than a hundred countries where paraquat is now used, most of which have strict regulations governing the use of pesticides.

In cases of human poisoning by paraquat, and in experimental animals, the highest concentrations are found in the kidneys and liver and though these organs show signs of damage there is no subsequent proliferation of any of their component cells. It would be expected that were induction of "near anaerobic conditions" a cause of the cellular reaction these organs would show more proliferation than the lungs. Measurement of ATP concentrations in paraquat poisoned animals also shows no change. There is therefore no parallel between Warburg's theory of carcinogenesis and the actions of paraquat as Drs. Stokes and Walker suggest.—We are, etc.,

K. FLETCHER.
A. A. B. SWAN.

Industrial Hygiene
Research Laboratories,
I.C.I. Ltd.,
Macclesfield, Cheshire.

REFERENCE

- ¹ Canning, D. M., Fletcher, K., and Swan, A. A. B., *British Medical Bulletin*, 1969, 5, 245.

SIR,—In their letter (22 August, p. 462) Drs. D. M. Stokes and D. A. Walker state that it is well established that poisoning by both paraquat and diquat is characterized by proliferation of the epithelium of the lung. The papers they quote refer only to cases of paraquat poisoning. As far as I am aware D. G. Oreopoulos and I¹ described the only case of diquat poisoning published to date, and there was no evidence of any lung lesion in this patient who recovered completely.—I am, etc.,

J. McEvoy.

Renal Unit,
Belfast City Hospital,
Belfast.

REFERENCE

- ¹ Oreopoulos, D. G., and McEvoy, J., *Postgraduate Medical Journal*, 1970, 45, 635.

Undiagnosed Abdominal Pain

SIR,—In your leading article entitled "Undiagnosed Abdominal Pain" (22 August, p. 415) you refer to Howie's suggestion "that the place of planned appendicectomy for mild or recurrent iliac fossa pain is a very restricted one,"¹ but quote figures from Ingram and Evans² showing that 90% of young women who had had diseased appendices removed were satisfied with the result, whereas only 45% with normal appendices had been satisfied post-operatively. Thus one needs some indication of those patients in whom recurrent pain in the right iliac fossa is, in fact, likely to be due to appendicular disease.

A few years ago I described a simple radiological method of demonstrating appendices using a barium mixture which contains a cellulose preparation (Raybar 75—Damancy).³ By this method presumptive diagnosis can be made of an appendix which has suffered recurrent attacks of inflammation, so that unnecessary (and sometimes harmful) operations can be

avoided. At the same time, in most cases, the terminal ileum and caecum are also well shown, so that other causes of the pain, such as regional ileitis, may be revealed.

Follow-up in this series showed an 85% improvement rate in those operated on, which corresponds closely with Ingram and Evans's figures. Furthermore, since only a limited number of films are taken with as little screening as possible, the amount of radiation is kept to a minimum.—I am, etc.,

MYER GOLDMAN.

X-ray Department,
Fazakerley Hospital,
Liverpool.

REFERENCES

- ¹ Howie, J. G. R., *Lancet*, 1968, 1, 1365.
² Ingram, P. W., and Evans, G., *British Medical Journal*, 1965, 2, 149.
³ Goldman, M., *Clinical Radiology*, 1966, 17, 289.

Breast-milk Jaundice

SIR,—Your leading article (25 July, p. 178) comments that breast-milk jaundice is a complex problem. I wish to report certain aspects of the laboratory diagnosis of this condition which increase the complexity still further.

The inhibitory activity of human breast milk was examined by determining its effect on the conjugation of bilirubin by male rat liver slices.¹ Breast milk 0.2 ml. was added in a final incubation medium volume of 3 ml. Using this technique I have examined milk from 163 nursing mothers, including 10 specimens from mothers of babies in whom a clinical diagnosis of breast-milk jaundice had been made. Most of the specimens were examined within one week of collection. This is essential since specimens kept at -12°C . increase their inhibitory activity toward conjugation in rat liver. This was examined by retesting 17 control breast milks for inhibitory activity against bilirubin conjugation in rat liver slices after keeping for 16 weeks at -12°C . All the milks showed an increase of inhibitory activity, the mean increase being 20.3%. A number of breast milks have been further tested serially for inhibitory activity against bilirubin conjugation in rat liver slices. The results obtained with a representative breast milk are shown in the Table. The milk was kept at -12°C . after the first analysis.

Age of Specimen	Inhibitory Activity (% Inhibition of Bilirubin Conjugation)
8 hours	+5
6 days	+1
12 "	14
20 "	7
40 "	38
54 "	57
64 "	75

Each result is a mean of duplicate analyses.

This observation has practical implications in that sterilized deep-frozen breast milk is used for feeding premature infants. Sterilized breast milks from a bank have been serially tested, but in the specimens tested there was no development of inhibitory activity. It is possible that sterilization

prevents the development of inhibition but this has not yet been fully investigated.

Another puzzling factor has been the high incidence of inhibitory activity toward bilirubin conjugation in milk from the control mothers. In the 153 control milks eight gave 100% inhibition of bilirubin conjugation in rat liver slices although the infants of these mothers were not sufficiently jaundiced to warrant serum bilirubin analyses. Complete inhibition of conjugation also occurred when these milks were added to other conjugation test systems. Preliminary experiments have shown that this inhibitory milk has an effect on conjugation similar to milk from mothers of infants with breast-milk jaundice.

These problems are being investigated further but give support to your observation that this is a very complex problem and may depend on infant susceptibility as well as secretion of inhibitory substances in maternal milk.

I thank my colleagues for referring specimens to me and the South-western Regional Hospital Board for financial assistance.—I am, etc.,

TOM HARGREAVES.

Area Department of Pathology,
Exeter, Devon.

REFERENCE

- ¹ Lathe, G. H., and Walker, M., *Biochemical Journal*, 1958, 70, 705.

Unified Filing System

SIR,—Referring to the proposal made (1 August, p. 277) it may be pointed out that the numerical date indication given as example, with the sequence day, month, year, runs counter to the proposed British Standard (in draft as BSI doc. 70/4476) on "Rules for Writing Calendar Dates," which states "An all-numerical date shall be written in the following order: year-month-day."—I am, etc.,

V. BISKE.

Chester,
Cheshire.

Acute Epiglottitis

SIR,—Acute epiglottitis, a fulminating and often a fatal infection in young children, is infrequently recognized. In view of the laryngeal obstruction, urgent and specific treatment is required. Only few cases have been reported (Dr. J. D. Andrew and others 31 August 1968, p. 524), but probably many more go unrecognized. In view of a need for the widespread awareness of this condition it may be useful to report the following case.

A two-month-old baby girl was admitted to hospital on 21 September 1968 with increasing respiratory stridor and slight cyanosis. She looked ill, had a marked respiratory stridor with prominent substernal recession, and her temperature was raised to 100°F . (38°C). Clinically and radiologically her chest was clear, laryngoscopy showed supraglottic oedema. The epiglottis was inflamed and oedematous and more or less occluding the glottic opening. A Jackson Rees nasendotracheal tube was passed to establish a clear airway. The tube was left in for two days while the infection was controlled

by parenteral ampicillin. Laryngoscopy after removal of the tube revealed a marked improvement. The stridor disappeared, and having recovered completely the infant was discharged home a few days later.

The condition occurs mainly in children and infants, but sometimes also in adults. The literature on the subject is rather scanty (30 August 1969, p. 487), but is more likely owing to infrequent recognition than rarity. The characteristic pathognomonic feature is a swollen inflamed epiglottis blocking the laryngeal opening. Urgent tracheostomy or endotracheal intubation to maintain an airway is necessary while the infection is promptly treated. Ampicillin or chloramphenicol may be tried since the condition is most usually caused by *Haemophilus influenzae* type B. Recognition of this respiratory emergency may substantially lower the number of unexplained but avoidable deaths in children and infants.

I would like to thank Mr. J. F. Dark for permission to report this case.
—I am, etc.,

H. P. GAUTAM.

University of Kanpur,
India.

Cataracts

SIR,—Mr. P. D. Trevor-Roper was quite right (4 July, p. 33) to stress the abnormal nature of the usual correction of aphakia by spectacles. It is indeed a wonder that our aphakic patients do not complain more than they do. His observations opened the way for Mr. M. Ruben (25 July, p. 221) to draw the attention of your readers to the undisputed advantages over spectacles of contact lenses, but he stated that the management of such appliances may fail owing to psychic problems.

Unfortunately the very patients who suffer most from aphakic spectacles are likely to be those with a psychic block to the use of contact lenses, which enables me to point out the even greater advantages which accrue by correcting aphakia by means of an intraocular lens implant—for example, anterior chamber acrylic implants.

Their use in the correction of unilateral aphakia is becoming more and more accepted, but their help in bilateral cases is scarcely known. In fact, out of my own personal series of almost 1,000 aphakic cases corrected in this manner, nearly 70 are bilateral. The functional results of this small series are so good that it is as though they were never troubled by cataracts at all. In the majority an implant was inserted into the second eye because of a successful implant procedure carried out on the first eye many years previously, but in recent years there has been an increase in the number of bilateral aphakics being referred because of inability to tolerate spectacles or contact lenses.

It is as well to remember that we have this third technique up our sleeves in case of need.—I am, etc.,

D. P. CHOYCE.

London W.1.

Other Side of Table Mountain

SIR,—Professor W. P. U. Jackson's description (1 August, p. 281) of his idyllic life on the (white) side of Table Mountain, with its attached plea for emigration to, and co-operation with, South Africa, in

order to make that country "more amenable to change" rang a little false to me.

I read it while a news bulletin reported the opening of the trial of Mrs. Winnie Mandela and 20 other South Africans accused of offences which include studying Communism and disseminating the wave-lengths on which Radio Tanzania broadcasts. Most of them have already been tried and acquitted in February this year, only to be re-arrested as they left the court. Their real crime, of course, is their inability to see that the immigration of Professor Jackson, 20 years ago, as a climax of a hundred years of bridge building, has actually solved any of the problems of their homeland. Perhaps recent reports from the Transkei missionary Dr. Guy Daynes that there has been a 600% increase in malnutrition in the past three years, and the estimate that one in five Transkeians suffers from tuberculosis weigh more heavily with them than soft words, heart transplants, and talk of an "open university." But then, they have always lived with the as-yet fairly silent majority of South Africans on the black side of Table Mountain—and perhaps Professor Jackson would not know about that.

On the subject of brain-drains, it is no wonder that South Africa needs these not-so-subtle advertisements. Medical faculties all over the world are adorned by South African doctors who were forced, or who chose, to leave that delectable climate and its flora and fauna, for the sake of their principles.—I am, etc.,

JOYCE LEESON.

Department of Social and Preventive Medicine,
University of Manchester.

Race and Commonweath

SIR,—It is a tragedy that the Rhodesian Medical Association has been dismissed from the C.M.A. (29 August, p. 516). To dismiss such a member, unanimously elected only two years ago, without prior notice of intention to discuss the issue, and with no Rhodesian delegate even present, is damaging to both parties. Such action has no influence at Rhodesian Government level; it merely disheartens the Rhodesian medical profession, which forms one of the largest liberal minded groups of people in that country.—I am, etc.,

BRIAN BEACH.

General Hospital,
Hereford.

Psychotherapy of the Dying Patient

SIR,—As a consultant psychiatrist (retired) with previous experience in general practice, I was very interested in Professor W. A. Cramond's paper (15 August, p. 389).

It dealt with emotional or psychological situations which any practising physician may be called upon to meet and manage, and he should certainly have some equipment for the purpose, but the nature and methods of "training" for this aspect of his work described in the paper are perhaps open to question, both as to what they advise and what they omit. I cannot help thinking that any tolerably sane individual, within a few days, or weeks, of death, might well have fears induced or greatly

aggravated if already existing by the efforts of a mixed hospital staff, all previously briefed and "trained" under a "key therapist" (? in the role of St. Peter), and working pretty much on the lines and theories of Freudian psychoanalysis.

Medical and other scientists should surely know from their own human experience that there are aspects of everyday living (and dying) in regard to which scientific training and methods, however humane, are completely inapplicable and irrelevant.—I am, etc.,

DAVID YELLOWLEES.

Comrie,
Perthshire.

Handicapped Children

SIR,—I was surprised that in your leading article about the report *Living with Handicap*¹ (25 July, p. 179) you omitted to mention Dr. D. Egam's most interesting and constructive contribution in her note of dissent.

Dr. Egam's disagreement with several of the conclusions of the report will undoubtedly find a great measure of support among many doctors engaged in the care of handicapped children. I hope her wise viewpoint, based on her tremendous experience in both clinical and administrative child health services, will not be dismissed lightly.

I have a few of my own reservations on points raised in the report. For example, the perpetuation of some established practices long in disrepute is recommended. Why should a handicap register be reviewed annually? Surely this should not be governed by administratively convenient procedures, but by the need of the individual cases? Why should "case conferences" be the only means to overcome lack of communication between medicosocial agencies involved in the care of a child? Among severely retarded children under the age of five on my own observation/handicap register 27 attend two hospitals, 11 three hospitals, 3 four hospitals, and 4 five hospitals. How would one even begin solving the situation by calling case conferences?

At the present time the paediatric aspect of handicap is often overshadowed by administrative procedures. It is sad to note that the report tones down the vital importance of intensive medical care of a young child by emphasizing all but this aspect of its handicap.

The need for "a whole child approach" is used as another argument for placing the responsibility for a handicap register in the lap of the Department of Social Services. Isn't it right to say that a global approach to a child is a quality of the individual caring for it and not an attribute of any particular profession?

I suggest that there should be a degree of caution in accepting the conclusions of *Living with Handicap*.—I am, etc.,

OLGA NIETUPSKA.

Sunbury on Thames,
Middlesex.

REFERENCE

- ¹ *Living with Handicap*, ed. E. Younghusband et al., National Bureau for Cooperation in Child Care, London, 1970.