the word "period" was not used, menses was clearly understood (and was an everyday word), although women were usually rather coy of mentioning having missed them and that they might be pregnant. It was often rewarding because of this to question any woman in her reproductive years about her menses if she came along with some other rather trivial complaint.

Hypertension was common to an extent that I often found myself considering whether the English idea of normality ought to apply. Strokes were common, a stroke being referred to as a "passover," but interestingly enough hypertensive left ventricular failure was infrequent, possibly because their coronary arteries are better able to deal with the muscular hypertrophy. It might be of interest to note here, for those interested in the aetiology of coronary artery disease, that although the sugar content of the diet was high (a sugar-producing country) there seemed to be very few cases of coronary artery disease in the practice. A common complaint was of "a beatin' in the head" and this was invariably associated with concern regarding their blood pressure, and it was always expected of the doctor to check their blood pressure if they came with this complaint. Often it was normal and they could go away happily reassured.

With further reference to the anatomy I found it helped a great deal when I learnt from my seniors that a complaint regarding the foot could apply to any part between the toes and the buttock, and a complaint regarding the hand to any part between the fingers and the shoulder; up till then I had found it a little confusing when the patient placed his hand on his hip and referred to a pain in the foot.

I must make it clear that the coloured section of the practice was principally drawn from agricultural workers on the sugar plantations together with a smattering from other occupations (hotels, etc.) and the observations I have made deal solely with my experience in this practice. The work was practical, interesting, and variable and if private general practice could be associated with a free national pharmaceutical service as well as a free hospital service it would seem to me the ideal way to practise medicine. Poverty was no barrier to proper medical care, abuse particularly with regard to visits was minimal, and the frivolous use of one's time was at a premium which the patient both expected and accepted.—I am, etc.,

Stowmarket, Suffolk. NORMAN V. EDWARDS.

"Izeised" English

SIR,—We feel that the editors of journals have a duty to protect the English language. You have just published an article entitled "Lymphocyte Transformation in Thymectomized and Nonthymectomized Patients with Myasthenia Gravis" (10 June, p. 679). Would not "The Influence of Thymectomy on Lymphocyte Transformation in Myasthenia Gravis" have been a better title?—We are, etc.,

J. R. BELCHER,
L. H. CAPEL,
Editors,
British Journal of Diseases of the Chest.
London E.2.

Pericarditis in the Tropics

SIR,—Dr. K. Somers's article "Pericarditis" (13 May, p. 423) makes many statements with which I agree entirely, but the following exception prompts me to write, lest a useful drug be discarded by some of your readers. Saying that "emetine usually has no effect on hepatic amoebiasis" is as far from the truth as making the same statement about penicillin G and beta-haemolytic streptococci. On occasion one may find chloroquine to be more effective in a specific case than emetine, but just as often the opposite may be found. The advantages of an oral versus an intramuscular medication should not be overemphasized when the patient is ill enough to be in hospital. The toxicity of both drugs makes it valuable to be able to choose between the two and not be forced to use only one.

Emetine has been effective for the treatment of hepatic amoebiasis since first reported by Rogers,[1] and it continues to be a most useful and life-saving drug. Our experience[2] would make us think that the batch of the alkaloid used by Dr. Somers must have come from an unreliable source before we would consider that the Ugandese variety of *Entamoeba histolytica* is emetine-resistant.—I am, etc.,

RODOLFO HERRERA LLERANDI.
University of San Carlos Medical School, Guatemala, C.A.

REFERENCES
1 Rogers, L., *Brit. med. J.*, 1912, 1, 1424.
2 Herrera-Llerandi, R., *J. Thorac. cardiovasc. Surg.*, 1966, 52, 361.

Infant-scalp Vein Needles

SIR,—Dr. C. F. P. Wharton's description about the use of infant-scalp vein needles (10 June, p. 702) has been quite interesting. I describe here a further use that these can be put to in adults, best illustrated by a brief case history:

A 29-year-old man with acute fulminating ulcerative colitis had to have four operations in a period of three months. Repeated blood transfusions, continuous intravenous feeding, checks on haemoglobin, blood urea, electrolytes, etc., together with an extreme degree of wasting, had led to the blockage of almost all his superficial venous channels by thrombosis. These felt like thick cords under his skin. Nearing the end of his last operation for removal of the terminal colon and rectum his intravenous infusion stopped and intravenous cannulation became impossible. As the patient was slightly shocked, immediate cut-downs were made, first on both his cephalics, and then his saphenous, only to reveal thick cords without any lumen.

In desperation a scalp vein needle was inserted into a small peripheral vein on the right wrist. To our surprise, in spite of all his superficial veins being blocked proximally, the flow through this was rapid and adequate, and 2 pints (1,080 ml.) of blood and 1 pint (540 ml.) of plasma could easily be pumped through this with the aid of a Martin's pump. Intravenous infusion was continued through the same needle for four days postoperatively, when it finally stopped. A similar one was put into a small vein on the other side and continued for a further four days.

Thus it seems that an infant-scalp vein needle can be used in shocked adults with collapsed veins where it may be difficult to get into a vein with a Branula, Intracath, or an ordinary "giving" set needle, especially when a cut-down has failed, as contrary to expectation one can easily pump blood, plasma, or fluid through it at great speed.—I am, etc.,

H. F. NAGAMIA.
Dorset County Hospital, Dorchester.

Cephaloridine in Acute Pulmonary Infections

SIR,—Dr. P. Howard (27 May, p. 573) states that cephaloridine in a dose of 6 or 8 g. daily might be very effective in bronchial infections. This has been confirmed in a controlled trial in patients with severe and resistant, chronic, purulent bronchial infections.[1] Cephaloridine was compared in doses of 2, 4, and 6 g. daily to penicillin 6,000,000 units with streptomycin 1 g. daily. With the 2 g. dose of cephaloridine, penicillin and streptomycin was significantly more effective, with the 4 g. dose equal in effect, and with 6 g. definitely inferior both in short- and long-term clinical and sputum assessment. Unfortunately 6 g. daily of cephaloridine is associated with massive outpouring of hyaline casts.[2] Although this cast excretion is of uncertain and doubtful significance, 6 g. of cephaloridine daily should be given only when other antibiotics have failed and/or where the patient is very ill.—I am, etc.,

Ware Park Hospital, Ware, Hertfordshire. A. PINES.

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1 Pines, A., Raafat, H., Plucinski, K., Greenfield, J. S. B., and Linsell, W. D., *Brit. J. Dis. Chest*, 1967, 61, 101.
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Banning of Heroin

SIR,—May I point out that the manufacture and distribution of heroin has been banned in Australia for a number of years (1 April, p. 53). This does not seem to have hindered the illegal trafficking of this drug, but merely to have pushed up the price on the black market. After using heroin in practice in England for a number of years I find its prohibition in Australia irksome to me, and an unnecessary injustice to an unfortunate few of my patients.

A letter on this subject published in the *Medical Journal of Australia* recently[1] produced no response at all from fellow practitioners. The greatest tragedy of this ban seems to be that we have a generation of doctors here that is unaware of the merits of this drug, but only the dangers they read of in the Sunday papers.—I am, etc.,

Mudgee, New South Wales, Australia. B. HEBER.

REFERENCE
1 Heber, B., *Med. J. Aust.*, 1966, 1, 1091.

Drug Addiction

SIR,—In your leading article on "Drug Treatment Centres" (20 May, p. 455) you point out that we know little yet of the ecology of the different types of drug addiction, or of the social factors which encourage