Incidentally the cerebrospinal fluid in these fatal series was either clear or slightly hazy, death ensuing before the development of a frankly purulent meningitis; thus meningismus was not a clinical feature.

I noted that the condition was not included in your excellent medical emergencies series, but, despite its rarity, it deserves a place in any future series.

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Hong Kong dog and the Tokyo trots

SIR,—In the *BMJ* (4 August, p 316) there is a query asking if the writer may take a small dose of sulphaguanidine when visiting Hong Kong. No doubt he has the Hong Kong dog in mind and I note that your correspondent thinks that he should not take the drug.

This puzzles me, as in my travels around the world I have become familiar with the Hong Kong dog, the gippy tummy, the Trinidad dog, the Tokyo trot, and several other strange animals that can ruin a week of one's holiday, and I have never failed to cure it in 12 hours or less with three or four four-hourly doses of Guanimycin (sulphaguanidine, dihydrostreptomycin sulphate, and kaolin) or Streptotriad (sulphadiazine, sulphadimidine, sulphathiazole, and streptomycin sulphate). Not only in civilised areas but also on archaeological digs at some of the wildest camp sites in Egypt, Sudan, and the Middle East, it works equally well in people who, otherwise healthy, have been stricken with the dog, which can come like a bolt from the blue and lay a man low in a very short time. The victims of the dog have always regarded it, as I have done, as a gift from the gods, so I wonder greatly why you do not recommend such marvellous, wonderful, and almost instant health-giving remedies as Guanimycin and Streptotriad for this vicious animal.

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Primary anaerobic peritonitis

SIR,—In his article on anaerobic peritonitis (13 October, p 903) Mr Philip Matthews comments that his reported case appears to be the first such case of primary origin recorded in the literature. We should like to report a recent fatal case from the Western Infirmary, Glasgow, which shows some notable similarities.

A 16-year-old girl with no previous medical problems and no recent illness developed epigastric pain, vomiting, and diarrhoea. The illness was associated with a fever and was initially thought to be of viral origin. However, the symptoms progressed and by the third day she was severely ill and showed signs of peritonitis. She was transferred from an island off the west coast of Scotland to the Western Infirmary, Glasgow, where she was found to be gravely ill, being semi-comatose with a blood pressure of 80/100 mm Hg, pulse 160 beats /min, and a temperature of 39·5°C. Her abdomen was slightly distended, resonant, and silent, with widespread peritonism, notably in the right iliac fossa. Some mottling of the lower legs was noted. *X*-rays showed free gas under the right diaphragm. Full blood count showed a profound neutropenia with a total white cell count of $2{\cdot}5 \times 10^9$/l in spite of severe dehydration. The complement of white cells was composed mostly of premyelocytes.

Despite intensive resuscitative measures to improve her general condition prior to any surgery, including rapid fluid replacement and the administration of gentamicin and metronidazole, her blood pressure remained low and unstable. Four hours after her admission and despite her grave condition it was decided to operate as a definitive step to remove the source of the presumed septicaemia. At laparotomy, the presence of free air was confirmed and a large quantity of straw-coloured intraperitoneal fluid was present. The lower ileum, caecum, and ascending colon were grossly odematous and discoloured, although not frankly gangrenous. All retroperitoneal tissues in the right flank were swollen and crepitant. The liver was enlarged and also contained gas. There was a general peritonitis, although the appendix and pelvic organs were otherwise quite normal. Unfortunately, but not unexpectedly, the patient had a cardiac arrest during surgery and could not be revived.

At the necropsy the next day the body showed advanced decomposition. The operative findings were confirmed and showed the absence of any pathology either within the abdomen or in other tissues to account for the origin of the infection. In particular there was no evidence of disease of pelvic organs. The bacteriologist reported a heavy pure growth of *Clostridium oedematiens* from the intraperitoneal fluid.

The above case is similar in several respects to Mr Matthews's reported case. Notably, both patients were 16 years old and were otherwise healthy with no precipitating factors. The organisms in the two cases differed. The clostridium found in the present case probably accounts for the irreversible shock, profound neutropenia, and ultimate death. The severity of this terminal infection was out of keeping with the three-day history and may indicate that the original infection was more mixed—in Mr Matthews's case infection with a fusobacterium was accompanied by a leucocytosis of $27{\cdot}6 \times 10^9$/l despite a history of only 24 hours.

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Treatment of hyperhidrosis

SIR,—We read with interest the paper by Dr I A MacFarlane and others (13 October, p 901) confirming previous reports of the effectiveness of aluminium chloride hexahydrate in absolute alcohol for the treatment of hyperhidrosis.

We have treated three patients with this condition for up to 18 months with 20% aluminium chloride hexahydrate in industrial methylated spirit with excellent results. The cost of absolute alcohol is currently £4·47 per 100 ml including excise duty. The cost of industrial methylated spirit is 7·5p per 100 ml.

If, as seems likely, this preparation is to become the first-line therapy for hyperhidrosis, we think that it should be prescribed in industrial methylated spirit, as we can think of no justification for using the vastly more expensive absolute alcohol.

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Penis captivus

SIR,—The fascinating review by Dr F Kräuph Taylor (20 October, p 977) on the emotive subject of penis captivus deserves to be followed by a spate of anecdotal correspondence. Perhaps I might make a small contribution.

While serving with the RAMC in the Gold Coast in 1941 I became aware of an African publication known as the *Ashanti Pioneer*. I cannot recall whether it was published daily or weekly but its content had a Rabelaisian flavour that endeared it to some of the European expatriots. I was shown a paragraph cut from the paper and carefully preserved by its delighted owner. It described a case of penis captivus with a wealth of detail, including the name of the remote village where the affair took place and the difficulty in hoisting the embarrassed couple on to a lorry for 30 miles of bumpy transport to the nearest government medical officer. His use of chloroform for the woman resolved the situation.

It is, of course, possible that the episode was a journalistic fabrication but the naming of the village and of the doctor concerned made me feel at the time that the event had indeed taken place. It is probable that others of your readers who have worked overseas will be able to add other cases to the few records collected by Dr Taylor.

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Medicine in the USSR

SIR,—As a doctor who qualified in the USSR, I feel obliged to challenge one of Dr Michael Ryan's conclusions (20 October, p 979). On the basis of one case of poor prescribing and another case of a hernia being missed he arrives at the alarming conclusion that "By British standards, these [Soviet medical education and practice] appear to leave a lot to be desired. . . ." Surely, as one who claims knowledge of the scientific method, Dr Ryan should know better. These cases do reflect badly on Soviet medicine but are insufficient evidence to justify the conclusion reached. Isolated cases of laziness, lack of attention to detail, or even frank incompetence on the part of doctors can be found everywhere, including Britain. I have recently been associated with a case of missed femoral hernia and yet I have not concluded that British doctors cannot diagnose hernias.

Statistics were introduced into medicine to curtail prejudice and encourage logical conclusions. If Dr Ryan seriously thinks that Soviet medical education and practice are inferior, he must come up with scientific evidence to prove it. I found his article very prejudiced.

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Lack of flexibility in vocational training?

SIR,—I write to say how profoundly I agree with Dr D P Brown's letter (27 October, p 1078). The best general practitioners are born, not made. By a combination of instinct and insight they know already much of what many vocational training courses seek to spell out so laboriously today. One encountered the same instinctive ability in good grammar school masters between the wars, who did not need three years' instruction at a teachers' training college to become good teachers.