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.,

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R. ARKY.

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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

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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.

Port Elizabeth,
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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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.,

W. A. LINDSAY.

Lambeth Hospital,
London S.E.11.

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

accepted with enthusiasm. Mention may be made particularly of those aimed at keeping down the bulk of material to be stored and the use of a folder rather than an envelope.

Most of the smaller hospitals are coping with a shortage of all categories of medical staff. A consultant's time is saved and his work eased if the notes are typed on a clearly marked folded sheet holding all the notes and correspondence related to his specialty. Considerable time is wasted and special investigations are repeated unnecessarily if notes are not quickly and easily read. Illegible longhand notes written consecutively regardless of the specialty gravely lower standards and morale of medical and other staff and of the standard of care available to the patient.

If notes are typed any form of fastener tends to waste secretarial time and causes damage to the notes. A folder with a pocket to prevent loss of its contents is simple, less frustrating, and no more expensive than the method recommended in the report. Many of us have tried and discarded different forms of fastener and clip.

The remarks from Hammersmith Hospital (20 November, p. 1242) relating to several of these points are very important.—I am, etc.,

London W.C.1. M. SPENCER HARRISON.

Carbon Tetrachloride Toxicity

SIR,—The widespread use of carbon tetrachloride, and proprietary products containing it, has undoubtedly resulted in a high incidence of accidental poisoning, though recent recognition of this danger has reduced the incidence of this. Nevertheless, severe symptoms may develop even after minimal contact with carbon tetrachloride, and may be delayed for several weeks. Often the patient is seriously ill on admission to hospital, and the history of exposure may neither be easily established nor considered. Toxicity is known to occur after either drinking the agent or inhaling the vapour.

Considerable individual sensitivity to carbon tetrachloride exists, but certain factors are known to influence the toxic effects. Most significant among these is the history of exposure to alcohol. Carbon tetrachloride dissolves in alcohol and is freely absorbed from the gastro-intestinal tract, and when both are taken together the toxicity is greatly increased. Alcohol is thought to increase the urinary excretion of carbon tetrachloride and may thus contribute to the observed nephrotoxic action.

In the following case report a very small quantity of carbon tetrachloride in proprietary form was accidentally ingested along with alcohol, with resulting severe hepato-renal damage.

The patient, a 53-year-old male, had been relatively well until two weeks before admission to the Victoria Hospital. At that time he had developed mild "influenza," with joint pain, mild headache, fever, and general malaise. Salicylates were administered, and while making himself a "hot toddy" he accidentally swallowed a mouthful of Thawpit as well as a quantity of alcohol. He immediately spat out most of this, but undoubtedly swallowed a small amount. He felt nauseated, and shortly afterwards was actively sick. He made an initial good recovery but 24 hours afterwards again complained of weakness and had a small haematemesis. His general condition improved on bed-rest, Aludrox (mist. alumin. hydrox.), and phenobarbitone. Ten days later he again became nauseated and disorientated, and progressive jaundice developed associated with general deterioration and hiccup.

On admission he was confused, incoherent, markedly dehydrated, and slightly jaundiced. His face and eyes were puffy, and a trace of oedema of both ankles was present. Pulse 70 per minute. Blood-pressure 205/105 mm. Hg. His abdomen appeared distended but no free fluid was found. The liver edge was palpable three fingerbreadths below the costal margin, and was very tender on palpation. Laboratory investigations: blood urea 408 mg./100 ml. Liver function tests showed intracellular damage with bilirubin 6.0 mg./100 ml. Serum glutamic pyruvic transaminase 100 I.U. Hb 92%. E.S.R. 40 mm. in the first hour. W.B.C. 7,100/c.mm. Treatment was instituted with intravenous therapy, strict fluid balance, electrolyte control, and he was given a high-carbohydrate, low-protein diet with supplements.

He responded well to therapy, and by the end of two weeks the blood urea had fallen to 26 mg./100 ml. Shortly after admission he developed a generalized rash especially in the flexures, and this was attributed to delayed skin reaction to carbon tetrachloride. The rash subsided as his condition improved.

When seen at the review clinic three, six, and nine months after discharge he was entirely well, and blood urea and liver-function tests were within normal limits.

Thus, in spite of the small ingested dose, in the presence of alcohol, serious but fortunately reversible hepato-renal damage occurred.

My thanks are due to Dr. J. W. Buchanan, under whose care the patient was admitted, for permission to publish this case.

—I am, etc.,

Victoria Hospital, Kirkcaldy, East Fife. D. H. K. SMITH.

Thymectomy and Myasthenia Gravis

SIR,—In the issue of 20 November (p. 1201) you quote Henson *et al.*,[1] and state that one of the categories of patients in whom operation is recommended is that with less than two years' history, under 30 years of age, and "in whom symptoms were not adequately controlled by drug treatment." You conclude as an indication for operation, ". . . in whom the disability is getting worse despite adequate medical treatment." Elsewhere,[2] we have shown that, irrespective of age and sex, the best prognosis to be expected is in those patients in whom thymectomy is undertaken as soon as possible after the onset of the disease.

My reason for writing is this. All too often we have patients referred who have been treated medically, perhaps for years, because they have shown good response to the drugs. Eventually, when increasing dosage of the anticholinesterase drug is required or the patient becomes less responsive to these drugs, then, and only then, is surgery considered. We feel that the optimum time for thymectomy is then past, though we do of course still offer the patient surgery.

Our contention is that thymectomy should be offered to the large majority of myasthenics as soon as possible after the onset of the disease. Possible exceptions being localized ocular myasthenia, the elderly patient with static weaknesses readily controlled by drugs, and certain other cases with specific contraindications to surgery.

In myasthenia gravis associated with tumours of the thymus (and the majority can be diagnosed by the history, mediastinal tomography, and pneumo-mediastinography[3]) we too have found that the prognosis, poor as rule, can be improved by irradiation prior to thymectomy.—I am, etc.,

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Bed-belt for the Elderly

SIR,—Having worked in three geriatric units and having had the experience of dealing with old people falling out of bed, even out of their cot-bed, I have devised an "accident belt," hoping to prevent those preventable accidents which sometimes cause fractured femurs, head injuries, cuts, etc. The belt contains no metal, can be fixed to any bed (in hospital or outside) of any size and any width to suit requirements.

The specification of the belt is as follows: (1) Length 6 ft. (183 cm.) made in two parts—one part 4½ ft. (137 cm.) long and the other 1½ ft. (46 cm.). This allows the two parts to be joined at the side of the patient. For very obese patients a 7½-ft. (229-cm.) belt is made. (2) Width of the two parts is 6 in. (15.5 cm.) and 8 in. (20 cm.). (3) The belt is made out of a double layer of calico stuffed with cotton-wool. At each end that ties to the bed there are three rows of rubber buttons set 1 in. (2.5 cm.) apart from each other to allow for adjusting the length of the belt.

It works on the principle that when the patient has found his comfortable position and is dropping off to sleep the belt is buckled at the level of the umbilicus, allowing room for the patient to turn from side to side. Should the patient require any attention at night all that is necessary is to unlock the belt. It will be most useful for (1) restless, arthritic, and confused patients; (2) the hemiplegic and elderly in convalescent homes; (3) unsteady old people nursed at home by relatives.

If it prevents some of these accidents it will have served its purpose.—I am, etc.,

St. Michael's Hospital, Enfield, Middlesex. M. GEORGE.

Histoplasmosis or Leishmaniasis?

SIR,—In the case described as of histoplasmosis (Drs. P. J. S. Murray and R. A. Sladden, 11 September, p. 631) another diagnosis may be considered. Purpura, bleeding, leucopenia, and a greatly increased sedimentation rate are more characteristic of leishmaniasis than of histoplasmosis. Besides, the patient had had kala-azar years before, and the protozoan is able to reside *in vivo* harmlessly for years. The two diseases have been confused before.[1] The microbes in tissue are identical in appearance and can be differentiated by visualizing the kinetoplasts of leishmanias by Giemsa's stain. Unless the