sated by the rarity with which emergency visits are necessary.

Status asthmaticus must be one of the more common causes of emergency admission to hospital, yet in this general practice of over 4,000 patients there have been only nine occasions in the last six years when an adult asthmatic patient has been admitted as an emergency. Analysis of these nine emergency admissions shows that in four cases the episode which necessitated admission was apparently the first overt manifestation of asthma which the patient had experienced. Three emergency admissions were not for status asthmaticus (two being for spontaneous pneumothorax and one for complete obstruction of the main bronchus by a plug of aspergillus). Thus, in six years there have been only two occasions when a patient, who was already known to have severe asthma, has required emergency admission for status asthmaticus.

During the last six years a prospective study of all patients with asthma has been in progress. Twenty-eight patients have required treatment with steroids. All patients are followed up regularly and the dosage of steroid is carefully controlled by measurement of peak expiratory flow. At least one attempt is made to discontinue steroid therapy and this has been possible in nine patients. In the other 19 patients relapse occurred, despite very gradual reduction of dosage and, in several cases, injections of corticotrophin. In those patients who require continuous steroids the dose is kept as low as possible, the aim being not to achieve complete reversal of their airway obstruction but rather to find that dose which just suppresses their symptoms of asthma. In many patients the maintenance dose of prednisone is 4-7 mg. per day, apart from temporary increases for exacerbations, and only five patients required a dose greater than 10 mg. per day.

It is important to recognize that chronic asthma may become unaccountably refractory to a dose of steroid which previously has suppressed it satisfactorily. Usually such refractory periods are of short duration, but in some patients it proves impossible to revert to the previous maintenance dose. Although Dr. Maunsell and her colleagues found that in general there was no tendency for prolonged treatment, this certainly does occur in some individual patients.—I am, etc.,

IAN GREGG.

London S.W.15.

Deaths from Asthma

SIR,—If the physical outlet of an emotional disturbance is blocked by an effective suppressor—that is, a corticosteroid—which also has the delayed effect of increasing mortality, the mortality first falls and then rises slowly; or it may fall and then stay level if the pressure to have asthma from the bottled-up emotional disturbance is balanced by the lowered mortality from the corticosteroids. When less effective suppressors (the pressurized aerosols) which have an acute mortality are introduced a few years later the death rate will rise immediately. Children will be most affected, because their parents will assiduously administer the suppressive agents not knowing that their emotional

relationship with their children is the most common cause of the asthma.

When the public and the medical profession realize that asthma is a symptom of a cry for emotional help, and that it can be entirely relieved by giving the necessary assistance and desensitizing the patient when there is an allergy, the suppressive agents will be used with sufficient discrimination to allow their effectiveness to be realized advantageously.—I am, etc.,

Plymouth,
Devon.

ALEX FORBES.

Pelvic Examination

SIR,—The letters on the subject of pelvic examination (30 March, p. 839) indicate that the left lateral position is a kinder and quite satisfactory alternative to the "patient on her back and her legs supported [?] restrained] by a nurse or in stirrups." The left lateral position is ideal for the initial examination of the unmarried or the teenager, or for demonstrating the signs of prolapse, but it has no advantage over the dorsal position in other cases, and is much less satisfactory for teaching undergraduates to examine the pelvis of the female.

The technique described of the patient's legs being supported by nurse or stirrups has surely been generally abandoned as unnecessary, the exception being under operating conditions in theatre or for induction of labour.

In outpatient clinics or in ward beds the patient can lie on her back covered from chest to knees by a sheet. If, on request, she flexes her knees, places her heels together, and allows her knees to fall widely apart, her pelvis can be examined digitally or per speculum without her being further uncovered. This last point needs to be emphasized in the training of doctors and gynaecologists, for I regret to say I frequently see patients exposed from the waist down to facilitate pelvic examination. It seems as if the examiner believes that his complete lack of embarrassment removes the possibility of the patient feeling embarrassment.—I am, etc.,

Glasgow.

J. A. MCGARRY.

Ventilation Equipment

SIR,—We think readers should be informed or reminded, whichever applies, that despite assertions that the Ambu-E valve cannot be assembled incorrectly it is possible to reassemble this valve in the wrong way.

One of us was recently given an Ambu bag for ventilation of a patient who was being transferred from one ward to another. He was greatly confused when he found that he could not maintain ventilation smoothly. Expiration was only possible if the face mask was lifted between breaths, because the apparatus was functioning as a to-and-fro system without the absorber. The reason why was not immediately obvious, but later inspection showed that the rubber valve normally positioned at the outlet of the bag had been put over the expiratory port, thus completely stopping escape of gases through the normal channel. The patient could only

breathe out into the bag, which had of course refilled meantime.

Inspection of a valve will reveal that the rubber flap-valve within it easily and neatly slips on to the expiratory port, and the mistake could occur in any department where staff unused to the mechanics of such things are expected to wash and clean the bag after its occasional use.—I am, etc.,

MURRAY P. KELLY.

Rigshospital,
Copenhagen.

Measuring Blood-flow in Dialysis

SIR,—An adequate blood-flow is essential for effective haemodialysis. Measurement of the blood-flow along the arterial and venous blood lines connecting the patient to the artificial kidney is customarily performed by timing the progress of an air bubble along a fixed distance and calculating the flow rate from a graph. Inaccuracies arise if the tubing is not horizontal and the flexible plastic tubing is difficult to maintain at a constant distance between two fixed points for measurement.

This can be remedied by the use of a simple device consisting of a wooden plank with a measured distance marked out on it. The plastic blood lines are held in position along these distances by a series of "Terry" clips, and to ensure that the board is horizontal during measurement a spirit level is screwed on to the device. For compactness and convenience the length of tubing can be doubled back along the known distance so that the device can be made portable for use in home dialysis. This apparatus is easily made for a cost of under 10s.—I am, etc.,

R. M. JAMESON.

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Urological Centre,
Sefton General Hospital,
Liverpool 15.

Oral Lichen Planus and Betamethasone

SIR,—It may be of interest to know the results of following up the patients treated with oral Betnovate, reported upon earlier (13 January, p. 86). These are as follows:

Remained healed	13
Recurrence	2
Continuing to take Betnovate	2
Partial improvement maintained	1
Lost to follow-up	12
	30

Of the 12 that failed to attend again two were severely ill patients and two lived in distant parts of the country. The two patients who had recurrence of lesions were both young (that is, 20 and 21 years), but in neither case was the recurrence severe enough to cause complaints. These results are gratifying but somewhat surprising to me in that I would not have expected so minute a dosage of a corticosteroid to have so persistent an effect on what must be regarded as something more than a mere local lesion.

May I also point out a possible source of misunderstanding in my article? The trial was concerned only with betamethasone-17-valerate (Betnovate, Glaxo), and it is this

drug that is meant when "betamethasone" is referred to, without qualification, for brevity. I must apologize for this, as it will obviously be confused with another product, betamethasone disodium phosphate (Beta-Corlan, Glaxo), which was not used. It should also be pointed out that while betamethasone (Beta-Corlan) is freely available, Betnovate oral pellets as used in this trial are not available on prescription.—I am, etc.,

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and Pathology,
Guy's Hospital,
London S.E.1.

Restrictions on Doctor in South Africa

SIR,—I cannot allow Dr. G. F. C. Troskie's remarks (17 February, p. 445), denying that academic life in South Africa is being intruded on by politics, to pass unchallenged, and I would be interested if Dr. Troskie could clarify and amplify the "half-truths and false impressions" to which he referred in connexion with the recent correspondence (26 August 1967, pp. 512 and 516) concerning the banning of Dr. R. Hoffenberg.

The facts were that Dr. Hoffenberg, teacher and research worker, was arbitrarily banned by ministerial decree without charge, trial, or opportunity to defend himself. In terms of the banning order, Dr. Hoffenberg was deprived of contact with students and access to his research laboratory and the medical library. Further, he was not allowed out of the magisterial district in which he lived. He was allowed social contact with only one person at a time. Initially, the ban stated that he was not allowed to publish any material. Later, in a "clarifying" statement, the Minister of Justice personally gave Dr. Hoffenberg permission to publish scientific material. But what can a research worker publish if he is allowed neither access to his laboratory nor to the medical library? Surely this is "academic life in a politically suppressive atmosphere"? (Dr. S. Shapiro, 16 December 1967, p. 684).

Dr. Troskie has attempted to present this Government as a promoter of racial harmony, especially within the medical profession and in academic circles. Is he aware that the South African Government pays doctors in their employ on different scales? Not according to merit or ability, but based solely on race classification. For example, registrars, white, R.3,000 to R.4,500 (£1,500 to £2,250); Coloured and Asiatic, R.2,070 to R.3,240 (£1,035 to £1,620); and Bantu, R.1,800 to R.3,000 (£900 to £1,500).

Certainly medical and scientific research extend over all sections of the population, but not as Dr. Troskie would have us believe "irrespective of colour, creed, race, or personal political beliefs." This is the sad state of affairs in which we find ourselves in South Africa—academically suppressed, politically frustrated, and legally blocked.

It is significant that this correspondence takes place through the courtesy of the Editor of the *British Medical Journal*, as the *South African Medical Journal* has refused to print any correspondence or comment on the Hoffenberg affair.—I am, etc.,

LOUIS H. DIAMOND.

Groote Schuur Hospital,
Cape Town, South Africa.

SIR,—Dr. G. F. C. Troskie (17 February, p. 445) states that it is false to assert that academic or medical life is influenced by politics in South Africa.

As a non-white medical practitioner in South Africa, I find that life, both medically and academically, exists in a politically suppressive environment. Every facet of medical and academic life is permeated with the Government's policy of apartheid. The non-white patient is provided with separate and inferior medical services. The *per caput* expenditure of both the provincial and central Governments on non-white medical services in urban areas is only a fraction of that spent on the white section of the population. In the African reserves these services are virtually nonexistent.

I do agree that South Africa can boast of having advanced medical facilities, but these unfortunately exist largely for the privileged white section of the community. To illustrate this point, Natal, a province with an overwhelmingly large non-white population, recently acquired artificial kidneys from Government funds for the exclusive use of white patients. No similar service is available for the non-whites. Academic life is riddled with similar injustices. Non-whites are not allowed at the Universities of Pretoria and Stellenbosch. A limited number of non-white medical students are admitted to the Universities of Cape Town and the Witwatersrand, but even here they may not examine a white patient nor are they allowed to be present at the post-mortem examination on a white body.

Postgraduate facilities for non-white doctors are very limited. Furthermore, not only are they barred from working in the white hospitals, but even the doors of some of the non-white hospitals are closed to them. Is it therefore not surprising that some of the most highly qualified from among us have left South Africa to settle elsewhere?

The policy of discrimination in the salaries paid to doctors on the grounds of race and colour is yet another feature that contributes to frustration. This discrimination in salaries is ridiculous to the extent that a non-white consultant gets a lower salary than a white houseman working in the same hospital.

In the light of all this, it is very difficult to accept Dr. Troskie's view that a politically suppressive atmosphere does not exist in South Africa.—I am, etc.,

SOUTH AFRICAN PRACTITIONER.

Missing Loop

SIR,—The interesting and informative paper by Mr. S. S. Ratnam and Dr. J. C. K. Yin (9 March, p. 612) on translocation of Lippes loop focuses attention on this important complication of an I.U.C.D., and reminds me of a case I saw while working in a mission hospital in western India in 1967.

The patient had had seven pregnancies, and a Lippes loop size 30 was inserted six months after her last confinement by a doctor who had several years' gynaecological experience. After the insertion there were no symptoms to suggest perforation of the uterus. Seven months later the patient attended hospital

with the complaint that she could not feel the nylon threads, and she thought she might have passed the loop. Clinical examination confirmed the absence of the threads and x-ray examination of the abdomen showed what appeared to be an intrauterine Lippes loop. Fifteen months after insertion the patient again attended hospital. On this occasion she complained of vomiting and upper abdominal pain associated with pyrexia of some hours' duration. She was sure that her symptoms were due to the Lippes loop, and she requested removal of the loop and tubal ligation.

On pelvic examination the uterus was found to be retroverted, and there was some swelling in the right fornix. On anteversion of the uterus the swelling was more marked, and could readily be defined as a Lippes loop. It transpired that the patient's symptoms were due to enteric fever, and laparotomy was postponed until she recovered. At operation the Lippes loop was found deeply embedded in the right broad ligament, and firmly adherent to the right ovary and Fallopian tube. The leading portion of the loop was adjacent to the right ureter. Right salpingo-oophorectomy, left partial salpingectomy (Pomeroy method), and appendectomy were performed.

Translocation of a Lippes loop may occur more frequently than the literature would suggest, and it would be helpful in assessing the position if all such cases were reported.—I am, etc.,

JOHN BREEZE.

Enniskillen,
N. Ireland.

SIR,—The possibility that the uterus might have been perforated by the I.U.C.D. must be considered whenever the threads are not visible emerging from the cervix. In some cases the device will have been extruded and passed unnoticed, but in the majority, as Mr. H. E. Reiss (6 April, p. 49) observes, the device will have rotated within the uterine cavity. If an x-ray is considered advisable to demonstrate the device in the pelvis it will usually be a sensible precaution to have a uterine sound in place, thus showing more clearly whether the device is still within the uterine cavity.

Complete perforation of the uterus is rare, but partial degrees in which some part of the I.U.C.D. penetrates the myometrium are not so uncommon. In one important respect my experience differs from that of Mr. Reiss. The use of the vulsellum or tenaculum is avoided whenever possible, and among the last thousand or so cases at my clinic no case of complete perforation has been observed. Of the four known cases of perforation in the first 600 cases the vulsellum is known to have been used in three and probably also in the fourth case. On theoretical grounds also it seems extremely unlikely that it would be possible to perforate the uterus unless the cervix was pulled down to counter the thrust of the introducing stilette. The vulsellum is generally necessary for the fully retroflexed or retroverted uterus, and in these cases the danger of perforation is certainly increased.—I am, etc.,

WILFRID MILLS.

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