mean level of serum vitamin B_{12} among smokers is significantly less than among non-smokers. They discuss various factors which may have affected the serum B_{12} level, but they do not mention folate deficiency, which is common during pregnancy.

Low serum B_{12} levels have been observed in over 40% of patients with megaloblastic anaemia due to folate deficiency, and the levels rise slowly to within the normal range on treatment with folic acid alone.[1 2] As Dr. McGarry and Miss Andrews have not published the serum folate levels in their group of pregnant women, it is not possible to draw conclusions from the B_{12} levels unless all the women were taking folic acid.—I am, etc.,

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1 Mollin, D. L., Waters, A. H., and Harris, E., in *Vitamin B12 and Intrinsic Factor, Europäisches Symposium, Hamburg*. ed. H. C. Heinrich, p. 737, Stuttgart, Enke, 1961.
2 Forshaw, J., and Harwood, L., *Journal of Clinical Pathology*, 1971, **24**, 244.

Truncal Vagotomy and Pyloroplasty

SIR,—Mr. F. I. Tovey (29 January, p. 311) is quite right in advising surgeons working in developing countries against a reversion to the old policy of gastrectomy for duodenal ulcer. In my own experience with peptic ulcer surgery among rural patients, mostly refugees from erstwhile East Pakistan resettled in this region over the past 13 years, the patients were happier after vagotomy and drainage, as they could resume their bulky diets more easily. Truncal vagotomy did not produce troublesome diarrhoea in any of our patients. The drainage procedure was to a great extent determined by the site and state of the ulcer.

According to Aird,[1] "in the 'twenties of the present century the commonest site of a duodenal ulcer submitted to operation was the anterior wall of the first part"; but he had "not since the war seen an unperforated ulcer of the anterior wall of the duodenum which could have been locally excised." He was "tempted to conclude that anterior wall ulcer of the duodenum is always acute, perforating before it can become chronic." In my series[2] 56 out of 95 duodenal ulcers, all chronic and unperforated, were situated on the anterior wall. This is interesting and perhaps proves that, in the natural history of duodenal ulcer, India is 40-50 years behind Britain.

An anterior ulcer, especially with gross scarring and stenosis as seen in many of our cases, may make pyloroplasty technically difficult.—I am, etc.,

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1 Aird, I., *A Companion in Surgical Studies*, 2nd edn., p. 707. Edinburgh and London, Livingstone, 1957.
2 Mitra, A., *Indian Journal of Surgery*, 1971, **23**, 151.

Value of the M.C.V.

SIR,—Recent correspondence[1 2] in this journal has indicated the relationship between the red cell mean corpuscular volume (M.C.V.) and mean corpuscular haemoglobin concentration (M.C.H.) when the values are obtained from a Coulter Model "S" automatic counter. We have been conducting in Coventry a haematological survey using this apparatus on a random population sample of 81 male and 89 female subjects aged 65 years and over. As the correlation coefficients were homogenous ($P > 0.05$) in the two sexes, we have pooled the data (Table). Statistically we found little to choose between M.C.H. and M.C.V., which confirms our findings in other population studies where r for this correlation lay between +0·89 and +0·98.

		1	2	3	4	5
Haemoglobin (g/100 ml)	1	1·00				
Haematocrit (%) ..	2	0·95	1·00			
M.C.V. (μ^3)	3	0·22	0·19	1·00		
M.C.H. (pg)	4	0·38	0·23	0·91	1·00	
M.C.H.C. (%)	5	0·50	0·20	0·19	0·58	1·00

The poor correlation of the mean corpuscular haemoglobin concentration with either the M.C.V. or M.C.H. is not surprising in view of its curious distribution,[3] which adds another statistical objection to its use.—We are, etc.,

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Coventry and Warwickshire Hospital,
Coventry

1 Rose, M. S., *British Medical Journal*, 1971, **4**, 169.
2 England, J. M., Walford, D. M., and Waters, D. A. W., *British Medical Journal*, 1971, **4**, 232.
3 Elwood, P. C., *British Journal of Social and Preventive Medicine*, 1964, **18**, 81.

Vaccination against Rubella

SIR,—There are a few points which might, perhaps, be added to Dr. Constance A. C. Ross's comprehensive review of this subject (8 January, p. 109).

Although there is some presumptive evidence that rubella vaccine will produce a long period of immunity, perhaps lifelong, it should be emphasized that this is presumptive only and that one cannot say definitely that a girl of 12 years immunized against rubella will retain that immunity until the end of her reproductive life. In addition, natural immunity may be maintained by intermittent exposure of the immune to the natural virus, and if the epidemiology of the disease is altered radically by immunization this may prove to be a factor of some importance.

By far the most important place for the transmission of rubella infection is the primary school, and the majority of pregnant women come into contact with the disease through an infected primary school child, either directly or through an intermediate case. In spite of the theoretical advantage of protecting women in their child-bearing years against rubella by immunizing girls before they reach the reproductive age, it may be more logical to immunize children of both sexes before they attend school or kindergarten. This would produce an immune population in the group who were previously most susceptible and were the main vehicles of spread of the disease.

An advantage of this method of protection is that reactions to the vaccine are generally less in children of 4-5 years than in children of 11-14 years; this is important with regard to acceptability of the vaccine by the public. Should the duration of protection of the vaccine prove to be lasting, then adults would be directly as well as indirectly protected.—I am, etc.,

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Pantie-girdle Syndrome

SIR,—Recently in this department we have been seeing an increasing number of patients with symptoms ranging from tingling to swelling of the feet and legs, with or without ulceration. Sometimes they present with meralgia paraesthetica. All these patients are wearing pantie-girdles, of a new type which I personally have not seen before. Removal of the pantie-girdle very rapidly produces a "cure."

Most people unfortunately seem to buy one of a size smaller than they should, and all of course are overweight. The age range is from 20 to 70 and over. The older patients combine this pantie-girdle with knickers with elasticated bottoms. It needs little imagination to appreciate what happens to the venous return from the leg. When these patients sit up it acts as a very effective venous tourniquet, and when they cross one leg over another—which many of them have to do because of the brevity of their skirts—it acts as a partial arterial tourniquet.

There has been a lot of correspondence recently about deep vein thrombosis. Such people suffer from chronic venous stasis, and if they are admitted for emergency operation they run an increased risk of deep vein thrombosis. We in this department now refer to it as the "pantie-girdle syndrome."—I am, etc.,

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Inexpensive One-way Screen

SIR,—In many hospitals the advantages of a one-way window are outweighed by the cost. Not only the price of the window itself, but also that of sound equipment has to be found. While such sophistication is both desirable and possible in a large teaching hospital this is often not the case in a small hospital for the mentally ill or handicapped. A simple but effective one-way screen can, however, be made for little cost—if there is no need for the interview room to be soundproof.

An aperture of suitable size is made in the party wall between two rooms (or even one room and a large broom cupboard). A window frame can then be fitted; it makes a neat finish but is not essential. The opening is covered by fine mesh black nylon facing material (normally used for interfacing coat collars etc. and available from most drapers at less than 50p per yard). The material may be stuck down or stapled, the latter method being preferable as wire or equipment may