of aspirin described by Hanzlik and his colleagues in a series of papers published in 1917.³

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¹ Seaman, W E, and Plotz, P H, *Arthritis and Rheumatism*, 1976, **19**, 155.

² Huskisson, E C, et al, *British Medical Journal*, 1974, **1**, 176.

³ Hanzlik, P J, Scott, R W, and Thoburn, T W, *Archives of Internal Medicine*, 1917, **19**, 1029.

Superficial carcinoma of the stomach

SIR,—We have read with interest the article by Dr G Machado and others (10 July, p 77). Since the introduction of fiberoptic endoscopy at St Luke's Hospital, Malta, in October 1975 we have diagnosed two cases of superficial gastric carcinoma in a total of 120 patients subjected to gastroscopy. In both cases the endoscopic appearances were not impressive and in one case there was a long history of dyspepsia with negative barium studies. This has stimulated us to perform biopsy on any lesion or irregularity of gastric mucosa, no matter how insignificant the appearance, with a view to the early detection of gastric carcinoma.

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Aplastic anaemia and hair dye

SIR,—One must take exception to Dr A J Jouhar's contention (1 May, p 1074) that the fatal case of aplastic anaemia described by Drs P J Toghil and R G Wilcox (28 February, p 502) "was probably if not definitely due to either oxytetracycline or penicillin and that it is doubtful that the hair dye in question was causal."

There appear to be no published case reports of aplastic anaemia unequivocally associated with penicillin, and the report cited by Dr Jouhar for oxytetracycline appears to be unique. Agreed, isolated cases have been privately communicated to drug safety committees, but the significance of these is often compromised by inadequate reporting and follow-up. Even so, the Panel on Hematology, Registry on Adverse Reactions of the Council on Drugs of the American Medical Association, between 1 July 1963 and 31 December 1966 tabulated only two cases with penicillin alone and one case each with penicillin and oxytetracycline combined with other presumably innocuous drugs.

On the other hand there are four apparently valid published cases and two Registry cases associated with hair dyes. In addition to the case reported by Drs Toghil and Wilcox and the one reported more recently by Drs S Hamilton and J G Sheridan (3 April, p 834) there are two earlier cases published by Baldridge¹ and Thompson.² In the first of these one of the hair dyes was specifically identified as *para*-phenylenediamine. In all

four there was a definite temporal relationship between exposure and clinical symptoms. An additional two unpublished cases involving hair dyes, rinses, and tints were reported to the Panel on Hematology, Registry on Adverse Reactions of the Council on Drugs of the American Medical Association, between 1 July 1963 and 30 June 1964.

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¹ Baldridge, C W, *American Journal of the Medical Sciences*, 1935, **189**, 759.

² Thompson, S J, *Nursing Times*, 1965, **61**, 12.

Compulsory seat belts

SIR,—Dr W A Fraser-Moodie (17 July, p 178) expresses the hope that the public would respond to legislation to make them wear seat belts, but his own figures show that only half of those who have suffered injury from not wearing a belt are now regular wearers. So what hope has legislation? His cases, like those I see, were mostly cuts from windscreen glass, which presumably would not have happened if the windscreen had been laminated. The fitting of such windscreens can be effectively enforced by law, at least on all new cars, yet Britain still churns out cars with unlaminated ones. Even when specifically requested I was not given what I wished and I know of others who have had similar difficulties.

In Australia (Dr John Knight, 5 June, p 1391) it seems that injuries, although reduced by seat belts, still happen and laws restricting personal freedom are difficult to enforce. Without a breakdown of the figures to show whether more injuries are from lack of seat belts or lack of laminated windscreens and also what are attributable to the wearing of belts or to having laminated windscreens statistics are of little value. But a law that cannot be enforced and that the police do not like is a bad law and will continue to be flouted. One recent patient with a perforating eye injury with traumatic cataract from broken windscreen glass, when asked about seat belts, was quite adamant that she would continue to be a non-wearer.

I think one can expect the young especially to continue to drink, to drive, and to value their freedom rather than their safety in spite of any legislation.

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Tuberculosis of the colon

SIR,—Over the past few years there appears to have been an increase in the incidence of tuberculosis affecting the large bowel. This increase is not wholly confined to immigrant populations and consequently the diagnosis may not be initially considered. We have recently seen two patients, one thought to have a carcinoma and the other Crohn's disease, who illustrate different presentations of the disease.

Case 1—A 56-year-old Englishwoman who had never been abroad presented with a microcytic hypochromic anaemia. During investigation a barium enema examination revealed a stricture in the ascending colon suggestive of a carcinoma. At

laparotomy a narrowed ring lesion was found in the distal right colon with nodes in the meso-colon. A right hemicolectomy was performed and she made an uneventful recovery. Histological examination showed a constricting lesion consisting of caseating giant-cell granulomas with mucosal ulceration. Acid-fast bacilli were present. There was no other evidence of tuberculosis either in the chest or urinary tract. She has been started on a course of antituberculosis treatment (isoniazid, rifampicin, and streptomycin) and is progressing well.

Case 2—A 43-year-old male Pakistani who had been resident in Britain for 18 years presented with typical small-bowel obstruction. At laparotomy a large hard mass was found in the caecum and an initial diagnosis of Crohn's disease was made. A right hemicolectomy was performed and he made an uneventful recovery. Histological examination showed mucosal ulceration and fissure formation in the caecum with caseous granulomas within the large bowel and lymph nodes. Acid- and alkali-fast bacilli were identified in the granulomas. There was no evidence of active tuberculosis elsewhere and he has been started on antituberculosis therapy.

In both these cases it is most probable that the lesions occurred as a result of post-primary activation of previously acquired foci. Frequently one finds no evidence of tuberculosis elsewhere, either active or old,¹ and this should not distract one from the diagnosis.

We feel bound to comment also on the very real increase in the incidence of Crohn's disease affecting the large bowel which has also occurred in recent years.

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¹ Kaufman, H D, and Donovan, I, *Journal of the Royal College of Surgeons of Edinburgh*, 1974, **19**, 377.

Sacroccygeal teratoma and "non-immunological" hydrops fetalis

SIR,—Hydrops fetalis due to rhesus blood group incompatibility is becoming progressively less common and fetal hydrops from other causes (sometimes referred to as "non-immunological" or "idiopathic") attracts increasing interest. A number of conditions associated with the latter have been reported with varying frequency; these include instances of anaemia due to haemoglobinopathy (Hb Barts),¹ anaemia due to transplacental leakage (feto-fetal or feto-maternal^{2 3}), congenital leukaemia,⁴ fetal heart disease (for example, endocardial fibroelastosis,⁵ premature closure of the ductus arteriosus,⁶ premature closure of the foramen ovale⁷), cystic malformation of the lungs,⁵ intrauterine infections,⁵ chromosomal aberrations,⁵ and, last but not least, haemangiomas of the placenta.⁸ This is by no means a complete list. Mechanisms by which one or the other of these associations can cause hydrops have been suggested, but clarification of many problems is still being awaited.

Recently I had the opportunity of observing a stillborn fetus which was undoubtedly hydropic, even though macerative changes were superimposed. The placenta too was hydropic and this was confirmed by histological examination. The common type of blood group incompatibility was excluded by routine antenatal tests. Post-mortem examination did not suggest other forms of blood disorder; in particular, the liver and spleen were of appropriate size. A large sacroccygeal teratoma measuring approximately 20 cm

in its longest diameter was the only lesion detected. No evidence was found by which the latter could be aetiologicaly linked to the hydrops. In particular, there were no "vulnerable" blood vessels of the placenta that might have been obstructed by the tumour, nor was this excessively vascular, so that an arteriovenous shunt effect was unlikely. Explanations such as protein sequestration by the tumour or unduly rapid increase in the vascular bed are within the realms of speculation.

This association has not been reported before so far as I am aware (although Macafee *et al*⁵ mention a case of mediastinal teratoma associated with hydrops) and I should be grateful to hear from any of your readers who know of a similar observation.

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¹ Lie-Injo, L E, *et al*, *British Journal of Haematology*, 1962, 8, 1.

² Halle, H, *Zentralblatt für Gynäkologie*, 1972, 94, 1487.

³ Turbeville, D F, *et al*, *Obstetrics and Gynecology*, 1974, 43, 567.

⁴ Kohler, H G, Unpublished observation.

⁵ Macafee, C A J, *et al*, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, 77, 226.

⁶ Alexandrowsky, A, Inaugural Dissertation, University of Berne, 1916.

⁷ Tait, L, *Transactions of the Obstetric Society of London*, 1875, 17, 307.

⁸ Jones, C E M, *et al*, *Pediatrics*, 1972, 50, 901.

Death from asthma

SIR,—I am guilty—according to Dr E Posner (17 July, p 179)—of a most heinous crime: that of not referring every asthma patient to a "specialist." While I fully agree that patients with severe recurrent symptoms require specialist supervision, I am rather annoyed by the implication that we general practitioners are incapable of dealing with mild to moderate asthma.

Do we really need to send this latter group to a consultant chest physician for diagnosis and follow-up for "at least five years"? Perhaps Dr Posner should be reminded that we have access to simple but useful investigations such as differential white cell counts, chest x-rays, peak flow meters, and Vitalographs—and some of us even use them. If it is not justified to send them to a chest physician, then should they perhaps see a general physician? Consultant physicians probably see no more cases of mild to moderate asthma than do most GPs. Certainly this is true of the junior hospital doctors—in many cases housemen and senior house officers—who see the majority of the "follow-ups."

Perhaps Dr Posner did not really mean every patient, but none the less he might add to his list of quotations as follows: "Not all asthma that is treated in general practice alone is done so negligently" (Woodward, 1976).

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"Comprehensive Psychiatric Care"

SIR,—Your reviewer of *Comprehensive Psychiatric Care*, my old colleague and opponent Dr H R Rollin (24 July, p 242), has been a distinguished contributor for many years. His review will appeal to those who still regret the passing of the medical superintendent and the

style of life in mental hospitals which that system represented. Criticising the present concept of multidisciplinary team work Dr Rollin says, "in the bad old days pretty much the same relationship existed between those parties who worked together towards a common end." In the "old days" the medical superintendent controlled the nurses, administrators, social workers, and doctors. Perhaps Dr Rollin has not noticed that the first three are now independent professions and that doctors prefer a more democratic system. Whether doctors like it or not, decisions on patterns of care for patients can be reached only by agreement with the other professions and not because the doctor has authority over them. His criticisms are of importance because they stem from a failure to come to terms with the new relationships between the professions. This failure is not uncommon and explains many of the current complaints by doctors about nurses, social workers, and administrators and complaints of the latter about doctors.

His comments on leadership do not correspond with the opinions expressed in the book—for example, page 211 commences with, "The consultant has a major leadership role in many situations." He also criticises the nurse's and the administrators' chapters, but it will be of interest to see whether nurses and administrators make the same judgment.

May I suggest that readers compare Dr Rollin's review with that in the *Lancet*¹? Better still, they might read the book for themselves to see whether or not it represents the realities of psychiatry in 1976.

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¹ *Lancet*, 1976, 2, 129.

New look at monoamine oxidase inhibitors

SIR,—Your leading article on this subject (10 July, p 69) practically repeats what we reported over 10 years ago in *Physical Methods of Treatment in Psychiatry*¹ on the value of the monoamine oxidase inhibitors (MAOIs). This knowledge was obtained from the bedside; double-blind testing is useful only for leading astray chairborn professors who are not active bedside observers. What caused so much trouble was that a later Medical Research Council double-blind trial of phenelzine on "Bedlam melancholics," for whom the MAOIs alone are useless, was reported² and this specialised finding got applied to the rest of the anxiety states and lesser depressions.

And now Dr C L Brewer's figures (10 July, p 110) on the increasing number of tricyclic antidepressant suicides and deaths also repeat our similar bedside observations. If a patient feels much worse when given tricyclics during the day don't go on giving them till he tries to kill himself; for this worsening with tricyclics is often an important indication for the substitution of an MAOI, just as it is when a patient with depression still sleeps deeply.

Finally, the results of the trials on combined antidepressants which, you state, are now in progress will depend on the clinical types of depression chosen for them. The combination of MAOIs with other drugs will not work if the patient sleeps deeply but only if he has the type of depression characterised by early morning waking. And the doses of both drugs

must be individually adjusted to the patient's depth of symptoms. How can you double-blind test all this?

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¹ Sargent, W, and Slater, E, *An Introduction to Physical Methods of Treatment in Psychiatry*, 4th edn. London and Edinburgh, Livingstone, 1963.

² MRC Clinical Psychiatry Committee, *British Medical Journal*, 1965, 1, 881.

Detection of scanty blood parasites

SIR,—Mr M Conradie and Professor P Jacobs (17 July, p 181) point out that buffy coat smears are superior to thin films, thick films, and cytocentrifuge techniques for the identification of protozoa in the blood, particularly in the diagnosis of malaria. They ask for comment.

I would like to support their observation and add a few points. Firstly, it is my impression that in buffy coat preparations gametocytes are even better concentrated than trophozoites, and among the latter *Plasmodium vivax* appears also to be preferentially concentrated as compared with *P. malariae* or *P. falciparum*; this must be due to differences in density, and it is known that red cells containing *P. vivax* are swollen. Secondly, as mentioned by your correspondents, the morphology of the parasites themselves and of the surviving erythrocytes containing them is much clearer in buffy coat films than in thick films, which lyse the latter. Thirdly, malarial pigment in phagocytes (monocytes and neutrophils) is more readily identified in such preparations and, especially in partly treated cases, this may be an aid to diagnosis. Finally, giant nuclear masses, which may well be of endothelial origin and indicative of microvascular damage, can best be seen in buffy coat preparations and, given several buffy coat smears from blood samples of the order of 1 ml, can possibly be used to assess the presence of such damage in subtertian, malignant malaria.¹

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¹ Goodall, H B, *Lancet*, 1973, 2, 1124.

Management of acute myocardial infarction

SIR,—Professor J F Pantridge and Dr J S Geddes (17 July, p 168) draw attention to the installation of life support systems in American factories and office blocks, and quote the recent report of the Royal College of Physicians and the British Cardiac Society¹ which advises that lay or medical personnel working in factories should be trained in cardiac resuscitation techniques. Information on the extent of the problem would be useful to those who may be considering the matter. In a recent study of myocardial infarction in an Oxford car assembly plant² we were able to obtain some data on the number of heart attacks occurring at work.

In the seven years 1966-72, with a mean of 8300 male employees, there were six fatal heart attacks at work. The factory operated day and night shifts with cover from a medical centre that was not equipped with facilities for cardiac resuscitation, but another 23 attacks