on all matters concerning nursing that are controlled by governing bodies; to present to those governing bodies the profession's concept of nursing policy; and as far as possible . . . to decide policy." By this concept alone can we ensure that the future of our profession remains in our own hands.—I am, etc.,

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¹ Ministry of Health, *Report of the Committee on Senior Nursing Staff Structure*, London, H.M.S.O., 1965.

SIR,—I read with interest the letter from Professor R. Y. Calne (3 July, p. 45) and further correspondence (17 July, p. 181) criticizing the Salmon Report.¹

I agree with all that is said about the position of the ward sister. She is indeed the key person in the clinical situation, she always has been and will, I know, continue to be. There is no question of any change in her status. I would also support the view that those wishing to remain in the clinical field should receive suitable financial reward for knowledge and experience. At the present time the Royal College of Nursing is looking at some form of clinical career for the nurse. This has until now stopped at the bedside.

I am perhaps now in a stronger position than in the past to stress the importance of the ward sister, having left the ward after 23 years in order to become a nursing officer. I took this step after considerable thought and because I believe in the implementation of the report. I do not regret this decision and find it challenging and stimulating and it still gives me contact with patients and student nurses.

To answer some of the criticisms made: I would not wish to see lay administration in charge of nursing services. I can only speak from personal experience, but it is obvious that our senior nursing administrators are very concerned to provide the best possible patient care. Nurse administrators have the necessary understanding of the many problems that occur at ward level. This is very comforting for those working with the patients. The ward sisters are responsible for the nursing care of the patients to the matron and the nursing officers are available to assist them on this vital task, as well as to help train the student nurses. Ward sisters are on duty approximately one third of the 24 hours, and inexperienced staff nurses and senior students need help in her absence.

It is still early days for so much condemnation of Salmon; all new innovations are suspect. Indeed Machievelli (1446-1567) made this point and goes on to say ". . . the innovator has for enemies all those who did well under the old conditions, and luke-warm defenders in those who may do well under the new." With the implementation of the Salmon scheme it is hoped we shall achieve better communications and understanding and shall therefore continue to give and even improve the bedside care of our patients, of which we in Britain are justly proud.—I am, etc.,

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¹ Ministry of Health, *Report of the Committee on Senior Nursing Staff Structure*, London, H.M.S.O., 1965.

Kveim Test

SIR,—Your leading article on the Kveim test (12 June, p. 604) challenging the specificity of the test is interesting and will not surprise many physicians who are working in the field of pulmonary disease. I have some further evidence of the non-specificity of this test which indicates that the Kveim antigen is unnecessary to produce a typical skin nodule in early cases of sarcoidosis.

In 1957, when I was a medical officer in the R.A.F. Medical Service working on a pulmonary disease unit, I became exasperated by the difficulty in obtaining Kveim antigen and began to look for an alternative.

I found that the intradermal injection of 0.20 ml of the standard typhoid paratyphoid vaccine would produce a typical nodule in early cases of pulmonary sarcoidosis in a 4 to 6 week period. Biopsy of these nodules showed that the reaction was similar to that obtained using Kveim antigen and the biopsy material was read as "a positive Kveim reaction" by several pathologists. I tested six patients and had positive results in all of them. They were, however, all young R.A.F. servicemen with early pulmonary lesions and hilar lymphadenopathy and I did not have an opportunity to conduct tests in more chronic cases of sarcoidosis. I regarded my results as an incomplete study, which was not published, and did not have an opportunity to continue this investigation after I left the R.A.F. Medical Service. I did discuss my findings with several specialists in pulmonary diseases, but I do not have information that the use of the typhoid paratyphoid vaccine was investigated any further.

I think my results were interesting in the light of subsequent studies of the Kveim test reported in your leading article. They also challenge the specificity of the Kveim antigen, and, in addition, they indicate that a positive Kveim test is not dependent on an antigen prepared from a lymph node. It is also possible that there is a readily available antigen in the typhoid paratyphoid vaccine which is not expensive and much easier to produce than the Kveim antigen.

I am writing this letter in the hope that it will stimulate someone working in pulmonary diseases to carry out further investigations with intradermal typhoid paratyphoid vaccine. I think it could be a very interesting and informative clinical research project.—I am, etc.,

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Glove Powder

SIR,—I would like to confirm the experience of Mr. D. F. Ellison Nash with regard to the serious effects of starch powder on the tissues (17 July, p. 183).

As a hospital pathologist in Canada I encountered granulomatous inflammatory lesions due to corn starch glove powder frequently on microscopic study after surgical operations on the peritoneum and pleura. This condition is difficult to diagnose grossly; an excess of fluid exudate, small grey nodules, or dense fibrosis with adhesions are the main features. Microscopical examination of surgical or postmortem material shows an inflammatory reaction of histiocytes, lymphocytes, and foreign body giant cells with the starch granules easily

identifiable as spherical or polyhedral, birefringent bodies, 10-20 microns in diameter, with a basophilic appearance in H. and E.-stained sections and a brilliant red appearance after staining with periodic-acid-Schiff.

My experience of the clinical results of this condition may be summarized under the following headings: (1) ascites soon after an abdominal operation (starch granules and neutrophils are seen in large numbers on cytological examination of the exudate); (2) recurrence of abdominal symptoms following abdominal surgery; (3) miliary peritoneal nodules mistakenly diagnosed as tumour metastasis until microscopic examination; (4) undue peritoneal fibrosis. I examined abdominal adhesions histologically at post-mortem in cases that had previously had an abdominal operation, and found residua of a starch powder reaction in several cases.

Experiments carried out with the late Mr. Robin Poole, in 1968, who was then chief of surgery at Sudbury General Hospital, Canada, showed that after careful rinsing of gloves in a bowl of water after putting them on, much starch was still demonstrable with Lugol's iodine solution. Even after a second careful rinsing starch was still present between the fingers, but it seems likely that there is now much less danger of a serious inflammatory reaction and I would suggest that such a double rinsing be carried out before operations on the peritoneal and pleural cavity.—I am, etc.,

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Lymphocyte Sensitization

SIR,—The report of Drs. J. M. T. Willoughby and D. N. Mitchell (17 July, p. 155) that blood leucocytes from two thirds of their series of patients with Crohn's disease showed sensitization to Kveim reagent correlates well with recent findings in this unit on lymphocyte sensitization in sarcoidosis (17 April, p. 143). All 19 of a series of sarcoid subjects had blood lymphocytes sensitized to a variety of antigens including Kveim reagent and P.P.D. Among controls for our series were two cases of Crohn's disease and two subjects (apparently healthy) who had remained consistently Mantoux negative after repeated B.C.G. vaccination. All four showed the same cellular sensitization as frank cases of sarcoidosis. Our findings, like those of Drs. Willoughby and Mitchell, suggest a link between sarcoidosis and Crohn's disease, but also raise the possibility that unexpected lymphocyte sensitization to Kveim material (as well as a number of other antigens) may occur in subjects who are apparently normal. It would thus seem possible that either "normal" people may have a sarcoid pathological process in some non-obtrusive region of the body—that is, they may be cases of latent sarcoidosis and betray themselves by their cellular sensitization, or the cellular sensitization to multiple antigens is not really fundamental to either disease.

It must be added that similar sensitization is found in disseminated lupus erythematosus and in erythema nodosum. We have as yet studied ulcerative colitis in only two patients (females aged 15 and 44) and both showed lymphocyte sensitization of a degree intermediate between that customarily found