should be mandatory, rather than exploration. Secondly, the aetiological classification suggested in this interesting article should include amoebiasis. This disease is not limited nowadays to tropical areas and it is known to mimic many intra-abdominal emergencies.¹ It is especially apt to cause colonic dilatation similar to pseudo-obstruction of the large bowel, and we know that exploration in these cases may be associated with high morbidity and mortality, though in cases of toxic megacolon of amoebic origin a caecostomy may be life-saving. This is the only surgical procedure which I think is justified for pseudo-obstruction. If there is acute cholecystitis, then of course cholecystectomy or cholecystostomy are justified (Case 2), but then it is no longer pseudo-obstruction but sentinel ileus.—I am, etc.,

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REFERENCE

- ¹ Herrera-Llerandi, R., *Bulletin de la Société Internationale de Chirurgie*, 1968, 27, 162.

Nutritional Megaloblastic Anaemia in Immigrants

SIR,—Nutritional megaloblastic anaemia has been considered rare in Britain until the present time. In two years cases of nutritional megaloblastic anaemia have been seen in this hospital in non-pregnant Sikh and Hindu lacto-vegetarian immigrants of both sexes from the Punjab. This stimulates us to draw the attention of others to this finding.

Five of these have presented with profound anaemia with a haemoglobin concentration below 5 g./100 ml., and there has been one death with haemorrhage from acute ulceration of the duodenum associated with thrombocytopenia. Three of the severe cases were teenage girls. The deficiencies have been variable, some pure vitamin B₁₂, some pure folic acid, the remainder mixed vitamin B₁₂ and folic acid. These cases are being reported in greater detail. Pernicious anaemia may also be found in Indian immigrants.¹—We are, etc.,

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REFERENCE

- ¹ Britt, R. P., Stranc, W., and Harper, C., *British Journal of Haematology*, 1970, 18, 637.

English Language Problems

SIR,—I feel disgusted in reading repeated discussions about poor command of English language of Commonwealth doctors.

I feel from personal experience that real problem is not of language but of accent, and one cannot learn language-accent without visiting that place. Not many British people would deny that at one time or other they had difficulty in understanding accent of different part of Britain. Then how would you expect from a Commonwealth graduate to speak and understand Cockney or Cumbrian language (not English)?—I am, etc.,

HAREN JOSHI.

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Breast-milk Jaundice

SIR,—In your timely leading article with its excellent list of references on breast-milk jaundice (25 July, p. 178) you did not mention in the differential diagnosis drugs taken by lactating mothers. Many of them take for somatic or psychiatric reasons a variety of drugs which are excreted in the breast milk and could cause jaundice.

In my humble opinion, with some exceptions, "medicated mums" should not breast feed.—I am, etc.,

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near Norwich, Norfolk.

Induction of Labour

SIR,—While believing in active management once the decision has been taken to induce labour I would deprecate the indiscriminate use of intravenous oxytocin in all patients at the time of amniotomy, as advocated by Mr. M. E. Pawson and Mr. S. C. Simmons (25 July, p. 191) and endorsed

The authors claim to have had only four failures out of their 290 inductions. However, study of their Table III shows that of the 13 caesarean sections necessary seven could be described as failures or complications of induction (three failed induction, two brow and one face presentation, and one transverse lie in labour). During 1968-9, 238 patients under my care had amniotomy carried out, and intravenous syntocinon (two units per pint) was commenced either prior to this or very shortly afterwards in 45 patients (18.8%). The indications for use of the oxytocin were either an "unfavourable" cervix, a high head, or a history of prolonged induction-delivery interval in a previous pregnancy.

Table I shows that my figures are very similar to those of Mr. Pawson and Mr. Simmons, apart from use of oxytocin. Of the six caesarean sections for "failure" all but one had had immediate oxytocin at the time of amniotomy. It would seem, therefore, that it is possible to reduce the use of oxytocin to under 20% of amniotomy cases without increasing the caesarean section rate.

TABLE I.

	Total Inductions	Incidence of Immediate Oxytocin	Total Caesareans	Caesareans for Failures of Method
Pawson and Simmons	290	100%	13	7
Personal Series	234	18.8%	10	6

TABLE II.—Induction-Delivery Intervals

	0-12 hours	12-24 hours	Over 24 hrs.
Pawson and Simmons	220 (75.9%)	41 (14.1%)	29 (10.0%)
Personal Series	133 (55.9%)	67 (28.1%)	38 (16.0%)

in your accompanying leading article (p. 176). The authors state that a patient questionnaire confirmed that patient discomfort was not a significant factor. However, many maternity patients are entering hospital for the first time and apart from any discomfort from a drip the extra interference will frighten many. There seems a danger that increased hospitalization for delivery may be converting an inherently physiological process into a major psychological ordeal for an unnecessarily large number of patients.

Table II compares the induction-delivery intervals in our series with those of Mr. Pawson and Mr. Simmons. While there can be no doubt that this method shortens the interval, the routine use of oxytocin in all cases has only increased the number of patients delivered within 24 hours from 84% to 90%. Does this justify such widespread use of intravenous oxytocin?—I am, etc.,

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Independence and the Presidency

SIR,—Your leading article entitled "Independence and the Presidency" (18 July) is of particular interest in view of recent medicopolitical events. None surely would dispute the tradition that the president of the British Medical Association should stand apart from the rough-and-tumble of medical politics. If this be the tradition for the president of a predominantly medico-political body such as the B.M.A. it should surely apply with even greater force to the presidents of our royal colleges.

The royal colleges are academic institutions, registered as charities, and they are therefore specifically barred from political activity and controversy. In these circumstances it is surely strongly to be deprecated that the presidents of certain royal colleges (with the notable and commendable exception of the president of the Royal College of Surgeons of England) wrote to *The Times* on 9 June. At a time of acute poli-

tical crisis that letter tended to sound a dissenting note when membership and leadership of the B.M.A. were united as never before.

The presidents who signed that letter erred in three ways. Firstly, they sought to intervene in a medicopolitical controversy; secondly, they adopted an attitude in opposition to that of the B.M.A. or, at any rate, they showed no disposition to support the democratically elected representatives of the profession; and lastly in signing as presidents of their colleges they tended to give the impression that they were propagating official policy. However, had any one of them felt sufficiently strongly about the situation to send a letter to *The Times* I would see nothing improper in such an individual writing so long as he made it plain that he was expressing a personal opinion.

A similar situation arose in another letter