follow-up clinic the results obtained were not far removed from those in healthy adults. The twenty patients with clinical syndromes following surgery for peptic ulcer—that is, recurrent peptic ulceration, afferent or efferent loop hold-up, dumping syndromes, or malabsorptive states—showed evidence of leucocyte ascorbic acid depletion. Patients with duodenal ulcer on admission for surgical management were found to have values similar to those in the subjects with clinical syndromes following operation.

Our findings indicate that it is in these patients with symptoms following gastric surgery that ascorbic acid depletion may be expected.—We are, etc.,

IAN W. DYMCK. W. P. SMALL.
W. P. G. TURCK. W. SIRCUS.
P. W. BROWN.

Western General Hospital,
Edinburgh.

Elastic Band Injuries

SIR,—I have read with interest the paper by Mr. Ian Kitchin and others (22 April, p. 218) on the production of artifact ulcers and bone lesions by elastic bands. It is not unusual for mental defectives to place elastic bands over their teeth and to leave them in situ. The elastic band moves slowly towards the apex of the teeth, and as it does it strips the mucoperiosteum from the bone, resulting in loose hypertrophic tissue which can be lifted from the bone with a probe. I have seen two such cases, which healed satisfactorily after removal of the elastic band and periodontal therapy.—I am, etc.,

LAWRENCE COHEN.

Institute of Dental Surgery,
London W.C.1.

SIR,—I read with interest the article published in your journal last week (22 April, p. 218) entitled "Artifact Ulcers and Bone Lesions Produced by Elastic Bands." In it the authors state "... but for the band to have been lost and recovered at operation must be rare indeed. An extensive search of the literature has revealed no such case. ..."

I admit that the two cases I reported¹ were not, as far as I was aware at the time, deliberately self-inflicted, but they did illustrate the damage caused by elastic bands hidden under wedding rings in just such a way as the first case reported in the current article. By a remarkable coincidence, my two patients both presented on the same morning in Lewisham Hospital Casualty Department.

It was only because I had found an elastic band under the ring of the first patient that I deliberately searched for one in the second. Both patients had presented with a swollen ring finger apparently due to a tight wedding ring. The photograph shows the patient's finger after removal of wedding ring and elastic band, both of which are shown alongside.

I admit that the cases reported by Dr. I. D. Kitchin, Dr. C. McGibbon, and Dr. R. H. Seville were deliberately self-inflicted injuries and involved bone, which mine did not, but I felt I could not let their comments pass without drawing attention to my report of four years ago.—I am, etc.,

Westminster Hospital,
London S.W.1.

JOHN THURSTON.

REFERENCE

- ¹ Thurston, J. G. B., *Brit. med. J.*, 1963, 1, 542.

Accidental Hypothermia

SIR,—Dr. C. W. Thomson (1 April, p. 51) has described some of the hazards of shivering and their treatment, and suggests these might be relevant to the problem of rewarming following accidental hypothermia. While it would certainly be important to control shivering occurring at this time, it seems probable that the cause of hypoxia and respiratory acidosis in this condition should be sought for other than in shivering.

Of 51 patients with accidental hypothermia¹⁻⁴ shivering was stated to be absent in 48, present in two, and slight in one. Of another 32 patients⁵ it was stated that "the shivering response to cold is usually abolished" below 32.2° C. (90.0° F.). In 21 of these patients rectal temperature was below this level. Emslie-Smith⁶ described E.C.G. changes associated with accidental hypothermia, including changes similar to those referred to by Dr. Thomson, but noted that shivering was not often evident clinically in his eight patients. This suggests that the coarse interference on the E.C.G. referred to by Dr. Thomson might not necessarily presage the onset of shivering in accidental hypothermia.

References to shivering during rewarming following accidental hypothermia are scanty, though Rees¹ reported its absence in an 86-year-old man at 27.8° C. (82° F.) and during rewarming to 32.2° C. (90.0° F.). Since various observers have commented specifically on the absence of shivering during accidental hypothermia, it might be supposed that its appearance during rewarming would occasion comment. Presumably, therefore, shivering is mostly absent also during rewarming. In neonates and infants shivering is absent during accidental hypothermia and subsequent rewarming.⁷ In 71 episodes of induced hypothermia of 30-198 hours at 29-33° C. (84.2-91.4° F.), and during rewarming shivering was mostly absent except during active cooling or in association with a large fall in ambient temperature.⁸ In dogs kept at 23-24° C. (73.4-75.2° F.) for up to 12 hours shivering was avoided during rewarming by immersing the animals in a water bath at 40° C. (104° F.) until body temperature reached 35° C. (95° F.).⁹

Since patients may remain alert and rational during eight days of hypothermia at 30° C. (86° F.), it is unlikely that uncomplicated prolonged hypothermia of this degree will be associated with serious disturbance of ventilation or acid-base balance. The following pH, PCO₂, and PO₂ values for arterial blood relate to two mildly drowsy patients at 30.1° C. (86.2° F.) and 29.3° C. (84.7° F.) (rectal temperature) after 95 and 91 hours of induced hypothermia, respectively: 7.43, 35, 56, and 7.46, 28, 41, corrected for temperature and pH.⁸

Certainly, as indicated by the interesting references provided by Dr. J. D. Whitby (1

April, p. 51), the high mortality associated with active rewarming following prolonged hypothermia has been recognized for more than 25 years. During this latter period, however, prolonged induced hypothermia has been introduced into clinical practice. Conclusions based on hypothermia induced under control conditions of anaesthesia and maintained at comparatively fixed body temperatures, in conscious subjects, must have an especial validity for determining the effects of prolonged hypothermia and rewarming, while detracting nothing from the skill of earlier observers obliged to base their opinions on more complex and less controlled situations.

I am indebted to Dr. Knowle O'Brien, The Brompton Hospital, London, for the blood gas analyses.

—I am, etc.,

Queen Victoria Hospital,
East Grinstead.

MAURICE BLOCH.

REFERENCES

- ¹ Rees, J. R., *Lancet*, 1958, 1, 556.
² Duguid, H., Simpson, R. G., and Stowers, J. M., *ibid.*, 1961, 2, 1213.
³ Prescott, L. F., Peard, M. C., and Wallace, I. R., *Brit. med. J.*, 1962, 2, 1367.
⁴ McNicol, M. W., and Smith, R., *ibid.*, 1964, 1, 19.
⁵ Rosin, A. J., and Exton-Smith, A. N., *ibid.*, 1964, 1, 16.
⁶ Emslie-Smith, D., *Lancet*, 1958, 2, 492.
⁷ Mann, T. P., Personal communication.
⁸ Bloch, M., *M.D. Thesis*, 1965. University of London Library.
⁹ Fedor, E. J., Fisher, B., and Lee, S. H., *Ann. Surg.*, 1958, 147, 515.

Uterine Perforation with I.U.C.D. During Puerperium

SIR,—The letter of Mr. Wilfrid G. Mills in your columns (18 February, p. 427) brings me to record two cases of uterine perforation by contraceptive devices. In this country all but a small percentage of devices used are the Lippes loop.

Case 1.—A woman aged 31 was fitted with a loop 6 weeks after her second confinement. An hour later she experienced severe abdominal pain and the device was therefore removed. The pain persisted and she was thought to have salpingitis and this was treated with tetracyclines.

Ten days later severe pain returned and she was referred. Examination revealed a cystic mass in the right adnexa, some 6 inches in diameter. At laparotomy 20 ounces of old blood was removed from the right broad ligament. Both ovaries and tubes appeared normal. Careful examination of the uterus showed no obvious perforation but an area of bleeding just above the level of the internal os was ligated on the right side.

Case 2.—A woman aged 23 years was delivered normally after severe pre-eclampsia. A Lippes loop was inserted 8 weeks after delivery. She was later found to be pregnant again and in view of her previous history termination was carried out. However, attempts at removal of the loop resulted in the nylon threads breaking off on firm traction. X-ray showed the loop to be within or near the uterus. She was then referred. Examination under anaesthesia confirmed that no loop was present within the uterine cavity.

At laparotomy the loop was found lying between the vesical peritoneum and the uterus, its distal end imbedded in the uterine wall.

It would seem that the leading end of the loop is most likely to perforate the uterus, more so if pushed out of the inserter too quickly. A useful precaution would be to

push the loop out of the inserter into the uterine cavity extremely slowly at the beginning, while the remainder of the loop may be extruded more rapidly. Since both the above perforations occurred in the puerperal uterus I am of the opinion that those less experienced in the procedure should defer insertion of the I.U.C.D. until three or four months following delivery.—I am, etc.,

Nairobi,
Kenya.

D. WAGHMARAE.

Cardiac Catheter Introducer

SIR,—Occasionally difficulty may be experienced in introducing a cardiac catheter into a small vein or artery. To overcome this a shoehorn type of introducer has been designed. The narrow end of the shoehorn is easily introduced into the lumen of a small vessel and advanced to distend it. The tip of the catheter is then passed into the vessel through the hollowed-out shoehorn. The crook on the handle ensures easy manoeuvrability.

The introducer is obtainable from Charles F. Thackray Ltd., Park Street, Leeds 1.
—I am, etc.,

Dudley Road Hospital,
Birmingham 18.

J. MACKINNON.

Abortion Bill

SIR,—In the discussions and letters about the Abortion Bill, except in the letter from Dr. W. J. Stanley (22 April, p. 247), too much emphasis has been laid on the side issues. Important though these may be, the main point to my mind is the one of principle.

Here we have a Bill, which may become law soon, introduced by a layman doubtless influenced by pressure groups and debated in a largely lay House of Commons, which seems to direct the members of our profession on how they shall conduct their practices. This strikes at the very heart of our professional ethics, and will direct us in our professional conduct in that we shall be obliged to implement and execute the objects of the Bill. Any medical man or woman who claims conscientious objections will have the onus of proof upon himself, and if it can be shown that he has ever advised a therapeutic abortion his objections will be overruled.

The present law covers all the essential needs in relation to therapeutic abortion, and any desirable amendment should come from our profession and be introduced preferably by a medical Member of Parliament. It is intolerable that we should be dictated to, and our professional standards altered in this manner.

I realize that I am writing as an old man, with old standards of ethics, but if this Bill becomes law I shall be thankful that I am old.—I am, etc.,

Brede,
Sussex

CYRIL F. MAYNE.

New Forms

SIR,—May I adapt the words of Shakespeare to general practice today and say that the curse never fell upon our profession till now; I never felt it till now? The forms for use by general practitioners in the years since 1948 were child's play compared with what is now being thought up for us. That for cervical smear screening is almost a masterpiece and the first edition will probably fetch thousands of guineas in years to come; and all to record results, the only value of which will be to prove the futility of the whole exercise, as has already been done in New Zealand and British Columbia.

I understand the pathologists are hard at work on producing bigger and better forms for all investigations required of them; others will doubtless follow, and these, in addition to those required for claiming payment for items of service and partial refund of rent and rates, will keep us up to scratch in that first essential for citizenship in the Welfare State—skill in form filling.

There is some method on the part of the Ministry in this apparent madness, for it is certain that doctors will become so weary of forms that they will let many items of service remain unpaid for, and so benefit the Treasury. Also there is something here by which to measure the calibre of a really good "merit" award candidate. Truly it is wonderful to be alive and in general practice in the form-fillers' computerized Utopia of today.—I am, etc.,

Bath.

W. B. S. CRAWFORD.

SIR,—Among the recent proliferation of new certificates associated with the new financial arrangements for general practitioners there are two forms to which general practitioners should take the strongest exception. These are forms E.C.74 (Scotland) and E.C.81 (Scotland) for cervical cytology and night-visit fees. These can only undermine further the reduced status of the family doctor and debase the consultation as such.

It is surely a gratuitous insult to expect family doctors to obtain a patient's signature on these forms to verify that a visit or examination has been made. Is the doctor no longer regarded as a responsible professional person with a degree of integrity? These forms, as they stand, should be rejected and a more acceptable form drafted.—I am, etc.,

Greenlaw,
Berwickshire.

IAN W. FINGLAND.

Depression

SIR,—Ducats are clipped, pence are not. I see that yet another colleague (15 April, p. 180) is taking Professor Henry Miller to task over his Morison Lecture (4 February, p. 257). With the sole exception of Dr. F. Avery Jones (11 March, p. 632), your correspondents overlook that "Depression" is not an article submitted on the subject, but the record of an oration given before the Royal College of Physicians of Edinburgh. Lack of discernment is illustrated in Dr. A. D. Isaacs's (25 February, p. 498) "... complete absence of any references," as well as Dr. Wybrow's "... he omits to mention ... and falls back on personal hunches and textbook descriptions." In my experience hunches go

well with orations, while textbooks do not abound in gems such as "the neurotic gives up his work, while the depressive abandons his pleasures."—I am, etc.,

H. PULLAR-STRECKER.

Isleworth, Middlesex.

Humanizing the Basic Sciences

SIR,—Mr. D. W. Bracey in his letter (8 April, p. 114) suggests the need for preclinical students to have some contact with patients. I am at present a preclinical student at Liverpool University. In my first year, when I was studying anatomy, once a week patients who were presenting symptoms which were interesting from an anatomical point of view were demonstrated during our lectures. Small groups of us were also taken round an x-ray department and some of us were given the opportunity to attend a postmortem examination.

I am now in my second year, studying physiology and biochemistry, and once a fortnight a group of about 30 of us attend one of the local hospitals, where, during a short lecture, some patients presenting symptoms interesting from a physiological point of view are demonstrated to us. Then small groups of about six are taken round wards to examine a few more cases.

This system is excellent; it helps by making otherwise seemingly purely academic subjects acquire practical interest. It also makes the student familiar with hospital etiquette and procedure.—I am, etc.,

Wallasey,
Cheshire.

JENNIFER DUGUID.

Senile Purpura

SIR,—The trial described in the *British Medical Journal* by Dr. G. Arthur and colleagues (25 March, p. 732) lasted six weeks. During the last two years I have observed the results of treatment in England of glossitis and sublingual and skin haemorrhages with large doses of the B group of vitamins and vitamin C over longer periods.

A nutrition committee at the Ministry of Health has seen the results of this treatment in cases in a geriatric unit in Gloucestershire. These results were reported in two articles.^{1,2} I had earlier reported preliminary findings to the Ministry of Health and the Royal College of Physicians.

The glossitis cases were of two main types, bare smooth red tongues, and fissured red tongues with enlarged numerous fungiform papillae, often with cheilosis, angular stomatitis, and less often with changes in the nasolabial fold. Cases were of varying severity and often a mixed type. The surface of the tongue improved after three months' treatment, but after nine months' treatment some cases were still not normal, though still improving. They appeared to need at least one year's treatment.

Sublingual and skin haemorrhages have shown little or no change after six months' treatment, though I thought the under surface of the tongue was often less red. After nine months' treatment there are suggestions that some recent sublingual haemorrhages are smaller and have a more definite, less blurred, edge, and that there are fewer, but clearer, more defined, tiny vessels in the fern-like pattern of sublingual blood vessels. There is a suggestion that skin haemorrhages may be fewer in number in treated than in untreated cases, and that there are many fewer petechiae in the Hess tests in