt apart from a cystic ovary. In view of her grand-multiparity and history a curettage and a possible hysterectomy were advised. Two weeks before she was due to enter hospital she complained that her abdominal pains had returned and the vaginal bleeding was more profuse. Her admission to hospital was expedited and a laparotomy performed on 1 October. About 4-5 oz. (120-150 ml.) of blood was found in the pouch of Douglas. The distal half of the left Fallopian tube was more than twice the normal size, and its site of junction with the proximal half was well defined. No gestation sac or early foetus could be found. The left ovary contained a ruptured cyst. A diagnosis of an early tubal abortion was considered, but doubt was expressed on account of the oral contraception. A total hysterectomy and left salpingo-oophorectomy were then performed, and the patient was discharged 10 days later. The histological report stated: "Section of uterus having a dilated tube with blood clot filling one part of lumen shows remnant of chorionic villous material in blood clot in the tubal lumen."

The patient was an intelligent woman, and in spite of close questioning she was absolutely certain that she had never failed to take the pill regularly and according to instructions. As there was nothing in her history to suggest interference with the absorption of the Lyndiol, this would appear to be a true case of failure of oral contraception.—I am, etc.,

G. MAIZELS.

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South Africa.

Treatment of Acute Pancreatitis

SIR,—I agree with the observations made by Dr. A. Douglas McCutcheon in his letter (6 November, p. 1125) that the Trasylol-treated group did better than the placebo-treated group, the opposite to the claim made by the authors (11 September, p. 627).

In a study we made on twelve cases of Trasylol-treated patients, comparing them with cases not treated with Trasylol before 1959,[1] we got the impression that Trasylol gave a beneficial response in acute pancreatitis.

Bedacht,[2 3] with his experience with 15 patients, points out that kallikrein inactivator is a great advance in treatment of acute and chronic pancreatic disorders. Werle *et al.*,[4] testing the therapeutic effect of the gland inactivator in 16 patients with acute pancreatic necrosis, found that it favourably influences the course of the disease, and even very severe cases, which would otherwise have almost certainly proved fatal, recovered. Moshal *et al.*,[5] in a series composed of 32 consecutive patients with acute pancreatitis (of which 17 were controls and 15 treated with Trasylol), concluded from their results that Trasylol was of value in reducing the duration of pain, and also observed that satisfactory reduction of serum trypsin to within normal limits was achieved in all patients given large doses of Trasylol.

Similar favourable results were also observed by McHardy *et al.*,[6] and they also confirmed earlier favourable results.[7-8] Good results were also reported by Kazmers[9] in his 12 cases treated with Trasylol.

As there seems to be still confusion, and until a clear-cut picture on efficacy of Trasylol therapy is proved, the best will be to accept the conclusions of Georg Maurer,[10] who suggests from his experience of 36 cases treated with Trasylol that the treatment of pancreatitis should be a combination of conservative regimen and surgery, and in this the inactivator (Trasylol) is an indispensable aid. With the combined regimen he had no fatality in 23 cases of proved pancreatic necrosis.—I am, etc.,

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Newcastle upon Tyne 1.

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10 Maurer, G., *Med. Press*, 1961, **246**, 287.

Shocks from Electrical Apparatus

SIR,—The letter of Drs. A. A. and Betty R. Warltier (20 November, p. 1245) offering an explanation for electric shocks noticed when handling patients connected to diathermy prompts me to report an accident occurring some months ago which electrical checks revealed *was* due to faulty apparatus.

The accident was suffered by an elderly lady undergoing pinning of the left femoral neck. She was on an orthopaedic table with only an "antistatic" mattress under her. Two *x*-ray machines were in use, and the diathermy pad was in contact with the right thigh. At the head end of the table the patient was noticed to feel "charged" when touched. The significance of this was not appreciated until a few minutes later, when both legs went rigid for a few seconds and then relaxed. Simultaneously, the radiographer, whilst repositioning the lateral *x*-ray machine, saw a blue spark where the cone of the *x*-ray tube touched the footpiece of the table.

Electrical checks confirmed the *x*-ray machine to be in sound order, but revealed the earth lead in the diathermy mains plug to be disconnected. A leak in the diathermy apparatus had found a route to earth through the patient's right leg and *x*-ray machine.

Although the patient suffered no obvious ill effects, the accident might easily have been fatal, especially if the earthing of the diathermy mains leak had occurred at a point on the body more distant from the diathermy pad than the foot.—I am, etc.,

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Standardization of Medical Records

SIR,—Dr. Eirian Williams's views (20 November, p. 1242) on the application of the recommendations for the standardization of medical records to the smaller district hospital are of great importance. Hospital staffs have long awaited direction on problems concerning patients' records, and many of the views expressed in the report will be