lished for some time. The school eye clinic, therefore, has not been significantly involved in truly preventive medicine.

I did not know of Gardiner's work¹ when I wrote my paper (3 February, p. 278). He has, however, shown that the school eye clinic can be used for the detection of squint and amblyopia in the preschool children. Examination of younger siblings of those already attending hospital clinics for squint has been carried out for some time, but the search has been for a definite squint or a tendency to break down to one.² Gardiner has gone one step further and searched for refractive errors in those cases who have not developed strabismus. He uses the two separate clinics for this, while I have merely joined them together under one organization and with one set of records. I strongly believe that one organization is necessary to deal with the whole range of children's ophthalmic problems, and it should be under the active direction of a consultant. Its precise location is immaterial.

Kramar³ found that detection of certain refractive errors offered the best chance of identifying children at risk for developing a squint. Publication of her findings was delayed until they had been confirmed in a different sample.⁴ We now examine clinically and refract all preschool siblings of children with a squint or amblyopia, or a positive family history or a refractive error which we think is significantly associated with these conditions. Our findings will be reported.

I disagree with Mr. Primrose over the problem of defaulters. I believe it is better to follow-up a defaulting preschool child than one of school age, because it is more likely that we will achieve permanent visual improvement (in cases of amblyopia) in the younger child. We should, however, concentrate on those we think will really benefit rather than follow-up all defaulters. I think the parents should be responsible for myopic school children.

To conclude, I believe that more efficient treatment of squint and amblyopia will come from (1) making an accurate prognosis of the possible results of treatment when we first see the child, and (2) from better screening procedures. I cannot be persuaded that this can be achieved better with two separate services when I know it can be done through one.—I am, etc.,

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Safer Motoring

SIR,—Your leading article (28 April, p. 195) on this subject was most timely, and so was your warning that the present type of British lap-and-diagonal seat belt was satisfactory for the average-sized wearer but less so for the very tall or very small, to which in many instances one would have to add the big or people wearing bulky fur coats. At a time when there is increasing pressure for legislation to make the wearing of seat belts compulsory, we must first ensure that the standard belt can be worn comfortably and safely by all car occupants whatever their shape.

While the search for even better belts must continue apace, there is one simple measure that should be taken by car manufacturers at once to make the existing type more adaptable to the majority of users. The critical factor is the height of the pillar mounting of the diagonal strap. If it is too high (or with a short wearer), the webbing chafes uncomfortably across the neck and cheek, with possible risk of injury in an accident. If too low, it may slip off the shoulder; this too often is the unavoidable position in two-door cars or coupés which lack a centre pillar.

Ideally, the pillar mounting should be level with the lobe of the wearer's ear. To achieve this for the greatest number of users, it would only be necessary to provide a choice of, say, three alternative mounting points in the upper portion of the pillar.

Because they always tension and position themselves correctly on the wearer automatically, as well as for the freedom they give in reaching all the controls and other advantages such as neater stowage, retractable belts should be the only approved type, but care must be taken to provide enough webbing even to extend across a portly woman in furs.—I am, etc.,

KEITH E. JOLLES

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Anomalous Origin of Vermiform Appendix

SIR,—A 37-year-old man was admitted to hospital with a history of epigastric pain in the previous eight hours, associated with vomiting. The pain later settled around the umbilicus and a provisional diagnosis of appendicitis was made.

Diagrammatic representation of anomalous origin of appendix.

At operation there was no sign of the appendix in the ileocaecal region along the line of the anterior taenia coli. No other abnormality was found in any other organ. The caecum and ascending colon were freed and an injected appendix was found lying proximally retrocolic and distally in the paracolic gutter. When followed proximally it was found to arise from the ascending colon; its base was lying near the lateral taenia about 10 cm from the ileocaecal region. The distal end of the appendix was lying near the neck of the gall-bladder. The appendicular artery was arising from the

right colic artery, and small branches from the right colic artery were supplying the distal part of the appendix. Routine appendectomy was performed and the patient's postoperative progress was satisfactory. The pathologist's report was: "Appendix, length 10 cm, contains liquid faeces. Microscopically, no histological abnormality."

Every surgeon is familiar with the various positions of the appendix, including the rare intramural,¹ intramesenteric,² and retrocaecal intramesenteric³ positions. In uncommon circumstances one may find the appendix on the left side⁴⁻⁵ or in the subhepatic region owing to malrotation of the gut. A similar thing can happen in situs inversus.⁶ In the present case the appendix was originating from the ascending colon near the lateral taenia about 8-10 cm away from the ileocaecal junction and was mostly retrocolic. No previous report of a similar case could be found. If one remembers the development of the appendix,⁷ the anomalous origin in this case can be explained by accepting the differential growth of the caecum on the medial side of the appendix instead of the usual lateral side.

I thank Mr. J. C. Morris for allowing me to report this case.

—I am, etc.,

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Nutrition of the Pregnant Woman

SIR,—In your leading article (5 May, p. 255) you state that it is "a question of philosophy rather than of science" as to "whether the mother's natural surge of appetite which results in her storing fat should be taken as the best guide to her dietary intake". This assumption is based on the false premise that excess fat "is usually lost between pregnancies without any conscious effort", and Billewicz and Thomson's paper from Aberdeen¹ is quoted in support. Their figures show in fact that the average or mean weight gain of 531 women after three pregnancies was as much as 4.3 kg (9.5 lb). This, to my mind, is a significant amount of fat, and its significance should not be discounted by adjusting the figure downwards because all Aberdeen women were gaining weight with age during the years concerned (1949-64) and by taking the median figure instead of the mean, as the authors do.

Africans living a natural life and eating unprocessed food do not gain weight with age during adult life,² and this is now being accepted as the ideal towards which we all should aim. Obesity is a major health problem in the western world, mainly because we eat sweet foods and refined cereals for pleasure rather than to satisfy hunger, and the best time to alter bad eating habits is during pregnancy, when women are especially health-conscious. In a consecutive series of 100 of my own antenatal patients