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.,

JAMES McCORMICK

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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.,

E. A. BENSON

General Infirmary,
Leeds

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.,

C. LANGTON HEWER

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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.

We feel that Gram-stain examination and culture of the fluid is the best means of differentiating between infection of the peritoneum and aseptic peritonitis, two conditions that require different management.—We are, etc.,

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S. IZATT

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Reaction to D-Penicillamine in Rheumatoid Arthritis

SIR,—We read with interest the letter from Drs. J. Shafer and F. D. Hollanders (4 August, p. 289) and would make the following comments. Firstly, like Dr. C. F. Hawkins (18 August, p. 406), we would expect an exacerbation of symptoms in a substantial proportion of patients in whom all therapy had been withdrawn immediately before being offered D-penicillamine. There can be no doubt that a latent period before the drug becomes effective is the norm with this therapy. Moreover, we do not consider withdrawal of concomitant therapy until the patient begins to show laboratory evidence of improvement, often six to eight weeks from the start. This does not apply to previous gold therapy, however, for the more we have used penicillamine during the past six years the more uneasy we feel about the incidence of bone-marrow depression in patients on penicillamine who had had previous cryotherapy. We do not offer penicillamine to these patients any longer.

Secondly, Drs. Shafer and Hollander's reference to "the disorder of taste which is known to occur in one-third of patients on penicillamine therapy" is worthy of comment. In our series of 107 patients (the first of whom started treatment in 1966) we have had to withdraw only one patient because of loss of taste. A further 16 had transient impairment of taste—10 of them while receiving a dose above 1.2 g/day, as reported before.¹ The incidence of impairment of taste has a correlation with high doses of penicillamine, and almost all those unfortunate enough to experience it on a low dose can expect recovery (without interruption of treatment) within two months.—We are, etc.,

ALBERT T. DAY
JOHN R. GOLDING

Harrogate, Yorks

¹ Golding, J. R., Wilson, J. V., and Day, A. T., *Postgraduate Medical Journal*, 1970, **46**, 599.

Sex and Social Class

SIR,—Apropos your leading article (21 July, p. 121) on the use of family planning services in England and Wales,¹ clearly much more can and must be done to encourage women of all ages in social classes 4 and 5 to follow the example of their middle-class contemporaries in enjoying the benefits of existing family planning services. But more must be done to improve further and expand services if the needs of many communities and of the nation as a whole are to be fulfilled and these must be suitably publicized via the responsible local press and informative public notices.

My experience in Aberdeen is that women in the late 30s and 40s of all classes are invariably very appreciative personally of

family planning advice. Such women can be encouraged by the doctor to discuss the topic with their teenage daughters and can be provided with booklets² and informative material. In Aberdeen family planning education is included in mothers' and parents' club programmes, and in one working class area mothers bring their teenage daughters to family planning talks and discussions at a clinic on a council housing estate.

Certainly some diffident women may be deterred from attending clinics where they feel a lack of privacy—"everyone knows what you've come for." This can easily be overcome, as in Aberdeen, by provision of multipurpose clinics. One Aberdeen clinic is in a building complex with medical and dental clinics, with a local library adjacent and near to a shopping centre. No embarrassment here! Obviously accessibility is vital, with convenient location and opening times. However, the need is often unvoiced where advice is most necessary. Parents in one Aberdeen urban area requested a clinic after they had organized an opinion poll, yet this was a low-density housing area with a low birth rate and high motivation for family planning advice. No such request was received from the highest-density housing area with the largest number of births, but when facilities were provided the attendance soared so much as to require a busy clinic twice weekly. Clearly the general practitioner has a vital role to play. But G.P.s require to take more interest in follow-up and domiciliary cases. In this the G.P. has an invaluable colleague in the health visitor to co-ordinate efforts.

The numbers of abortions in older women might level off and decrease if there was more discussion of the option of sterilization for women in their 30s whose families are complete. (There were 17,500 terminations in women over 30 years in England and Wales in 1969.³) Such sterilization is often the method of choice for some women who find years of continuous pill taking too much of an organization. Abortion in younger women could also be made safer by greater efforts to encourage advice at earlier stages of gestation. A publicized, confidential pregnancy diagnostic service provided along with family planning services could improve this. The knowledge of facilities available to prevent unwanted pregnancy is, as you state, passed by word of mouth but they can also be effectively publicized, as in Aberdeen, by circulating informative brochures to industry and work places.

Basic to all improvements is the inclusion of sex education in a first-class health education programme. One idea is the benefit of social studies courses in schools, in which studies and visits are undertaken to various places to show what the community has to offer.⁴ The numerous facilities relevant to the well-being of young people should be included in such courses so that information is combined with knowledge of services and facilities and confidence in obtaining professional advice.—I am, etc.,

ELEANOR STEINER

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Family Planning Clinic,
Aberdeen

¹ Bone, Margaret, *Family Planning Services in England and Wales*, London, H.M.S.O., 1973.
² Pilkington, R., *Facts of Life for Children*, Barnes, K., *15+ Facts of Life*, London Family Doctor Publications, 1971.

³ Registrar General's Statistical Review for England and Wales for 1969, Supplement on Abortion. London, H.M.S.O., 1971.

⁴ Dallas, D., *Sex Education—Exploring Education in School and Society*, National Foundation for Educational Research in England and Wales, 1972.

Child Injury Intensive Monitoring System

SIR,—Drs. Geoffrey Diggle and Graham Jackson (11 August, p. 334) raise several important issues. They believe that a "realistic and accurate assessment" of the scale and nature of the battered baby problem can be made by a computer-based system working initially at local authority, regional, and eventually national level. They fail to mention, however, that several local authorities have already established confidential central registers concerning such children. Furthermore, medical personnel now have at their disposal a "request for information form" that provides information similar to the more elaborate scheme they propose.

The use of these forms in Birmingham has been recently assessed during the course of an investigation based on 134 cases admitted to hospital. The relevant form was made available at casualty departments and paediatric wards throughout the region and doctors were instructed that when confronted with a case they should complete the form and forward it to the social service department. Following this they received a prompt reply informing them whether the child had been previously battered or suspected of being battered. A list of the names, telephone numbers, and addresses of those previously involved with the child were also supplied. This procedure was approved by the Medical Defence Union as involving no breach of confidentiality. Nevertheless, of 134 cases, in only one-third was the form completed.

Perhaps, therefore, Drs. Diggle and Jackson's confidential files might be used if they are made available at paediatric hospitals rather than social service departments. However, it may still be erroneous to assume that their scheme will necessarily provide reliable statistics because there are still likely to be a number of doctors who fail to provide their computer with information. To rely on the discretion of casualty officers and others to provide relevant information seems rather optimistic in the light of experience. Even in the U.S.A., where mandatory reporting of battered baby cases has been in existence for a number of years, "conflicting estimates" still occur. Improvement could readily be made if doctors accurately recorded the correct diagnosis on the summary discharge sheet. This still too rarely occurs.

Even if reliable statistics are available, this does not necessarily imply efficient management of the battered baby syndrome. Indeed, management of the problem has in the past too often been plagued by a tendency to rely on the case conference on the assumption that discussion alone is in the best interests of the child. I would suggest, however, that this is extremely inefficient and would instead propose that a regional team, hospital-based, consisting of a paediatrician, psychiatrist, social worker, and psychologist, should be established to tackle the overall problem. This would circumvent the present system of leaving the management of