

wave of adrenaline-induced aggregation. O'Brien concluded his article with these words: "Since platelets are undoubtedly involved in thrombosis and since many workers claim that adhesion to collagen is the first essential event, it follows that even the abnormalities following aspirin ingestion which I have described are quite sufficient to justify a therapeutic trial of aspirin in individuals at risk from thrombosis. Aspirin is relatively safe and is used probably more than any other drug; and nobody knows whether it decreases thrombosis or not." Cobb *et al.*² reviewed the necropsy findings in 191 patients with rheumatoid arthritis who might be expected to be aspirin takers. "Only 4% had myocardial infarction as a cause of death; only 2% died of cerebral accidents. In contrast, of all deaths in the United States in 1967, 30.9% were caused by atherosclerotic heart-disease and 10.8% were caused by vascular lesions of the central nervous system." A clear statement of the case for aspirin is made by Wood.³

The time has come when it would be both reasonable and valuable to undertake a prospective controlled trial of aspirin in the prophylaxis of ischaemic heart disease. Because of the risk of gastrointestinal haemorrhage those taking part should be volunteers who understand both the risks and the theoretical benefits. I am writing to ask for volunteers from the medical profession in Great Britain and Ireland. I should be glad to hear from any doctor aged 35 or over who is not known to have ischaemic heart disease and who would be prepared to participate. The suggested dose of aspirin is 300 mg twice a day. Allocation to control or treatment groups would be random.

The trial would last five years unless significant results appear earlier. At the beginning and at the end all participants would be requested to complete a simple questionnaire regarding smoking, exercise, and medical and family history. They would also be asked to undergo a simple examination which would include height, weight, blood pressure, E.C.G., fasting blood lipids, and blood sugar. The examinations would be carried out locally. Participation in the trial would end with the diagnosis of ischaemic heart disease or the development of significant side effects from taking aspirin.

I would be very grateful if anyone prepared to take part would write to me at the Department of Social Medicine, Trinity College Medical School Building, St. James's Hospital, James's Street, Dublin 8. If the response shows that such a trial is feasible, details will be sent to volunteers at a later date.—I am, etc.,

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¹ O'Brien, J. R., *Lancet*, 1968, 1, 779.

² Cobb, S., Anderson, F., and Bauer, W., *New England Journal of Medicine*, 1953, 249, 553.

³ Wood, L., *Lancet*, 1972, 2, 532.

Dangers of Corn Starch Powder

SIR,—Your leading article (2 June, p. 502) draws attention to the occurrence of the interesting postoperative phenomenon of starch peritonitis. A review of the literature since 1970 would indicate an apparent increase in the incidence of this condition. I have recently had a case myself and thought it might be worth while trying to assess how common the condition really is.

I therefore asked a number of my colleagues, who between them share approximately 100 years of consultant surgical experience, whether or not they had recognized this complication in any of their patients. Between them they were able to produce only nine cases of the condition.

It would appear then that this particular surgical hazard is either extremely uncommon or going undiagnosed. In view of its clear-cut presentation I have difficulty in believing that my colleagues have failed to recognize the condition. This being so I would hazard a guess that postoperative starch peritonitis is a rare condition. Bates¹ and Holgate *et al.*² have shown that the phenomenon of starch peritonitis appears to be a hypersensitivity reaction to starch. Thus the condition of starch granuloma is quite unlike that of talc granuloma, the latter being simply an inflammatory response to the irritating talc granules. Though it may be desirable to reduce the extremely small risk of starch peritonitis and to have our gloves lubricated inside and out with some material other than starch, it would appear from the figures that I have produced that the condition is not so common that strong pressure could be brought to bear upon the glove manufacturers. If the manufacturers are genuinely unable to provide a substitute for starch, then a simpler method of obviating the postoperative problem of starch peritonitis might be to ask the patients whether or not they have known allergy to starch, the only alternative being the somewhat time-consuming one of routinely skin-testing all patients for laparotomy with an intradermal injection of starch.—I am, etc.,

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¹ Bates, B., *Annals of Internal Medicine*, 1965, 62, 335.

² Holgate, S. T., Wheeler, J. H., and Bliss, B. P., *Annals of the Royal College of Surgeons of England*, 1973, 52, 182.

Tests of Acupuncture

SIR,—It was refreshing to read Sir Robert Macintosh's letter (25 August, p. 454) as it helps to put the practice of acupuncture into proper perspective.

Puncture of the human skin is of ancient origin and was malevolent in nature. It was first done by proxy on a wax image of the intended victim, the needling being supposed to cause disease in the corresponding areas of the man. About 1100 B.C. a trial was held in Egypt of members of the court of Rameses III who were accused of trying to murder the pharaoh by this means. In more modern times witchcraft was a capital offence in this country and one of the accepted methods of detecting a witch was to find areas of skin insensitive to needle pricks. Many unfortunate women were drowned or burnt on the evidence of this sign. In China, on the other hand, skin puncture was used with the laudable object of relieving pain, and a measure of success was undoubtedly obtained such as by the relief of pressure in boils or cysts or by the effect of counterirritation in other conditions.

When reading the many accounts now available by doctors who have watched acupuncture for analgesia during operations in China one is struck by the fact that in

practically every case one or more of four additional aids were used. These are intensive psychotherapy before operation, pre-medication (usually with phenobarbitone), local analgesia (usually with amethocaine), and intravenous pethidine during operation. An excellent article has recently appeared¹ on the experiences of an Australian surgeon and his wife (an anaesthetist) who visited Canton, Hangchow, Shanghai, Nanking, and Peking in December 1972. They travelled alone so that "shows" were not specially arranged, but they saw a wide variety of operations done with acupuncture. The anaesthetist had the technique performed upon herself by request on two occasions. On the first two needles were manually rotated in a hand; this was extremely painful and no skin analgesia ensued. Next, electrical stimulation was used with two needles in the right ear in order to relieve pain in the right hip following injury. This unfortunately did not occur, but the ear was sore for a week. The search for truth was clearly pursued with zeal by these two doctors and their final verdict should be treated with corresponding respect. "At its present stage of development, this technique appears to have little to offer."—I am, etc.,

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¹ Fergusson, N. L., *Anaesthesia and Intensive Care*, 1973, 1, 325.

Infection of Peritoneum during Dialysis

SIR,—We read with interest Dr. E. N. Wardle's paper on the detection of infection of the peritoneum by measuring the lysozyme content of the peritoneal fluid (2 June, p. 518).

We cannot understand how the author made the diagnosis of infection in the six patients with score 2 who had negative cultures. Since the cultures were negative, they were probably cases of aseptic (chemical) peritonitis. In a recent epidemic of aseptic peritonitis among all of our 20 patients on chronic peritoneal dialysis we had the opportunity to study in detail the manifestations of this entity. Diffuse severe abdominal pain with rebound tenderness was the predominant feature in all patients. The effluent fluid contained many white blood cells on microscopical examination. In almost half of the cases the number of W.B.C. was so large that the fluid was cloudy. Mild fever (highest 38°C) was present in only six patients. None of the patients had rigors or chills. Gram-stain examinations and cultures of the fluid were persistently negative. Relief from the pain and improvement of the disease was obtained when dialysis was discontinued. This is the opposite of what we would have done if they were suffering from bacterial peritonitis, in which case we would have continued dialysis, adding antibiotics to the dialysate fluid.

Since lysozyme is derived from granulocytes, it should be expected to increase in cases of chemical peritonitis, in which large numbers of leucocytes appear in the fluid despite the absence of infection of the peritoneum. As a result one may be misled as to the exact cause of the underlying disease if the diagnosis of peritonitis is based on the lysozyme level of the fluid.