adopt this approach to lactation inhibition and suppression routinely in the department.

We wish to thank Dr. John M. McGilchrist, medical director, of Messrs. William R. Warner and Company Ltd., not only for his encouragement and help in this survey, but also for supplying the Estrovis tablets; and we also wish to thank the midwives of the department for their most willing co-operation.

—We are, etc.,

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Treatment of Vitiligo

SIR,—In most cases of vitiligo the aetiological factor is not known. Treatment in the majority of cases is without effect. In a very limited number of patients there is a spontaneous recovery; in other patients the depigmented areas do not increase. It is well known that melanin-stimulating hormone and A.C.T.H. can influence the melanocytes even in man, although A.C.T.H. has a much weaker effect than melanin-stimulating hormone (see hyperpigmentations in Addison's disease).¹ Owing to a close relationship between A.C.T.H. and alpha-melanin-stimulating hormone (they have an identical 13 amino-acid sequence) it is possible that they can be produced and released in certain circumstances simultaneously—for example, during a highly increased A.C.T.H. production.

We tried using metyrapone (Metopirone) to increase both the A.C.T.H. production and probably melanin-stimulating hormone as well, through the change in the feedback mechanism (blocking of cortisol production). We used it with the above possibility in mind in the treatment of vitiligo in 10 patients, as an attempt to cause repigmentation of the depigmented, vitiliginous areas. We have not found any reference in the literature to this possible use of metyrapone. All our patients had been treated previously and without benefit by dermatologists.

The treatment of most patients started in hospital, with metyrapone administered to adults intravenously 2 g. every other day in 5% glucose, the infusions taking six hours. In children (their weight was 25–35 kg.) the infusions contained 1 g. of metyrapone. As outpatients, our patients received metyrapone in capsules, the usual dosage being six 250-mg. capsules every other day for two to three weeks with a subsequent one to two weeks' pause. We did not encounter any side-effects, except for a transient feeling of fatigue in a boy, probably as a consequence of depressed cortisol production. All patients were instructed about this possibility, and were regularly checked at one-week intervals. Abstinence from major physical activities was suggested for them during the treatment.

The best results were obtained in rapidly progressing cases with a not-too-extensive skin involvement. In such cases we observed not only an early cessation of vitiligo spreading, but repigmentation as well. Sometimes the vitiliginous areas of a few square centimetres were repigmented during a few days. The effect of treatment also depended on the total dosage used. In patients with very extensive involvement the areas affected did

not disappear, but many of them became darker and more pigmented. Their sensitivity to insolation definitely decreased and there was no further spread of vitiligo. Some patients have been followed for more than a year. The largest single dose in a patient was 27 g. of metyrapone over a period of three months. —I am, etc.,

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Salicylate Estimation in the Side-room

SIR,—The value of estimating plasma salicylate levels in the ward side-room has been pointed out.¹ Although this assay was effected with a photoelectric colorimeter, as in the laboratory method, it was suggested that clinically useful results might be obtained with a simple visual comparator. Standard solutions of ferric salicylate may be used for this purpose, but the colours fade, particularly on exposure to light. This problem is overcome by adapting the analysis to use with a set of permanent glass standards, in a Lovibond comparator disc, covering the range 0–110 mg./100 ml. in nine steps. The results of a series of 72 such estimations on patients admitted to this centre have been compared with the corresponding values obtained by photometric assay in the laboratory. Good correlation was found, as shown in the figure; the standard error is indicated by dashed lines.

We conclude that the comparator method offers a speedy and reliable means of estimating levels of plasma salicylate in the ward side-room. This is an important criterion for instituting forced diuresis² in severe salicylate poisoning, and the comparator is now in routine use here.

The comparator disc (No. 5/41) is available from Tintometer Ltd., of Salisbury, Wiltshire; we are grateful to Mr. G. J. Chamberlin of this firm for arranging its manufacture.

—We are, etc.,

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Surgery for Perforated Duodenal Ulcer

SIR,—Mr. M. G. Machayya (19 October, p. 155) must be congratulated on his report describing the emergency treatment by vagotomy and pyloroplasty of unselected patients suffering from perforated duodenal ulcer. His patients have been exposed to the double risk of perforation and an elective operation *simultaneously*. The results eloquently testify to his skilful care of the patients. I sincerely hope that inexperienced surgical enthusiasts do not take up this treatment.

Mr. Machayya quotes Mr. J. A. Shepherd (9 March, p. 625) as saying that only 25% of patients remain symptom-free following simple suture of a perforation. He continues "most of the remaining 75% will have further surgery." What Mr. Shepherd's admirable article stated was "75% have persistent or recurrent trouble, and of these at least a third come to elective or to further emergency surgery within five years."

If I had a perforated duodenal ulcer I should be chagrined to have an irrevocable operation performed which carries its own immediate and long-term complications. I might belong to the 25% who have no further symptoms following simple suture, or the 50% who, despite getting further symptoms, do not qualify for surgery during the next five years. A fit young man already eligible for an elective operation, who perforates his duodenal ulcer, arrives quickly at hospital, and is treated by an experienced surgeon supported by his full team, may be a candidate for curative surgery at the time of dealing with the perforation, after careful assessment before and during the operation.

I deprecate operations upon unselected patients in case of a future eventuality. To perform vagotomy and pyloroplasty on every patient with a perforated duodenal ulcer in order to protect 25% of them from another operation within five years is illogical. To carry out such an operation as an emergency procedure seems to court disaster.—I am, etc.,

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R. M. KIRK.

Winter Epidemics

SIR,—It seems likely that an epidemic of influenza will reach this country during the coming winter. The King Edward's Hospital Fund will shortly issue a study of the influenza epidemic as it affected London hospitals last winter. A number of practical suggestions are put forward for consideration by hospitals in this report, which will be circulated to London hospitals early in November. These include the need for early discussions with the matron, the hospital administrator, and the geriatric services.

It is very desirable that medical committees should review their arrangements for such an epidemic and consider the recommendations in this report.—I am, etc.,

London S.E.1.

F. AVERY JONES.

'Flu Inoculation

SIR,—In the winter of 1957–8, when Asian 'flu was pandemic, my partners and I inoculated each other against it in the hope of avoiding simultaneous partner morbidity such as we had previously experienced. We are now coming again under pressure from