often unfairly, for the unsatisfactory circumstances in which many overseas doctors now find themselves on arrival, and some have only themselves to blame. It might, however, be felt that a degree of cruelty is sometimes shown towards the plight and peculiar needs of some, if not all, overseas doctors that is scarcely excusable in any circumstances. Nor should knowledge of this be longer withheld from influential lay opinion, whose insistence, if the true facts were widely known, would surely urge better postgraduate facilities generally than now exist. There can be no reasonable argument against the proposal that once the legitimate needs of our own graduates are ordinarily met those overseas graduates who apply to the Department of Health for compulsory clinical attachment should, wherever possible, be given their first post if the "attachment" is favourable, without having to apply for it. Nothing can be more evasive than that the Department of Health should refuse to act as an employment bureau, since among its other functions this is precisely what the Department does do, though admittedly this function is normally delegated to regional boards or to boards of governors. It would, of course, be difficult, indeed impossible, to guarantee doctors from abroad arriving for attachment continuous employment throughout their stay here, but since the first post seems by far the most difficult to obtain, especially if temporary registration is also needed, then it would seem wholly fair we should at least help this type of immigrant to that extent. Anything less is surely a blatant and soulless denial of our overall responsibility.

Clearly the habit of reaching facile conclusions on many aspects relating to immigrant doctors must be resisted, but a few definitive conclusions now seem inescapable. Furthermore, deliberate refusal by the Department of Health actively to invite overseas governments purely on humanitarian grounds, if on no other, to recall their own doctors for service at home after an absence in this country on post-graduate study of about five years, seems a violation of basic human rights as applied to the great mass of peoples within the under-developed countries, whose access at present to the full benefits of modern, scientific medicine is a lot less than it should be. Preliminary discussion on this important aspect might well be considered a useful item on the Agenda (if it is not already on it) for the fifth meeting of the council of the Commonwealth Medical Association being held soon in South-east Asia.—I am, etc.,

H. VINCENT CORBETT.

Liverpool 1.

Deadly Diapers

SIR,—In your leading article "Deadly Diapers" (9 May, p. 314), a hazard to infants is attributed to dusting powders containing boric acid, whereas it is well established that the danger arises from the use of undiluted boric acid as a dusting powder in place of a borated talcum powder. It is important that the difference between these two should be realized.

Though R. B. Goldbloom and A. Goldbloom¹ reported a case of non-fatal boric acid poisoning from the use of a commercial borated baby powder applied liber-

ally to an infant's excoriated buttocks, R. B. Goldbloom later² published a statement that pure boric acid powder had also been applied to the infected umbilical cord of the infant and added "... the borated baby powder cannot be implicated *per se* as the sole cause of intoxication in this infant." Similarly in the cases you refer to reported by J. Ducey and D. B. Williams,³ a borated talcum powder had been used on one infant, but this had been followed by undiluted boric acid powder. There was no case of a borated talcum powder alone causing poisoning.

The safety of borated talcum powders for use with infants is well documented.^{4,5}—I am, etc.,

DORA L. SAMUEL.

Borax Consolidated Ltd.,
London S.W.1.

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Depressive Illness and Menstruation

SIR,—Dr. M. J. Wooldridge (18 April, p. 174) is surprised that Dr. A. M. W. Porter's paper (28 March, p. 773) on depressive illnesses in general practice did not reveal an increased frequency during the premenstruum. Dr. Porter in his letter (9 May, p. 363) shares equal concern, and states that he was correlating the time women "reported sick" with the time of the menstrual cycle.

This is only a partial explanation of the puzzle; a vitally important point has been overlooked. There is an appointment system operating in Dr. Porter's practice. An appointment system makes nonsense of any attempt to correlate the time of a woman's first attendance with the onset of an illness. Many extraneous factors are involved in finding a mutually convenient time for an appointment, such as the social and other commitments of patient and doctor, the proximity to a week-end, and the patient's working hours. The delay between a patient asking for an appointment and waiting only one to four days for a convenient time is quite sufficient to bring the time of first consultation into a different phase of the menstrual cycle. Therefore, an arbitrary time of an appointment cannot provide a datum line for correlating an illness with the menstrual cycle.

An increasing number of doctors with appointment systems are conducting studies into illness and menstruation; therefore, it is of paramount importance that the fallacy of using the first appointment as the time of onset of the illness is fully appreciated. Thus in the analysis of menstruation in relation to hospital admissions to psychiatric, accident, medical, and surgical wards, and even for children's admissions in relation to their mothers' menstruation,^{1,4} the surveys were specifically limited to emergency admissions, thus excluding cases admitted by *appointment* from outpatients or when a bed was available.

An illness starts when an illness starts, not when the patient attends by appointment.—I am, etc.,

KATHARINA DALTON.

London W.1.

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- 1 Dalton, K., *British Medical Journal*, 1959, **2**, 1307.
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Sickle Cell Trait and Leg Ulceration

SIR,—The findings and the conclusion in the letter by Dr. G. R. Serjeant and Mr. M. Gueri (28 March, p. 820) that "there would appear to be a definite relationship between leg ulceration and sickle cell trait" are surprising.

We have recently reviewed 34 Nigerian patients with osteomas due to "tropical ulcers." These ulcers are of a defined clinico-pathological nature and quite distinct from those due to varicose veins, yaws, syphilis, and open traumatic wounds, which we have assumed were included in the survey reported. None of our patients had the sickle cell trait even though over 25% of Nigerians carry the S gene.¹

We respect the findings of Dr. Serjeant and Mr. Gueri and eagerly await a non-statistical explanation for this relationship, remembering that leg ulcers are not a feature of all anaemias—for example, pernicious anaemia—and that the histology of these ulcers, especially the absence of thrombosis, does not differ from other chronic ulcers such as in chronic haemolytic jaundice.²—We are, etc.,

T. M. KOLAWOLE.

S. P. BOHRER.

Department of Radiology,
University College Hospital,
Ibadan, Nigeria.

REFERENCES

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New Bronchodilator Aerosol Preparations

SIR,—I would agree with the letters of Dr. J. H. Clarke (9 May, p. 367) and Dr. I. W. B. Grant (16 May, p. 421) suggesting that the advertising of Medihaler-duo as preventing a fall in Pao₂ in various lung conditions including asthma is, perhaps, a little premature being based on two letters to you (29 November, 1969, p. 557 and 17 January, p. 173) and, I should also add, a paper presented to the Societas Europaea Physiologiae Clinicae Respiratoriae at Bochum which is to be published shortly. However, I believe it is reasonable to expect that bronchodilator therapy should improve the function of the respiratory system which defined by E. J. M. Campbell¹ "... is to secure gas exchange between blood and ambient air so that arterial blood gas pressures are kept within certain limits." The same author, in the article referred to by Dr. Clarke,² warns against a sudden fall in Pao₂ in hypoxic patients which, in our experience, often happens in chronic obstructive lung disease after the use of bronchodilator aerosols.

I think, therefore, it is desirable that firms making these substances, while main-

taining an appropriate professional reticence in their advertising, should think along these more patho-physiological lines rather than accepting an increase in the forced expiratory volume as necessarily improving lung function. At the same time several valid points have been raised by both Dr. Clarke and Dr. Grant and it might be timely to have a meeting on this subject in order to correlate the work that has already been done by many workers in this interesting field.—I am, etc.,

T. T. CHAPMAN.

Pulmonary Function Unit,
Baggot Street Hospital,
Dublin 4.

REFERENCES

- 1 Campbell, E. J. M., *British Medical Journal*, 1965, 1, 1451.
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Promoting "No Smoking"

SIR,—We hope many professional colleagues will have noted with due appreciation the provision of "No Smoking" facilities by PanAm in their jumbo jet aircraft. We trust this overdue gesture will prompt other airlines to remedy their own inadequate environmental provisions.

This "clean air in the air" will be greatly welcomed by the many non-smoking passengers from whom we have received letters of complaint.—We are, etc.,

J. P. ANDERSON,
President,

Chest Clinic,
Musgrove Park Hospital,
Taunton.

T. W. HURST,
Chairman,

National Society of Non-Smokers.
Royal Infirmary,
Edinburgh.

Slot Machine Cigarettes

SIR,—Your correspondent's comment about the importance of the cigarette slot machines in the development of the smoking habit (9 May, p. 364) are supported by the research we carried out for the Department of Health.¹ Slot machines are a particularly important source of cigarettes to the smoker who is too young to persuade a shopkeeper to sell them to him.

In the first year of secondary school we found that 14% of schoolboy smokers usually obtained their cigarettes from slot machines whereas in the fourth year this proportion had dropped to 3%. The corresponding proportions for obtaining cigarettes from shops were 64% in the first year and 78% in the fourth year.—I am, etc.,

J. M. BYNNER,

Senior Research Officer,
Government Social Survey Department,
London, E.C.1.

REFERENCE

- 1 Bynner, J. M., *The Young Smoker*, London, H.M.S.O. 1969.

Cardiac Failure and Folate Deficiency

SIR,—Dr. F. P. Retief's letter (28 March, p. 820) concerning cardiac failure and folate deficiency draws attention to the role of excessive excretion as a contributory cause of folate deficiency.

It prompts me to point out that increased folate loss in the urine may also contribute to the low plasma folate activity found in pregnancy especially toward term. Estimations on 24-hour urine samples collected by six women at regular intervals throughout pregnancy gave a mean value for folate activity of $13.6 \pm 8.4 \mu\text{g}/24$ hours, compared with only $3.0 \pm 1.7 \mu\text{g}/24$ hours for the same women six weeks post partum ($t=6.8$, $p=0.005$).

This is a preliminary communication; full results will be published separately.—I am, etc.,

M. J. LANDON.

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University of Newcastle upon Tyne.
M.R.C. Reproduction and Growth Unit,
Princess Mary Maternity Hospital,
Newcastle upon Tyne.

Cat Leukaemia

SIR,—I should like to object to Dr. Alice M. Stewart's statement (4 April, p. 48) that her Table does not show any statistical difference between leukaemic children and controls who kept hens or household pets.

This is not the problem in question. It is not important that animals were kept in the same degree by leukaemic children and by controls, but it should be interesting to know if some leukaemic children were "infected" by leukaemic animals and if the animals of the controls were all or prevalently healthy.

Future research should try to ascertain these data.—I am, etc.,

FRANCESCO FISCHER.

Rome, Italy.

Diaphragmatic Defects and Laparoscopy

SIR,—Dr. R. L. Midgley's letter (9 May, p. 365) mentioning pneumothorax as a complication of therapeutic pneumoperitoneum suggests the possibility of similar trouble during laparoscopy. Laparoscopy is being used increasingly in the diagnosis and treatment of gynaecological ailments. It is performed under general anaesthesia as the required gaseous distension of the peritoneal cavity would be distressing to patients if it were attempted under local analgesia. The intraperitoneal gas pressure used to facilitate the observation of viscera may cause a tension pneumothorax in the presence of a diaphragmatic defect. The consequences of this hazard are illustrated in the following case.

Some time ago a laparoscopy was performed on a fit young woman who complained of infertility. She was lightly anaesthetized with halothane in oxygen via an endotracheal tube, fully curarized and atropinized. Respiration was manually controlled. She was placed in the lithotomy position with a head-down tilt. The peripheral pulse was continuously displayed by a digital plethysmograph and the systolic blood pressure recorded frequently. Oxygen was insufflated into the peritoneal cavity starting at 500 ml./min. and gradually increasing to 2 litres a minute until a pressure of 15 mm. Hg was reached. During the period of oxygen insufflation, which lasted about five minutes, the patient became cyanosed despite apparently adequate ventilation with oxygen. The blood pressure fell rapidly, the pulse became slower and stopped a few minutes later. External cardiac massage was performed without effect for about

20 seconds. The left pleural cavity was then opened to permit direct cardiac massage. The left lung was found to be completely collapsed, the mediastinum pushed to the right, and the heart in asystole. The lung reinflated easily and the heart resumed normal activity after a few manual compressions and normal blood pressure and tissue oxygenation returned. The chest incision was sutured, the anaesthetic withdrawn, and the patient recovered full consciousness a few minutes later. Her subsequent convalescence was uneventful.

It would seem that the patient sustained a cardiac arrest owing to tamponade caused by a tension pneumothorax on the left side. The most probable cause was the passage of oxygen under pressure from the peritoneal cavity to the pleural cavity via a defect in the diaphragm. The early recognition of the pneumothorax in these circumstances is difficult. The use of intraperitoneal carbon dioxide instead of oxygen is unlikely to alter the risk and introduces the problem of sympathetic overactivity of the heart if excessive amounts are absorbed; the latter can be controlled with beta adrenergic blocking drugs.¹ Localization of the cardiac apex beat before and during the procedure may be of some help, but the position of the heart is altered by the head-down posture and by the intraperitoneal pressure. Tracheal deviation may indicate the affected side. Chest percussion and auscultation may be helpful, but little time is available for accurate assessment. It is obvious that the rate of development and the severity of the pulmonary and cardiac collapse are dictated by the intraperitoneal pressure. It is not improbable that pressures in excess of 5 mm. Hg should be used with caution and in the minimal amounts required for good observation of the viscera.

We think that laparoscopy is neither a suitable nor safe alternative to laparotomy in patients with cardiopulmonary disease, because of the impairment of respiratory activity and venous return which may accompany the procedure, even in the absence of a diaphragmatic defect.—We are, etc.,

T. B. FITZGERALD.
M. W. JOHNSTONE.

St. Mary's Hospitals,
Manchester.

REFERENCE

- 1 Johnstone, M., *British Journal of Anaesthesia*, 1969, 41, 130.

Action on Amphetamines

SIR,—Heartiest congratulations to the interprofessional committee of Ipswich on their voluntary ban on the prescribing of amphetamines in the town (9 May, p. 361). I am not opposed to legislation as such, but I often feel that common sense, the application of existing measures, voluntary co-operation between the various disciplines, and, above all, a sincere appreciation of the basic causes of drug dependence will do more to combat this scourge than all the legislation—however welcome.

I am the chief pharmacist of a hospital in London. With the agreement of the medical staff involved, I have introduced a system of seven-day supply for drugs in circumstances where they are liable to misuse. Unfortunately it is felt that whatever doors are