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.,

R. M. INGRAM

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- ¹ Gardiner, P. A., *Community Medicine*, 1972, 127, 117.
- ² Pratt-Johnson, J. A., and Lunn, C. T., *Canadian Journal of Ophthalmology*, 1967, 2, 50.
- ³ Kramar, P. O., *British Orthoptic Journal*, 1973, in press.
- ⁴ Ingram, R. M., *British Orthoptic Journal*, 1973, in press.

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.,

S. GAYEN

Dartford District Hospital,
Dartford, Kent

- ¹ McGladdery, W. F., *Central African Journal of Medicine*, 1972, 18, 54.
- ² DiGiuglio, V. S., *Illinois Medical Journal*, 1969, 136, 252.
- ³ Shapiro, N. M., Michels, L. M., and Hurwitz, S., *California Medical Journal*, 1963, 98, 158.
- ⁴ Owen-Smith, M. S., *British Journal of Surgery*, 1969, 56, 233.
- ⁵ Beneventano, T. C., Schein, C. J., and Jacobson, H. G., *American Journal of Roentgenology*, 1966, 96, 344.
- ⁶ Wyndham, N., *Medical Journal of Australia*, 1970, 2, 726.
- ⁷ Solanke, T. F., *British Journal of Surgery*, 1970, 57, 100.

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

no fewer than 60 started to lay down fat early in pregnancy and all save two of them were prevented from laying down more unnecessary fat without any calorie control whatever, merely by cutting out sugar and sweet items of food and reducing the intake of products made from white flour.³ The average weight gain of the series, excluding toxæmic patients, was 10.0 kg (21.9 lb) as against the average uncontrolled weight gain in recent British series of 12.5 kg (27.5 lb), which Hytten and Leitch,⁴ from the Aberdeen team, estimate to include 3.5 kg (7.7 lb) of fat. Moreover 30 of my patients who were followed through a second pregnancy⁵ put on no weight between pregnancies on average, and women who have been under my antenatal care have no overweight children in their families, so that their children have also learnt to eat wisely.

Women, as a rule, do not like putting on weight. What weight is lost between pregnancies is not usually achieved "without conscious effort" in my opinion, and most women would prefer to prevent excess weight gain during pregnancy to having to cope with dieting while looking after a tiny baby. The teaching of healthy eating habits during pregnancy seems to me to be the most important positive action which doctors can take to prevent obesity and other diseases produced by our excessive intake of sugar and other refined foods.—I am, etc.,

DENIS CRADDOCK

South Croydon

- 1 Billewicz, W. Z., and Thomson, A. M., *British Journal of Preventive and Social Medicine*, 1970, 24, 97.
- 2 Slome, C., Gampel, B., Abramson, J. M., and Scotch, N., *South African Medical Journal*, 1960, 34, 505.
- 3 Craddock, D., *Obesity and its Management*, 2nd edn. Edinburgh, Churchill Livingstone, 1973.
- 4 Hytten, F. E., and Leitch, I., *The Physiology of Human Pregnancy*, 2nd edn. Oxford, Blackwell, 1971.
- 5 Craddock, D., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, 77, 728.

Plasma Digoxin Concentration in Children with Heart Failure

SIR,—We thank Professor V. Dubowitz (14 April, p. 118) for his interest in our paper (24 February, p. 443) and would like to answer the important points he raises.

Our purpose was to present the plasma digoxin concentrations measured during satisfactory maintenance therapy of infants and children with cardiac failure. We agree that plasma levels achieved during initial digitalization should be measured in order to determine the optimum digitalizing dose. This would require several samples of blood, and when we conducted our study 1.5 ml of plasma was necessary for each radioimmunoassay. We have now evolved a microassay requiring only 0.1–0.3 ml of plasma and are using this to determine the necessary digitalization dose in infants and children.

All our reported patients had moderate to severe cardiac failure with the clinical signs of tachycardia, tachypnoea, and hepatomegaly; some had pulmonary and peripheral oedema. An improvement in all these signs was indicative of a satisfactory clinical response.

Even in the presence of severe heart failure the oral maintenance dose was absorbed sufficiently to give plasma levels com-

parable to therapeutic adult levels. If oral or intragastric administration is not tolerated, it is our practice to give half the oral dose by the intramuscular route, but to date we have no measurement of the resulting plasma levels. The development of a microassay of digoxin will facilitate further studies of the infant's handling of this drug.—We are, etc.,

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D. JOHN COLTART

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Neonatal Renal Tumours

SIR,—At the end of your leading article entitled "Early Diagnosis of Nephroblastoma" (10 March, p. 567) you identify the small group of neonatal tumours for which you say that fibrosarcoma is an acceptable term. However, this is totally misleading in this context, as hinted at by Mr. R. B. Zachary and Dr. F. Harris (24 April, p. 179). Not only is there considerable doubt as to whether these tumours are totally of fibroblastic origin,^{1,3} though this may be a component, but, as you point out, there is no recorded instance of any child developing metastases from these tumours. There is therefore no evidence to justify the term sarcoma being applied to them. Also, in most cases they show none of the histological criteria of malignancy, though the occasional case does arise, such as that described by Fraser,⁴ in which the distinction from an undifferentiated Wilms's tumour may be difficult, though even this had not metastasized when described.

While there is some doubt as to the true nature of these mesenchymal tumours, as exemplified by such terms as congenital mesoblastic or mesonephric nephroma,^{1,3} they certainly also conform to the criteria of hamartoma as suggested by Willis.⁵ The title fetal hamartoma of the kidney, as used by Wigger,² bears the virtues of simplicity and probable accuracy. Nevertheless, fibrosarcomas they are not, and this term should surely not be used to describe these tumours.—I am, etc.,

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- 1 Favara, B. E., Johnson, W., and Ito, J., *Cancer*, 1968, 22, 845.
- 2 Wigman, H. J., *American Journal of Clinical Pathology*, 1969, 51, 323.
- 3 Bolande, R. P., Brough, A. J., and Izant, R. J., *Pediatrics*, 1967, 40, 272.
- 4 Fraser, G. C., *British Journal of Urology*, 1967, 39, 509.
- 5 Willis, R. A., *The Borderline of Embryology and Pathology*, 2nd edn. London, Butterworth, 1962.

Is Your Pain Really Necessary?

SIR,—In your leading article (12 May, p. 323) you refer to the common assumption that primary dysmenorrhoea is "necessarily psychogenic" as invalid since "suppression of ovulation nearly always relieves it." I have evidence that to label such pain as psychogenic may well be a misdiagnosis.

In the treatment of infertility, in large numbers of apparently healthy women no apparent cause can be found, but quite often there is a significant history of dysmenorrhoea, sometimes of abrupt onset in late adolescence. In some of these women a hysterosalpingogram has shown significant

impairment of tubal function, and some years ago I began to ask my gynaecological colleagues to laparoscope these women. Endometriosis has been found, sometimes perhaps as small a plaque as 3–4 mm diameter, but in a situation where it could cause interference with tubal transport but not be visible by salpingography. Very recently I have begun to refer patients with apparently normal x-rays and sometimes without dysmenorrhoea, and again significant endometriosis has been found by laparoscopy. These women have come from different towns and have been treated by different gynaecologists, and one cannot therefore say that they are a selection of Manchester women only.

The use of early laparoscopy has thus rescued many women not only from the diagnosis of psychogenic pain and completely cured their pain, at the same time curing their infertility, but also possibly prevented a hysterectomy later. It would seem that we are not perhaps justified in withholding laparoscopy from young women complaining of severe dysmenorrhoea.—I am, etc.,

BERNARD SANDLER

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Treatment of Dextropropoxyphene Poisoning

SIR,—We were interested to read Dr. Vanessa Hunt's report of a case of dextropropoxyphene poisoning successfully treated by nalorphine (3 March, p. 554). We too have had success with nalorphine in this type of poisoning. More recently, however, we have successfully treated a patient with severe dextropropoxyphene poisoning (taken as Distalgic) with the new narcotic antagonist naloxone (Narcan).

A 32-year-old woman was admitted to the Regional Poisoning Treatment Centre in grade 3 coma,¹ having been found unconscious in the street. Clinical examination revealed markedly constricted pupils a respiratory rate of 2/min, and hypotension. Within one minute of receiving 0.8 mg of naloxone intravenously her pupils dilated, the respiratory rate rose to 20/min, and she regained consciousness. She subsequently required one further intramuscular dose a few hours later. As with nalorphine the effect of naloxone may be shortlasting and in the individual patients further dosage has to be tailored to sustain a satisfactory respiratory rate.

The clinical uses and effects of naloxone have recently been reported by Evans *et al.*,² whose series, however, did not include dextropropoxyphene poisoning. We can now report that overdosage with this drug can be effectively treated with naloxone and we know of no such previously reported case. In addition, we have found that intravenous naloxone will rapidly terminate apomorphine-induced emesis without any untoward effects. Naloxone was supplied to us by Endo Laboratories, Inc., U.S.A., but at present is not commercially available in Britain.—We are, etc.,

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JOHN A. H. FORREST

Royal Infirmary,
Edinburgh

- 1 Matthew, H., and Lawson, A. A. H., *Treatment of Common Acute Poisonings*, 2nd edn. London and Edinburgh, Churchill Livingstone, 1970.
- 2 Evans, L. E. J., Roscoe, P., Swainson, C. F., and Prescott, L. F., *Lancet*, 1973, 1, 452.