ship was found between abortion and subsequent ectopic pregnancies.

Like Dr. A. Hordern (12 May, p. 368), we find the report biased; unlike him we find it neither carefully nor extensively referenced.—We are, etc.,

CAROL BUCK
KATHLEEN STAVRAKY

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University of Western Ontario,
London, Ontario

- ¹ Wynn, M., and Wynn, A., *Some Consequences of Induced Abortion to Children Born Subsequently*. London, Foundation for Education and Research in Childbearing, 1972.
- ² Klinger, A., in *Family Planning and Population Programs*, ed. B. Berelson. Chicago, University of Chicago Press, 1966.
- ³ Klinger, A., *International Journal of Gynaecology and Obstetrics*, 1970, 8, 680.
- ⁴ Horsky, J., in *Seventh World Congress on Fertility and Sterility*. Amsterdam, Excerpta Medica, International Congress Series No. 234, p. 146, 1971.
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- ⁶ Matsunaga, E., *Journal of the American Medical Association*, 1966, 198, 533.
- ⁷ Kolstad, P., *Acta Obstetrica et Gynecologica Scandinavica*, 1957, 36, Supplement 6.
- ⁸ Maramatsu, M., in *Proceedings of the Conference of the International Union of the Scientific Study of Population*, 1969.
- ⁹ Muller, C., *American Journal of Public Health*, 1971, 61, 1110.
- ¹⁰ Potts, D. M., *Eugenics Review*, 1967, 59, 232.

Hospital Medicine Sheets

SIR,—I would like to support Dr. D. A. Spencer's appeal (30 June, p. 774), for a standard prescription sheet and point out that such a standard is in use in Wales.

Two forms, for short- and long-term therapy respectively, were produced by the Representative Chief Pharmacists Committee of the Welsh Hospital Board at the request of the Medical Advisory Committee. Within a year they have been adopted by the majority of hospitals in Wales. Simultaneously an explanatory pamphlet was distributed and this has done much to ensure the ease with which the forms have been accepted and used.—I am, etc.,

A. R. ISAAC

Nevill Hall Hospital,
Abergavenny, Mon.

Redesign of Medical Records in General Practice

SIR,—May I join those who have written to you criticizing the proposed A4?

With the aid of a good secretary, I find the present record an ideal "tool," (to use Dr. J. J. C. Cormack's word (9 June, p. 613))—that is to say, when properly used all important points in the patient's history can be recorded in an orderly manner on appropriate sheets and can be retrieved in a few seconds. Further, those letters which cannot be summarized in a line or two, or which for any reason need keeping, take up little room and can be kept. Of course, a larger folder will do all this, but in my view no better, and in some respects the A4's bulk makes the task of retrieving relevant summaries—which is, after all, what one wants—more difficult. Also, it seems to me that the size of the A4 sheets will be an invitation to ramble.—I am, etc.,

J. E. HODGKIN

Bury St. Edmunds,
Suffolk

New Materials for Prostheses

SIR,—The Bath Institute of Medical Engineering is sponsoring a project in the School of Materials Science, University of Bath, for study of new materials covering a wide range of prostheses.

Previous development of such materials has been based on largely empirical methods of choice, and general development in co-operation with surgeons. The present project proposes to characterize the material before its use as fully as possible, including simulated tests where feasible to establish the likely performance. When such material is utilized as an implant it is our intention to collect the medical history of the patient and record it in a data bank for subsequent follow-up of the behaviour of the prosthesis. When an implant is subsequently removed for change or substitution, or following decease of a patient, it will be again examined for changes in structure or behaviour by repetition of measurements. Related to the original concept and medical history it is hoped to learn more from such examination of the material and thereby contribute to development of improvements.

To establish a basis for examination of implants after service. I now welcome the receipt of any prosthesis or implant removed from a patient during surgery or necropsy to guide this work. Wherever a medical history can be provided this information will greatly enhance the value of the examination, but even a brief reference to that history will be of importance. The Bath Institute will be happy to receive specimens on my behalf where appropriate.

May I appeal to surgeons and directors of pathological laboratories to assist in what we hope and believe may be of value to them in the future and of even greater assistance to patients. All types of material are included, metal, ceramic, and plastic, and size has no significance; even a simple joint pin may reveal surface effects when viewed on the scanning electron microscope.—I am, etc.,

C. R. TOTTLE

School of Materials Science,
University of Bath,
Bath, Somerset

Beta-blocking Agents in Hay Fever

SIR,—The danger of using beta-adrenergic blocking agents in known asthmatics was established early on in the history of these drugs. The risks with the subclinical bronchospasm which must often accompany hay fever may not be recognized, since most hay fever victims have gone into remission by middle age, before essential hypertension commonly occurs.¹

A woman aged 57 had been treated with propranolol since November 1971. Though her hypertension was well controlled on three 40 mg tablets a day, an increase in effort angina in March 1973 was treated by increasing the dose to five tablets a day. She had had mild hay fever since about the age of 30 but had never previously noticed any bronchospasm. This summer, coinciding with the onset of her rhinitis, she began to wake regularly at 3 a.m. with wheeze and cough which prevented further sleep. This symptom has completely cleared on treat-

ment with sodium cromoglycate inhalations.

A change of beta-blocking agent to oxprenolol was the obvious alternative management, but this patient has had side effects on several previous hypotensive drugs and was averse to a further change. The pollen season here is always over by the second week of July.—I am, etc.,

M. J. AYLETT

Corsham, Wilts

¹ Fry, J., *Profiles of Disease*, p. 83. Edinburgh, Livingstone, 1966.

Simple Finger Tourniquet

SIR,—The finger tourniquet improvised from the cut-off finger of a disposable rubber glove by Mr. M. Z. A. Salem (30 June, p. 779) is similar in principle to a commercially available clear plastic ring tourniquet. The main disadvantage with this type of tourniquet is that because of its small size and translucency it can be easily overlooked at the end of the operative procedure and left in place. This is by no means a theoretical objection to its use as I am informed that several cases of such tourniquets being left in place have been dealt with by the Medical Defence Union. It is for this reason that such tourniquets have been withdrawn from use in this hospital.

I have always found the traditional tourniquet of a rubber tube and artery forceps quite satisfactory for minor operations on the digits. The danger of forgetting to remove such a tourniquet is remote.—I am, etc.,

E. M. HOARE

Manchester Royal Infirmary,
Manchester

SIR,—I was interested to read Mr. M. Z. A. Salem's description of a simple digital tourniquet (30 June, p. 779). I have used a somewhat similar technique for the past two years: when the whole hand (or foot) has been prepared it is inserted into a sterile surgical glove. The tip of the appropriate glove finger is cut off and the remainder is rolled proximally to exsanguinate the digit and to form a tourniquet at the base.

In addition to its efficacy, this method has the outstanding advantage of absolute safety, as one cannot forget to remove the tourniquet.—I am, etc.,

D. J. BOUCHIER-HAYES

Department of Surgery,
University College Dublin

Leptospirosis in 1972

SIR,—I was most interested to read in the *B.M.J.* notes on 60 cases of leptospirosis reported from the United Kingdom and the Republic of Ireland during 1972 (23 June, p. 723) that the occupation was recorded in 47, or just over 78% of cases, and that there were five fatal cases, a mortality of over 8%.

Comparatively, I have much experience of leptospirosis—in Germany,¹ Western and Eastern Malaysia, and in the Sultanate of Brunei^{2,4}—and I have never seen a fatal case since I started treating this disease, in 1955, with penicillin,² which, when institu-

ted in the first few days of the disease in adequate doses four-hourly, is accompanied in the first 4-6 hours by a characteristic reaction which we termed the diagnostic penicillin-leptospirosis response.²

The highest concentration of leptospirosis is in Malaysia and Indonesia.⁵ Nevertheless, the presence of leptospirosis in Malaya, now Western Malaysia, was first noted by Fletcher in 1928.⁶ Yet in the 1950s it was reported that in the British armed Forces in Malaya 35% of all fevers, excluding malaria, were due to leptospirosis.⁷

I suggest that the number of cases of leptospirosis now being diagnosed in the United Kingdom at present represents only the tip of the iceberg if 85% or so of all cases are mild to moderately severe, and misdiagnosed as they were in Malaya in Fletcher's time and much later. The many confusing manifestations of this disease, or leptospirosis syndromes as they have been called, have been repeatedly stressed.^{1,2,8,9}

I believe that leptospirosis in the United Kingdom and the Republic of Ireland will be diagnosed more frequently in the future when, in febrile illnesses of apparently indeterminate origin, the overall history includes, in every case, not only the occupational history but a history of contact with cattle, pigs, dogs, rats, mice, and voles as well as with soil and water polluted with their infected urine. When such a history becomes routine there is bound to be an increasing awareness of leptospirosis in the United Kingdom. With that there will be earlier provisional diagnosis of leptospirosis, with the immediate early institution of adequate parenteral penicillin four-hourly for the first 24 hours and thereafter six-hourly. When such treatment begins in the first few days of the illness there is the inevitable appearance of the diagnostic penicillin-leptospirosis response; such is my experience and that of my colleagues.—I am, etc.,

JOHN MACKAY-DICK

Edinburgh

- 1 Mackay-Dick, J., and Watts, R. W. E., *Lancet*, 1919, 1, 907.
- 2 Mackay-Dick, J., and Robinson, J. F., *Journal of the Royal Army Medical Corps*, 1957, 103, 186.
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- 4 Mackay-Dick, J., *Journal of the Royal Army Medical Corps*, 1971, 117, 108.
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- 6 Fletcher, W., *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1928, 21, 265.
- 7 McCrumb, F. R., Jun. et al., *American Journal of Tropical Medicine and Hygiene*, 1957, 6, 238.
- 8 Trimble, A. P., *Proceedings of the Royal Society of Medicine*, 1957, 50, 125.
- 9 Turner, L. H., *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1967, 61, 842.

Adrenal Failure in Bronchial Asthma

SIR,—We appreciate that there are problems associated with oral corticosteroid reduction and the substitution of beclomethasone in the treatment of asthma, but we think that the dangers have been misrepresented and hope that this will not prevent the continued use of a promising form of treatment, whose main advantage is that it permits reduction of the dose of oral corticosteroids.

The real danger is that beclomethasone may not be so effective as oral corticosteroids and that the asthma may relapse, a risk that arises whenever effective treatment is withdrawn in any disease. This risk is present

regardless of hypothalamo-pituitary-adrenal (H.P.A.) function.

Drs. Ruth M. Clayton and P. Howard (2 June, p. 547) suggest that corticosteroid reduction exposes the patient to the possibility of failure of the adrenal to respond to stress, but this risk is already present in any patient who has H.P.A. suppression, and could be guarded against only by continually providing corticosteroids in a quantity equivalent to the maximal output of the normal adrenal—300-400 mg of hydrocortisone daily—which is obviously absurd. If the actual dose is reduced from 15 to 7.5 mg prednisolone daily and severe stress should occur either from status asthmaticus or some unrelated condition, high-dose replacement would be necessary and it would make little difference whether the patient was receiving 15 mg or 7.5 mg, as both of these are inadequate for stress replacement. The higher dose, however, will perpetuate H.P.A. suppression, whereas the lower dose may allow some function to return. If gradual reduction and withdrawal is possible, H.P.A. function will return to normal, often by the time the steroid is completely withdrawn or within a short time afterwards.^{1,2} Thus continuation of the higher dose actually increases the risk of adrenal failure.

It is difficult to draw any conclusion from the case quoted by Drs. Clayton and Howard in which the patient died within six hours of onset of a mysterious illness. Adrenal failure does not usually lead to such rapid death, and we do not believe that an extra 7.5 mg of prednisolone would have significantly altered the outcome.

We agree with Dr. A. O. Robson (30 June, p. 781) that the response to tetracosactrin has a loose correlation with the response to stress, but failure of the upper end of the H.P.A. axis is present in a significant proportion of corticosteroid-treated patients in whom the response to tetracosactrin is normal.^{2,3} The insulin hypoglycaemia test is the only adequate way of testing the integrity of the whole axis, and should be used if worthwhile conclusions are to be drawn.⁴—We are, etc.,

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Department of Chemical Pathology,
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London W.6.

- 1 Plumpton, F. S., Besser, G. M., and Cole, P. V., *Anaesthesia*, 1969, 24, 3.
- 2 Daly, J. R., Myles, A. B., Bacon, P. A., Beardwell, C. G., and Savage, O., *Annals of the Rheumatic Diseases*, 1967, 26, 18.
- 3 Jasan, M. K., et al., *Quarterly Journal of Medicine*, 1967, 36, 261.
- 4 Jacobs, H. S., and Nabarro, J. D. N., *Quarterly Journal of Medicine*, 1969, 38, 475.

Mediterranean Anaemia in Antiquity

SIR,—Dr. W. T. Menke's interesting case from the Hippocratic collection (26 May, p. 489) was not, I think, one of sickle-cell thalassaemia. Lehmann and Cutbush¹ suggested 20 years ago that the sickle cell had an Indian origin and came west comparatively recently, and I² put forward the view that its distribution in Africa might be explained by a migration during the Christian era which also left behind the shorthorn zebu breed of cattle. If this is so, there were not many sickle-cell genes in the Aegean in

the period during which the Hippocratic corpus was composed. The case may well have been one simply of thalassaemia, in which the spleen is characteristically large and leg ulcers, though not the rule, do sometimes occur. But the Greeks, I am sure, would have had a different word for it; the term thalassaemia ought surely to apply to the dilution of the blood with sea-water, such as occurs—for all I know—in those drowned at sea.—I am, etc.,

PETER BRAIN

Durban

- 1 Lehmann, H., and Cutbush, M., *British Medical Journal*, 1952, 1, 404.
- 2 Brain, P., *Man*, 1953, 53, 154.

Hazards of Laparoscopy

SIR,—I was interested to read Mr. M. McD. Usherwood's account of the breakage of Palmer's diathermy forceps (30 June, p. 773). I have had the same problem during a laparoscopic sterilization. Another pair of Palmer's forceps was not immediately available, but fortunately it was possible to remove the broken claw of the forceps by means of sigmoidoscopy biopsy forceps through the cannula, and after a short interval the sterilization was completed by the laparoscopic method.

The forceps were almost new, and I wonder if these were isolated incidents or whether some of the current instruments available are not strong enough for this purpose.—I am, etc.,

T. D. ANDERSON

Windsor, Berks.

The Suspended Retractor

SIR,—The deep-chested patient who needs a vagotomy and the patient with a high, small liver and adherent gall bladder present exposure problems which are very much helped by the suspended retractor. With the aid of the normal lithotomy poles and cross-bar, a Doyen retractor lifts up the chest cage and is suspended by tape from the cross-bar with a small Durham retractor.

This technique was developed by Mr. G. Dimopolous, of Durban. I have found it extremely valuable but have failed to secure the interest of manufacturers. I am therefore writing in the hope that surgeons will try it out—their assistants will be grateful and perhaps for the first time will be able to see for themselves what is going on, while the anaesthetist will raise no objection at all.—I am, etc.,

D. W. BRACEY

Peterborough District Hospital,
Peterborough

High-altitude Oedema Presenting as Coma

SIR,—The syndrome of high-altitude oedema has been increasingly documented over the past 10 years¹⁻⁶ Typically the disease presents with respiratory symptoms following on from severe mountain sickness. Cerebral forms are recorded, but according to Singh et al.,¹ unconsciousness takes days to appear. The patient recorded by Foster⁵ was unconscious, but this was in terminal pulmonary oedema. Pine's patient⁶ became comatose, but details of timing are not recorded.