Mucosal Ulceration in Coeliac Disease

SIR,—We have read with interest the article on mucosal ulceration in coeliac disease by Drs. P. E. Jones and M. H. Gleeson (28 July, p. 212) and feel that we must disagree with the title of their paper. In our opinion the authors have not established a diagnosis of coeliac disease according to generally accepted criteria. Though their patient was treated with "strict gluten withdrawal" there was no apparent improvement until prednisolone was introduced. Therefore the response to gluten withdrawal remains open to conjecture.

We recognize mucosal ulceration as being a rare complication of coeliac disease, but Crohn's disease and chronic ulcerative jejunitis¹ may produce a similar clinical and histological picture, and a further search for granulomata might be rewarding.—We are, etc.,

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¹ Jeffries, G. H., Steinberg, H., and Slesinger, M. H., *American Journal of Medicine*, 1968, **44**, 47.

St. John Ambulance Air Wing

SIR,—A patient of mine was severely injured in a road accident in France. Five weeks later she had recovered sufficiently to be transferred to England. The usual procedure is for the local consulate to arrange transfer by a commercial air flight (from France the cost might be up to £600). I approached the St. John Ambulance Air Wing at St. Margaret's Hospital, Epping, Essex (telephone Epping 2224) and the transfer was arranged within 24 hours at a cost of £125.

The Air Wing of St. John Ambulance provides a volunteer air service for the rapid transfer of organs, drugs, and patients in emergencies in the U.K. and abroad. The aircraft used in my case—an Islander—can operate from any short landing strip.

I thought that my experience might be of use to some of your readers.—I am, etc.,

Z. M. SHARNAGIEL

Harlow, Essex

Liver Injury by Salicylates

SIR,—In your leading article (30 June, p. 732) commenting on the findings of Rich and Johnson¹ you make no reference to the earlier paper by Russell *et al.* published in your own journal² and to my subsequent letter,³ both of which reported transaminase changes which amply supported previous observations on liver damage by salicylates.

As far as eosinophilia during salicylate treatment is concerned, I have re-examined the records of our 20 cases to date which showed increased transaminase levels during aspirin treatment. An increased proportion of eosinophils (more than 4%) was found in only three patients. Unfortunately no total eosinophil counts are available from our patients, but as none had leucocytosis at the height of increased transaminase activity, I assume that the eosinophil percentage fairly represents the actual number of eosinophils. In the three patients with eosinophilia this was noted at a time when

clinical and laboratory data indicated decreased activity of the disease. Similar observations have been made during the phase of recovery of many other diseases.

No concordance between the serum levels of salicylates or transaminases and blood eosinophilia could be established in our patients.—I am, etc.,

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- ¹ Rich, R. R., and Johnson, J. S., *Arthritis and Rheumatism*, 1973, **16**, 1.
- ² Russell, A. S., Sturge, R. A., and Smith, M. A., *British Medical Journal*, 1971, **2**, 428.
- ³ Iancu, T., *British Medical Journal*, 1972, **2**, 167.

Anticoagulants in Bacterial Endocarditis

SIR,—Drs. E. N. Wardle and M. Floyd (4 August, p. 255) warn us of the dangers of anticoagulant treatment in bacterial endocarditis. In 1940 I was associated, as house physician, with a trial of heparin and sulphonomide in the treatment of this disease, favourable results having been reported from the U.S.A. The aim was, of course, to attack the causative organism by dissolving the vegetations. All our patients except one died, and a prominent cause of death was intracranial bleeding from ruptured mycotic aneurysm. The account of your contributors' second case, taken with their concluding paragraph, seems to indicate that this man died in the same way. I appreciate the difficulty that arose when urgent aortic valve surgery was needed, but I am sad that this hazard should be rediscovered after over 30 years—I am, etc.,

C. P. PETCH

Cheam, Surrey

Care of Casualties

SIR,—It becomes tiring to read so much maligning of the G.P., his appointment system, and its multitude of shortcomings when the representation is so one-sided (leading article, 4 August, p. 248).

As a G.P. vocational trainee I am working sessions in both general practice and a hospital casualty department, seeing the situation simultaneously from each side of the fence. Various points have made themselves all too obvious, so that I wonder why so many in our profession choose to ignore them.

(1) If a G.P. is paid to provide a 24-hour service, he should do so. If not prepared to provide this, which entails seeing emergencies, he has probably chosen the wrong profession.

(2) Many casualty officers are not strict enough in refusing to treat non-casualties, referring them to their G.P.s instead. The patients concerned are usually on the lists of a minority of G.P.s well known to the casualty department for their unavailability, long appointment lists, and inflexibility in seeing emergencies. Attempts to send patients to their G.P.s result in much aggression and bad feeling directed at the casualty officer instead of at the G.P. concerned or his executive council, of which most patients are ignorant.

(3) The majority of practices, little known to the casualty department except through patients referred with a letter, operate

efficient appointment systems, always fitting in the emergencies, usually at one end of the surgery. Their patients are satisfied and consequently silent to the mass media.

Blessed in the eyes of the casualty officer is the G.P. who sews up his patient's scalp before referring him with a letter to casualty for a skull x-ray—that is service indeed. Unfortunately there is no recognition in the present pay and expenses structure for such a service and the saving it makes on hospital facilities.—I am, etc.,

R. C. REDMAN

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Reading

Topical Disodium Cromoglycate

SIR,—I would like to report a probably novel method of using disodium cromoglycate which may be of help to others. My wife, who suffers from allergic asthma, has used on and off with great benefit this drug in the insufflated form. During the high pollen count period of the summer she noticed that she developed urticarial wheals in parts of her exposed skin, particularly about the face. Also she had developed these in the past often when doing heavy cleaning in the house. On her own initiative she decided to try protecting her skin by breaking open a couple of capsules of disodium cromoglycate and applying this to her skin. She found that this gave her both protection and even relief at a stage when the urticaria had even partially begun to occur. When applied to the face the powder is hardly noticeable visually, and it could possibly be incorporated in some form of face powder. This proved a rather more satisfactory method of dealing with her problem than either remaining somewhat dozey on antihistamines or smearing her skin with various ointments.—I am, etc.,

G. SILVERMAN

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The Suspended Retractor

SIR,—I refer to the letter by Mr. D. W. Bracey (4 August, p. 294) describing a suspended retractor for use during the performance of a vagotomy. He will be pleased to learn that this manoeuvre is within the capability of a system of mechanical assistance (see fig.) which has recently become commercially available and which has versatility in the operation fields of all surgical specialties of which retraction is only one aspect.¹

I agree with Mr. Bracey that assistants should be grateful that retraction can be surrendered entirely to mechanical means. Obtaining and maintaining access to an operation site is an essential feature of operative technique. It is achieved by retracting the wound edges and adjacent structures, which task falls to the lot of the assistant. Anyone who has served his apprenticeship to surgery by holding on to the handles of retractors would not be likely to deny the truth of the statement that retracting is a boring, tedious, and tiring occupation. Furthermore, it immobilizes hands which would otherwise be available to participate more actively in the operation. Because of the boring nature of retracting, the attention of the assistant is liable to wander; consequently retraction can become ineffective