need not be removed, but the implication of the succeeding comments is that Lattimer is undoubtedly wrong. This seems to be based on the assumption that caseous tuberculous tissue cannot be sterilized. What evidence has the writer for the statement that "chemotherapeutic drugs diffuse with great difficulty, if at all, into the prostate and seminal vesicles"? There is, in fact, very adequate evidence that, if proper treatment is given for a sufficiently long period, it is impossible to isolate tubercle bacilli from resected tissues.² The evidence quoted in the article in favour of nephrectomy is completely unsupported. Borthwick, for instance, states "While operations on the lungs have reduced very much in number there are still many patients who, in our opinion, require surgical treatment for their genitourinary lesions (Table VII)."³ Table VII shows that 92 nephrectomies were carried out among 407 patients in 1960-5. If my reading of the relevant table is correct, Gow reports that about 90% of patients admitted to hospital in 1967-9 have undergone surgical treatment.⁴ What were the indications for the large number of nephrectomies and other operations?

Stress is rightly placed on ensuring patency of the urinary drainage system, for obstruction of drainage at any level can threaten or destroy more renal tissue than the disease itself.⁵ It is my opinion that the writer dismisses the value of steroids too lightly. Based on experience in pulmonary disease, I use prednisolone 20 mg daily for three months where there is evidence of ureteric obstruction at any level. Since beginning this form of treatment routinely for ureteric obstruction, in a personal series of 63 cases of renal tuberculosis managed jointly with a very experienced urological surgeon, 26 (41%) patients showed evidence of ureteric obstruction and were treated with corticosteroid therapy in addition to chemotherapy. In 22 (84%) of these patients evidence of hydro-ureter and/or hydronephrosis disappeared. Three patients required subsequent surgical dilatation of the ureter and another underwent nephrectomy because, having stopped his steroid therapy on his own account, he had a gross rebound hydronephrosis and was operated on in another hospital. We have learned from subsequent experience with two patients that such a "rebound" is reversible by the reintroduction of steroids. The urine has become negative on culture for tubercle bacilli in all patients. One patient has relapsed and admitted that she had taken treatment irregularly, but has been satisfactorily retreated with chemotherapy. One patient required a diversionary operation because of gross frequency due to a very small bladder. One patient underwent nephrectomy for a destroyed kidney. I believe that our experience supports the plea made by Dr. R. Gabriel (22 May, p. 463) that physician and surgeon should collaborate closely in the management of tuberculosis of the kidney and that renography is a valuable method of assessment.

It is 15 years since thoracic surgeons largely abandoned surgical treatment for pulmonary tuberculosis because they recognized the efficacy of long-term chemotherapy. It is to be hoped that those urological surgeons who have not already done so will cease doing operations on genitourinary tuberculosis when they are not necessary, and recognize the place of steroid therapy in

the management of ureteric obstruction. As with pulmonary tuberculosis, there are, of course, a few definite indications for surgery in genitourinary tuberculosis, but I agree with Lattimer¹ when he observes that nephrectomy has become an unimportant method of treating renal tuberculosis.—I am, etc.,

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- ¹ Lattimer, J. K., Reilly, R. J., Segawa, A., Wechsler, H., Siegel, J., Girgis, A., and Gleason, D., *Journal of Urology*, 1965, 93, 735.
- ² Crofton, J., *British Medical Journal*, 1960, 2, 679.
- ³ Borthwick, W. M., *British Journal of Urology*, 1970, 42, 642.
- ⁴ Gow, J. G., *British Journal of Urology*, 1970, 42, 647.
- ⁵ Barrie, H. J., Kerr, W. K., and Gale, G. L., *Journal of Urology*, 1967, 98, 584.

Whose Purpura?

SIR,—I am disappointed to read (15 May, p. 352) for the second time this year that the names of Henoch (1874) and Schönlein (1837) have been perpetuated in the title of a leading article. Why not that of our own illustrious William Heberden (senior) who described this same popular purpura and also its association with disorder of the gut and kidney?¹ Furthermore, Robert Willan's coloured lithographs of the skin signs are magnificent.²

It would seem to be correct here to indulge ourselves with a modicum of patriotic pleasure.—I am, etc.,

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- ¹ Heberden, W., *Commentaries on the History and Cure of Diseases*, 3rd edn. London, T. Payne, 1802.
- ² Willan, R., *On Cutaneous Diseases*. London, J. Johnson, 1808.

Personality and Rheumatoid Arthritis

SIR,—The results of Dr. D. J. Ward's investigation into personality and rheumatoid arthritis (8 May, p. 297) are most interesting but they are open to further possible interpretation.

In using tests like the Eysenck Personality Inventory it is easy to forget that they are constructed to draw conclusions about an individual on the basis of his self description on a number of items. Among the questions asked that determine the degree of extraversion are the extent to which an individual enjoys being with other people, goes to parties, etc. and questions that influence the neuroticism score are partly dependent on the extent to which the individual commonly experiences various forms of physical distress. In a normal person these sorts of behaviour and complaint are likely to be very revealing about him as a person, but in a person suffering from a chronic physical disability positive answers to these questions will often predictably be due to the effects of illness. I very much agree with Dr. Ward that this artefact is a likely explanation of the lower "extraversion" score found among the arthritics. However, this same argument at first sight makes it doubly surprising that the "neuroticism" score in Dr. Ward's series is lower than average, a finding made in some other possibly psychosomatic conditions—for example, coronary thrombosis¹ and eczema.² Possible explanations of

a subnormal index of neuroticism may be that these are patients who suppress their awareness of emotional responsiveness or at a more conscious level need to present themselves to the inquirer as paragons of stability.

There is some evidence that would tend to favour the first of these hypotheses. Moos and Solomon in a series of elegant studies on rheumatoid arthritis, summarized by Solomon,³ established, among other things, that there was a significant trend for the arthritic to be unable to express hostile or other socially deprecated feelings. Solomon also reviews the considerable evidence for psychological influence on rheumatoid arthritis and immunological responsiveness.—I am, etc.,

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- ¹ Bendien, J., and Groen, J., *Journal of Psychosomatic Research*, 1963, 7, 11.
- ² Brown, D. G., *Journal of Psychosomatic Research*, 1967, 11, 27.
- ³ Solomon, G., in *Modern Trends in Psychosomatic Medicine*, Ed. O. W. Hill, London, Butterworths, 1970.

Trichomonas and Oxytetracycline

SIR,—I read Dr. Stephen Szanto's account of a 66-year-old patient with vaginitis with interest (22 May, p. 467). He wondered whether antagonism between oxytetracycline and metronidazole might explain the persistence of symptoms and positive bacteriological tests until the former drug was stopped.

An alternative explanation might be that the lady's vaginitis was mainly due to *Candida albicans*, and that this organism was not found, as sometimes happens. In these circumstances her symptoms might also diminish after stopping oxytetracycline, recognized as it is as a cause of candidal infections in the lower genital tract and elsewhere. *Trichomonas vaginalis* does not always cause symptoms, and a second course of metronidazole is quite often needed to eliminate it, especially perhaps if it has been present for a considerable time and has had the opportunity to invade extravaginal structures.—I am, etc.,

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Malaria Prophylaxis and Treatment

SIR,—In the very interesting article by Professor W. Peters (10 April, p. 95), the formulation given for Daraclor in the Table is incorrect.

Each tablet of Daraclor contains 15 mg pyrimethamine and chloroquine sulphate equivalent to 150 mg chloroquine base.—I am, etc.,

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Reticuloendothelial Activity and Cancer

SIR,—The paper by Mr. C. J. Magarey and Mr. M. Baum (15 May, p. 367) on oestrogen as a reticuloendothelial stimulant in the defence against cancer reminded me of some work that I did that is unpublished. Reticulo-

endothelial stimulant clearances were estimated by autologous plasma haemoglobin clearance¹ and were found to be increased in 6 out of 10 patients with acute leukaemia, 5 out of 11 patients with chronic leukaemia, and in 8 out of 13 cases of Hodgkin's disease. Corticosteroid therapy appeared to make no difference, but those who had depressed clearances had recently been treated with radiotherapy or nitrogen mustard.

The results indicate that certain tumours themselves increase the functional state of the reticuloendothelial stimulant. Increased phagocytosis in patients with carcinomata has been described by Salky *et al.*² using reticuloendothelial test lipid emulsion and in Hodgkin's disease by Sheagren *et al.*³—I am, etc.

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¹ Gabrieli, E. R., and Pzykiewicz, T., *Journal of the Reticuloendothelial Society*, 1966, 3, 163.

² Salky, N. K., Di Luzio, N. R., Levin, A. G., and Goldsmith, H. S., *Journal of Laboratory and Clinical Medicine*, 1967, 70, 393.

³ Sheagren, J. N., Block, J. B., and Wolff, S. M., *Clinical Research*, 1966, 14, 360.

Hazard of Self-inflating Resuscitation Bag

SIR,—We would like to report a potentially hazardous defect in unlined self-inflating bags. The danger of insufflation with foam rubber particles from lined bags such as the Ambu is well known (11 October 1969, p. 111), and the Ambu and Ruben valves now incorporate a fine wire filter to prevent this accident. Several unlined bags have become available recently and most, if not all, of these do not incorporate a filter.

During use of the Aga revivator we became aware that flakes of rubber were coming from the inside of the bag (Fig. 1). This bag is manufactured from two hemispherical halves bonded together at the equator by a rubber adhesive solution. On cutting open the bag concerned, it was found that excess rubber bonding solution had been extruded from the joint and had run on to the inner surface (arrows, Fig. 2). During repeated use these strips of adhesive rubber had become detached. Extrusion of adhesive was found in 13 of a further 21 bags inspected.

FIG. 1

The Aga company has replaced the faulty bags and now provides, free of charge, nylon mesh filters to fit into the neck of the bag.

We suggest that all self-inflating bag systems should incorporate a filter between the bag and the patient to prevent possible insufflation of debris into the patient's tracheobronchial tree. Such debris could result from bags that were initially faulty or

FIG. 2.—Bag everted to show interior surface.

which have suffered deterioration during storage.—We are, etc.,

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Oestrogens in Oophorectomized Women

SIR—Dr. S. Gow and Professor I. Mac-Gillivray's article (10 April, p. 73) on metabolic, hormonal, and vascular changes after synthetic oestrogen therapy in oophorectomized women raises several interesting points, not least whether there is a role for such therapy and if so, which hormone. They conclude that the gravity of adverse effects with mestranol far outweighs any beneficial ones. My own investigations into the use of conjugated oestrogens (for example, oestradiol valerate and conjugated equine oestrogens) suggest that these hormones may be used with a far greater margin of safety.

For the past four years I have conducted, through a menopause clinic at the Groote Schuur Hospital, Cape Town, an intensive investigation into the menopause, including the clinical and metabolic effects of oophorectomy and the role of replacement exogenous oestrogen therapy.¹ This study has included several groups and a slightly different spectrum of investigations to those reported by Dr. Gow and Professor Mac-Gillivray. While in agreement in some respects, my own investigations show several significant differences.

Although 50 oophorectomized women received continuous oestradiol valerate therapy for six months none developed any form of thromboembolic disease. One patient developed a superficial thrombophlebitis when the same group was given conjugated equine oestrogen continuously for three months. It would appear that there is a real difference in effect of conjugated and non-conjugated oestrogens on the clotting mechanism, and such relationship is worthy of further investigation.

Oestrogen therapy was confirmed to cause the disappearance of the parabasal cell from the vaginal smear ($p < 0.0005$). There was no statistical change in the superficial and intermediate cell counts. It is therefore sug-

gested that the parabasal cell count, expressed as a percentage of the total cells present on vaginal smear, be used as the cytological (and clinical) index of response to oestrogen administration to postmenopausal or oophorectomized patients.²

The dogmatic assertion that the prevention of osteoporosis and coronary artery disease by adequate hormone replacement therapy is a recognized medical fact cannot go unchallenged. The evidence is somewhat more convincing in relation to osteoporosis³ than coronary artery diseases,⁴ but far more investigation is still necessary. My own studies have shown the difference in effect of various oestrogens on serum cholesterol after oophorectomy,⁵ but even here the complete relationship between oestrogens, cholesterol, and coronary artery disease is still in dispute.

The routine use of oestrogens in all women after the menopause cannot therefore be recommended at this time, not because of the possible adverse effects (which can be prevented), but because of the lack of supportive evidence for the potentially advantageous effects.—I am, etc.,

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¹ Utian, W. H., 1970, Ph.D. thesis, University of Cape Town.

² Utian, W. H. *South African Journal of Obstetrics and Gynaecology*, 1970, 8, 69.

³ Utian, W. H., *South African Medical Journal*, 1971, in press.

⁴ Utian, W. H., *South African Medical Journal*, 1971, 45, 359.

⁵ Utian, W. H., *International Journal of Obstetrics and Gynaecology*, in press.

Prescriptions for the Elderly

SIR,—As we are moving towards a greater concern for community care it would seem appropriate to make some investigation into the hardships of the elderly in obtaining medicines and drugs when at a distance from the chemist, and particularly when transport is not very regular, with special emphasis on holidays and weekends.

I fully appreciate that it is the practitioner's responsibility to supply drugs on an "ad hoc" basis when the situation demands it, but there are many categories of drugs which, though essential, do not fall into this category. It is not uncommon to find an elderly husband or wife having to trail the streets in inclement weather, particularly on Sundays, in order to obtain drugs supplied on prescription. This very often results in the well partner becoming ill, with subsequent great stress, not only on the already ill spouse, but on the available manpower—for example, home help, and district nurse.

Many chemists are extremely helpful in this situation and very often go out of their way to deliver a prescription, but of course, this depends entirely on the goodwill of the chemist concerned, and it would seem appropriate to give attention to this rather neglected side of community care.—I am, etc.,

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Blood Clotting and Contraception

SIR.—Dr. L. Poller and others (27 March, p. 705) make a valuable contribution to our knowledge of the effect of hormonal contraceptives on coagulation and fibrinolysis.