hospital admission in order to determine which patients may wish and be suitable for I.U.D. insertion or tubal ligation at the time of pregnancy termination.—I am, etc.,

EDWIN F. DAILY,

Director,

Maternity and Infant Care Family Planning Projects,
New York, U.S.A.

Schistosomal Involvement of the Bowel

SIR,—I was most interested in the paper by Dr. S. M. Sherif (14 March, p. 671) on malabsorption and schistosomal involvement of the jejunum.

I agree with Dr. Sherif about the rarity of schistosomal infestation of the small bowel, but my experience does not accord with the statement "Rarely the appendix and the caecum are affected." Here, at least, massive infiltration of the appendix with ova of *Schistosoma mansoni* is very common in appendices submitted to histological examination, whether acutely inflamed or not. We admit an average of 75 cases per annum of acute appendicitis to this hospital of 1,000 predominantly acute beds.—I am, etc.,

J. M. MYNORS.

Department of Surgery,
University College of Rhodesia,
Salisbury, Rhodesia.

E.E.G. and Survival

SIR,—I should like to draw the profession's attention to the fact that the E.E.G. Society has a subcommittee to deal with the problem of the study of resuscitation and survival. This subcommittee has made some provisional recommendations regarding the recording from subjects whose survival is in doubt. These are provisional because it is felt that further evidence is needed before more dogmatic statements can be made, and the main recommendations, which are summarized below, are largely concerned with the technique of recording to demonstrate the absence of E.E.G. activity.

Electrodes of the "stick-on" type seem preferable to pad electrodes; needle electrodes may sometimes have to be used. Placement of electrodes should allow bilateral assessment of all major brain areas, and the minimum number of recording electrodes should be eight. Electrode resistances should not exceed 5K Ω per electrode (or 10K Ω per pair—6K Ω impedance). Where resistances appear less than 1K Ω per pair, the electrodes should be specially checked. It is desirable to include E.C.G. and other extra-cephalic leads.

Equipment with at least eight channels is recommended to permit simultaneous recording from as many areas of the scalp as possible, with a minimum of six channels of E.E.G. There should be the usual range of high frequency filters and time constants; and the noise level should be such that cerebral potentials* of 2 μ V peak to peak could reasonably be recognized in the write-out.

It is advisable to use a time constant of at least 0.3 sec. for most of the recording, and a paper speed of 1.5 cm./sec. for at least part of the recording. The amplification should be such that 2 μ V signals could be readily identified; this may require increased gain to 3.5 or 2.5 μ V/mm. level. Montages should include long interelectrode distances (> 10 cm.) and preferably some monopolar/average reference derivations. The apparatus and connexions should be tested by systematic and deliberate touching of electrodes to produce extraneous potentials. It is desirable to demonstrate the absence of E.E.G. response to stimuli (e.g. pain, sound, light).

There should be 20 minutes actual recording though 30 minutes would be preferable. Attention should be paid to recording conditions to identify and eliminate extraneous signals. The record should be interpreted by a medically-qualified neurophysiologist / electroencephalographer, who has been present during at least part of the recording. Where satisfactory recording conditions cannot be obtained it may be impossible to provide a reliable assessment.¹

It remains certain that the E.E.G. on its own cannot enable one to give a definite prognosis on survival. The whole clinical situation has to be taken into account, especially since certain factors (e.g., intoxications, hypothermia) can appear to abolish temporarily much of the electrical activity of the brain. Nevertheless, the E.E.G. is one of the useful tools in assessing the chances of survival of an individual.

One important point on which evidence is still lacking is the minimum time for which the persistent absence of E.E.G. potentials in scalp recording can be regarded as indicating irreversible inactivity of the brain. It seems likely that many hours are necessary, and that such an interval may be needed between "inactive" records before a definitely bad prognosis may be given.—I am, etc.,

ELMAN POOLE,

Secretary,

E.E.G. Society Subcommittee for
Resuscitation and Survival.

Churchill Hospital,
Oxford.

REFERENCE

- 1 E.E.G. Society Subcommittee for Resuscitation and Survival, *Recommendations*, April, 1970.

Buruli Ulcer

SIR,—I was very interested to read your leading article entitled "Buruli Ulcer" (16 May, p. 378).

Last year I spent two months in Peru, and during my stay I spent some time in the humid jungle regions of the country in search of the Buruli ulcer. The climate of the Buruli district is similar to that of the Amazon basin in Northern Peru, and it seemed reasonable to suspect the existence of *Mycobacterium ulcerans* in this area. In Iquitos, situated on the Amazon and the largest town of Peru's jungle regions, I came across an interesting case which I would like to report here.

The patient was a boy aged 4 years living in the centre of Iquitos. He was brought to the dermatologist by his father who gave details of the history. The boy developed a small nodule above the right knee. The nodule grew until it reached the size of a pea when a small hole appeared in the centre and began exuding fluid. The ulcer grew in size as dead skin from the periphery sloughed off. No pain referable to the lesion had ever been experienced. After two months the boy was seen at the hospital. The ulcer was then 2 cm. in diameter, the skin was separated from the subcutaneous tissues, and a probe could be passed under the undermined edges of the ulcer. The surrounding skin was a pink-red colour and was not warmer than elsewhere. There was no pain or tenderness and no inguinal lymphadenopathy.

The ulcer was curetted and a considerable amount of abnormal adipose tissue evacuated. The destructive process extended deeply, involving the fascia of the quadriceps.

Unfortunately no pathological or bacteriological examinations were performed on the specimens because the necessary equipment was not available. The boy was Mantoux positive, and it was assumed that the ulcer was caused by *Mycobacterium tuberculosis*. The treatment for six months with P.A.S., isoniazid and streptomycin resulted in a complete cure leaving a well-formed scar.

In view of the history given and the nature of the ulcer it seems very likely that it may have been a result of infection with *Mycobacterium ulcerans*.—I am, etc.,

D. E. WARD,
Medical Student.

East Wing,
Guy's Hospital,
London S.E.1.

Home from Hospital

SIR,—I refer to your leading article (18 July, p. 119), discussing the home care of patients discharged from hospital, and how far their needs had been met.

The final paragraph contains the statement "Hospitals know little of their patients' home circumstances, doctors do not hear of their patients' hospital treatment. . . ." This is a generalization which is quite untrue of many hospitals. It is the practice in my own group to make every possible inquiry into home circumstances before the discharge of a patient, and every general practitioner receives two discharge reports—a brief interim one at the time of discharge, and a full copy of the summary within a week or two at the most.

Time spent on ward rounds at the bedside of patients whose hospital investigation and treatment are nearing completion and are shortly to be discharged is more concerned with the home circumstances and care available than with the clinical details. Consultants, residents, sisters, welfare officers, etc., are all involved, and repeated interviews with relatives are arranged, or attempted, in some cases without success. Obviously the results are not always satisfactory, but to imply that hospitals in general make no effort to this end is surely quite unjustifiable.—I am, etc.,

W. M. PRIEST.

Warneford General Hospital,
South Warwickshire Hospital Group,
Leamington Spa.

Oral Contraceptives and Hypertension

SIR,—I refer to your leading article (16 May, p. 378), just to hand.

It may be of interest to note that I first drew attention to this in 1963 and since then I have had three published references there-to.¹⁻³ May I draw attention to my comments at the World Congress,² and to the *Medical Journal of Australia*,³ where I wrote "The table suggests . . . rise of blood pressure [is] more likely to occur in those who have had toxæmia of pregnancy."

In conclusion, may I state that the blood pressure levels may be very high. In two of my patients the readings were 220/120 and 210/110, and since I have seen two patients on the pill for up to 10 years with a diastolic pressure of 150. It would seem that there

is much less rise in blood pressure on the new low-dosage formulations.—I am, etc.,

A. M. MACINTOSH.

Cronulla, N.S.W.,
Australia.

REFERENCES

- 1 Macintosh, A. M., *Proceedings of a Symposium*, Sydney 17-18 October, 1964, p. 242.
- 2 Macintosh, A. M. in *Proceedings of the 5th World Congress of Gynaecology and Obstetrics*, ed. C. Wood and W. A. W. Walters, p. 355. Sydney, Butterworths, 1967.
- 3 Macintosh, A. M., *Medical Journal of Australia*, 1968, 2, 1010.

Maintenance Digoxin

SIR,—The purpose of my paper (20 June, p. 705) was as Dr. R. Mulroy (18 July, p. 164) says "to draw attention to the dangers attending the use of digoxin" and to highlight the need to review drug therapy in elderly patients. The present pressure on hospital beds requires a policy of early discharge as soon as acute symptoms have settled, and often this means no time to review treatment, as was possible when the patient remained in the hospital during a convalescent period. Indeed, it is a cause of concern that many elderly patients are discharged to live alone on a complex therapeutic regimen which they are unable to manage. There is therefore an increasing need for careful evaluation of all drugs, not only digoxin, which we give on a maintenance basis, with the possible exception of hormone replacement therapy.

In my own series the patients were observed over a three-month period after withdrawal of digoxin, and only considered successful if no indication for restarting treatment presented. Some were restarted within that period, and I tried to indicate which features should be considered when reviewing each case.—I am, etc.,

J. L. C. DALL.

Victoria Infirmary,
Glasgow.

Obstetric Anaesthetic Deaths

SIR,—Your leading article on unnecessary deaths in anaesthesia (23 May, p. 437) deserves close attention. Anaesthesia for maternity patients is undoubtedly a very skilled aspect of anaesthetic work, and should not be left for inexperienced anaesthetists to handle.

In Hong Kong, in the University and Government hospitals, we make it a point that only anaesthetists with considerable experience in the specialty may anaesthetize obstetric patients.

I wonder, however, whether more deaths could have been prevented in these patients if some form of regional analgesia such as epidural, caudal, or spinal had been used, and the patient remained awake and in possession of all her protective reflexes, thereby avoiding inhalation of gastric contents. This point should not be overlooked in the assessments of maternal deaths.—I am, etc.,

Z. LETT,

Chairman,
Society of Anaesthetists of Hong Kong,
University of Hong Kong.

Overcrowding in Mental Hospitals

SIR,—Dr. D. A. Spencer's suggestion (13 June, p. 667) that the necessity for the admission of mentally subnormal patients to hospital should be assessed by a panel of agencies involved is potentially a very valuable one. I wonder, however, why he suggests that the parents and relatives of the patient should be available for interview only. The parents and relatives are likely to have to sustain the greater part of the burden if a patient remains at home, and, as they have a more intimate day-to-day knowledge of the patient than any of the members of Dr. Spencer's proposed panel, surely the parents and relatives should be members of the panel.

It is time it was recognized that so-called community care very often merely means family care, with occasional home visits from salaried officials who are not involved in the day-to-day care and management of the patient. With the current difficulties patients have in getting into long-stay hospitals we shall soon be returning to the dark era when these hospitals did not exist. Perhaps, before this, one could hope that the distinction between community care and hospital care will be recognized to be a false one, and that hospital care is a proper part of comprehensive community care.—I am, etc.,

A. M. SPENCER.

Powick Hospital,
nr. Worcester.

Compression Bandaging for Oedema

SIR,—Mr. Harold Dodd's letter (25 July, p. 223) gives me the impression that the bandages are put on the oedematous legs from above downwards.

Surely to reduce the oedema bandaging should start at the toes?—I am, etc.,

C. H. JOHNSON.

London N.19.

Burden of Cerebrovascular Disease

SIR,—As Professor R. M. Acheson and Dr. A. S. Fairbairn say (1 August, p. 284) I prefer to conduct such discussions in private rather than in public, but having started one must finish.

Professor Acheson and Dr. Fairbairn believe that there is only a negligible error in their estimate of incidence—because "the vast majority of cases (cerebrovascular) will either die within a month, or spend at least one night in hospital." Our preliminary figures from the Rhondda Borough (based on corrected notification data for 8 months), suggest that at least 60% of all "clinical" strokes are never in hospital and of these 75% survive one month. Were Professor Acheson's technique to be used in the Rhondda, the true incidence might be underestimated by as much as 45%. I do not know what happens in Oxfordshire.

They use the similarity with Eisenberg's data to prove their error must be small. I consider this a dangerous argument. Have they considered the possibility of the greater use of hypotensive drugs in the U.S. altering the natural history of the disease there?

They argue, very politely, that my interest in the treatment of coronary disease at home had been influential in encouraging the general practitioner's in the Rhondda to treat cerebrovascular disease at home. It's a nice idea, but I'm sure they've never heard of my views. My colleagues and I were even unable to get permission to do the randomized controlled trial of coronary home treatment in Cardiff. It was done in Bristol by Dr. Mather.

I remain unconvinced by Professor Acheson and Dr. Fairbairn, and I don't think further argument will help. The important thing is to measure the extent of the error in Oxfordshire.—I am, etc.,

A. L. COCHRANE.

Rhoose,
Barry, Glam.

Carbon Monoxide Poisoning

SIR,—I hope that your leading article on CO poisoning (25 July, p. 180) in which you conclude that "Doctors confronted with a patient suffering from CO poisoning should, then, treat the patient by the means most effective in reducing the level of carboxyhaemoglobin—hyperbaric oxygen—and this is true of all levels of CO poisoning" will not mislead doctors. To withhold oxygen at ordinary pressure (with or without CO₂) in order to transport victims to the nearest of the 17 hyperbaric units you quote might well be fatal.

Doctors are expected by the law (and may be reminded by patients) to be acquainted with the medical literature and au fait with advances in treatment. To be ignorant is to court criticism—sometimes openly in court.

The important operative words "wherever possible" should have been incorporated into your *B.M.J.* dictum, and a reminder on the vital importance of ventilation of the less sophisticated kinds at the earliest possible stage would have eased the lot of many practitioners. Incidentally no one would accept that "this" (i.e. hyperbaric oxygen treatment) "is true of all levels of CO poisoning" (my italics). Garage hands, furnacemen, even those packed in the "Smoking" on the 5.10 could afford to leave hyperbaric oxygen until a more major CO emergency arose.—I am, etc.,

KEITH SIMPSON.

Department of Forensic Medicine,
Guy's Hospital, London S.E.1.

**Our dictum continued: "Until the patient is placed in the hyperbaric atmosphere 95% oxygen and 5% carbon dioxide should be given . . .".—Ed., *B.M.J.*

Pseudo-obstruction of the Large Bowel

SIR,—Pseudo-obstruction of the large bowel is, I agree with Drs. P. K. Caves and H. A. Crockard (6 June, p. 583), a good way of describing the syndrome of dilatation of the large bowel without obstruction.

There are two points I wish to make. Firstly, if it is by definition "not obstruction," there should be no need for colostomy, which will only make things worse. Hence, when in doubt a barium enema with gentleness but with double contrast media