women throughout the world are exposed to incalculable risks.—I am, etc.,

House of Lords,
London S.W.1. EDITH SUMMERSKILL.

REFERENCES

- ¹ Beaconsfield, P., and Ginsburg, J., *Lancet*, 1968, 1, 592.
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Local Experience in Paediatric Relief

SIR,—We have been very heartened by the concern shown by our friends in Great Britain, America, and elsewhere for the starving children in the rebel-held territory of Nigeria, and your leading article (28 September, p. 753) emphasizes this point.

I must hasten to say, however, that paediatricians in Nigeria, albeit 13 of us, fear that the impression might be gained abroad that we do not share this concern for our brothers in the eastern states. This is particularly so when we note that paediatric teams are sent out to Nigeria without any of us being informed or invited to help with the various relief programmes. True, we cannot mount paediatric teams as elaborate as those suggested and described in your leading article, yet we do have some knowledge of local conditions which could be of value to any visiting paediatrician. Moreover, our undergraduates are taught, in their fourth year, to perform procedures such as lumbar puncture and the setting up of scalp vein infusion. Here again is a local source of medical manpower which could easily be used by these teams. Many of us have evolved or are evolving methods for administering treatment to large numbers of ill babies in outpatients or in the emergency room. Surely this knowledge must prove valuable to any visiting paediatrician to Nigeria.

The Paediatric Association of Nigeria has expressed its wish to the Federal Military Government to take part in any relief work that is being done in the eastern states of Nigeria. In the past, leaders and some members of the visiting paediatric teams have called on us in either Lagos or Ibadan for advice about the management of some local conditions—"instant tropical paediatrics". We have been very happy to teach them as much as we could in two to three hours, but this surely is not the best way to make use of the vast knowledge and experience available locally. We hope that in future our paediatric colleagues from abroad would make some effort to ensure that the local paediatricians in Nigeria are invited to partake in any of their plans in the eastern states of Nigeria for saving the lives of these unfortunate children.—I am, etc.,

O. RANSOME-KUTI,

President, Paediatric Association of Nigeria.

Department of Paediatrics,
College of Medicine of the
University of Lagos,
Lagos, Nigeria.

The Schweitzer Hospital

SIR,—On 19 October (p. 191) you kindly published my appeal for both a Land Rover and a locum surgeon for the Schweitzer Hospital. The first of many to apply was Mr. Frank Schweitzer, F.R.C.S., with his wife, a Guy's Hospital sister. He is actually

a distant relative, and one was thrilled with the prospect of a Schweitzer returning to Lambarené. But alas, after making all the arrangements, and with the willing consent of Guy's, we have been informed that he will not be granted a visa on account of the strained relations between Gabon and Great Britain over the Biafra question. And this, despite the fact that the hospital has offered a site for a camp of up to 500 refugee children whom the planes have evacuated after landing arms there. Thus do oil and power politics poison the springs of charity and descend like a noxious miasma over the swamps of tropical Africa. However, we could still provide a Land Rover if we really cared.—I am, etc.,

CLEMENT C. CHESTERMAN,
Chairman, Schweitzer Hospital Fund.

c/o The Leprosy Mission,
7 Bloomsbury Square,
London W.C.1.

Diarrhoea at the Olympics

SIR,—On my return from the Olympic Games in Mexico City my attention has been drawn to your leading article on (12 October, p. 69) diarrhoea at the Olympics. In this article you mention various preparations which have been used, with very unsatisfactory results, but do not mention whether any other measures as regards food or hygiene were observed.

With the British Olympic Team in Mexico City the following rules were observed:

- (1) Each member of the team took two tablets of Streptotriad (streptomycin sulphate; sulphadimidine; sulphadiazine; sulphathiazole) daily as a prophylactic.
- (2) No Mexican-type food was taken.
- (3) Salads and unpeeled fruit were avoided.
- (4) No food was taken other than that supplied in the Olympic village.
- (5) Bottles of hexachlorophane were provided for routine washing of hands after toilet purposes and before meals.
- (6) Every member of the team was instructed to report any abnormal looseness of the bowels, however slight, to the medical officers.

Out of a total number of 308 persons at risk our results showed the following: 18 cases complaining of slight looseness of the bowels lasting for one day, and which responded to one dose of Mist. Kaolin. Morph., and in which training was not interrupted; 9 cases of mild diarrhoea lasting for up to a maximum of two days, and in which training was not interrupted; 6 cases of rather more severe diarrhoea in which training had to be suspended for up to two days.

Diarrhoea is a very broad term, and I feel that only some classification, such as that above, gives any real meaning to figures produced. For the last three Olympic Games we have used Streptotriad as a prophylactic, and in no case has this had any ill effect either on performance or after ceasing to take it. While I agree that in Mexico City the cause of travellers' diarrhoea has never been satisfactorily established, I am sure that injudicious eating of hot, Mexican-type food is at least associated with it.

After the Games I compared our figures for diarrhoea with those of the U.S.A. and Australia, who took only a sulphur compound

tablet as a prophylactic. The incidence of diarrhoea in the teams from those countries was vastly in excess of those in the British team, and since we were all eating the same food in the same restaurant, and living under identical conditions, I feel that these results are of some significance.—I am, etc.,

J. RAYMOND OWEN,
Chief Medical Officer,
Great Britain's Olympic Team.
West Haddon,
Warwicks.

Fibrinogen and Fibrinogenuria

SIR,—Your excellent leading article (9 November, p. 341) on fibrinogen makes an omission about the possible loss of fibrinogen by the kidney in certain pathological conditions. I have demonstrated¹ that in rare cases of the nephrotic syndrome fibrinogen can be eliminated in the urine. This phenomenon was noted in 5 of 51 cases of different origin. The intensity of fibrinogenuria fluctuated in the examined samples between 0.040 and 0.16 mg./min.—that is, 0.0576–0.230 g./24 hours. In the same samples the amount of total proteinuria was always more than 4.0 g./24 hours. The fibrinogen clearance, often estimated, was two to ten times smaller than the total protein clearance.

In four of the five positive cases a marked decrease of the plasma fibrinogen was repeatedly noted (1.75–3.5 g./l.). Since the plasma fibrinogen is usually increased in the nephrotic syndrome, the noted diminution in these cases gives one more proof that the urinary loss was very significant and the main cause of the development of hypofibrinogen-aemia.—I am, etc.,

HIPPOCRATES YATZIDIS.

University of Athens School of
Medicine,
Athens, Greece.

REFERENCE

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Detecting Break in Insulation in
Negative Pacemaker Lead

SIR,—Workers in the cardiac pacemaker field may like to know of a method which can be used to establish that the insulation on the negative lead of a bipolar catheter has been ruptured.

We in Glasgow—as in other centres—have been monitoring pacemaker patients at two and three monthly intervals at weekly pacemaker clinics. Apart from clinical checks the pacemaker pulse is monitored using the standard E.C.G. limb leads (I, II, and III) which enables the orientation of the pacemaker electric vector to be drawn in the frontal plane. The exact orientation cannot be obtained by this simple method, since Einthoven's hypothesis is not satisfied. Nevertheless the general direction of the electric vector can be obtained: successive measurements on the same patient give vectors spread over a relatively small angle.

If the insulation on the negative lead breaks the patient may still be paced, since current will flow between the bipolar electrodes and between the indifferent electrode and the positive electrode. In these circumstances the resultant electric vector will be displaced through a large angle (45°–180°) anticlockwise. This has been observed in two patients in whom the insulation on the

negative lead ruptured near the point of entry of the catheter into the right external jugular vein.

A - August 1967) Both before insulation broke
B - November 1967)
C - January 1968)
D - April 1968) After insulation broke
E - August 1968)

If the insulation on the positive lead breaks then even if the "best" conditions obtain—that is, there is a break in the insulation in the "vertical" part of the catheter—the change in the direction of the resultant electric vector may be masked by the errors inherent in this simple approach to the problem.—We are, etc.,

G. D. GREEN.

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Bio-Engineering,
Glasgow.

Royal Infirmary,
Glasgow C.4.

W. FORBES.

Royal Infirmary,
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W. H. BAIN.

Southern General Hospital,
Glasgow S.W.1.

G. B. SHAW.

Diazepam in Tetanus

SIR,—The establishment of regional centres to treat cases of tetanus has frequently led to long ambulance journeys from the periphery to such centres. For those who have to escort such patients I would like to report the use of diazepam to provide sedation and abolition of tetanus spasms.^{1,2} Two patients with tetanus have been transported 25 miles (40 km.) under this regimen with no trouble.

The first was a male, aged 64, with early tetanus—lockjaw and pyrexia. Sudden noise provoked spasm, but at rest there was no opisthotonos. A slow infusion of intravenous diazepam was made until he was sedated (20 mg.). His transfer was easily completed. The second case was a 78-year-old male with advanced tetanus and constant opisthotonos. Diazepam 17 mg. was injected as before, with complete abolition of spasm and induction of a light sleep. Transfer then proceeded, with only one small spasm on the journey.

In both cases the intravenous cannula was left in situ, and facilities for immediate paralysis and intubation were taken in the ambulance, as well as suction and insufflation apparatus. This regimen would appear to be a considerable advance in the transfer of these patients, and is a logical extension of the role of diazepam in tetanus as shown in recent papers.³⁻⁵—I am, etc.,

A. K. BACON.

Salisbury General Hospital,
Salisbury, Wilts.

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- Hendrickse, R. G., and Sherman, P. M., *Brit. med. J.*, 1966, 2, 860.
- O'Donohoe, N. V., *J. Irish med. Ass.*, 1967, 60, 89.
- Lockwood, W. R., and Allison, F., *J. Miss. med. Ass.*, 1967, 8, 66.

Cancer of the Breast

SIR,—At the end of his review of *Prognostic Factors in Breast Cancer* (9 November, p. 376) Mr. R. W. Raven briefly indicates his own views on public education and mass screening in breast cancer. He might, however, have pointed out that these views differ from those given in the work being reviewed. Thus Dr. J. Wakefield, in his important paper on "Methods of Public Education," in which he examines fully and critically the various screening procedures for carcinoma of the breast (pp. 235-241), concludes that at present the correct objective is to educate women to report to their doctors as soon as they notice anything wrong in the breasts.—I am, etc.,

London W.1.

DAVID PATEY.

Antiseptics in Treatment of Burns

SIR,—The prevention of infections is the primary aim in the management of the local lesion in a burn or scald. The multiplicity of methods in use is a good indication that none is completely satisfactory. The use of 0.5% chlorhexidine (1,6-di-(4-chlorophenyl)-diguano) hexane; Hibitane) solution, as a local dressing for burns and scalds was described by Grant and Findlay in 1957.¹ The lesions were covered with gauze swabs soaked in 0.5% Hibitane solution. The dressings were changed twice daily, but the gauze adherent to the lesion was undisturbed, and this gauze was resoaked with the Hibitane solution.

This method has been used successfully during the last 11 years in the surgical paediatric unit, Stobhill General Hospital, Glasgow. One hundred and forty-eight patients were treated in this way, and there was clinical evidence of infection in only 14 (9.8%). A further 19 patients were treated with Aserbine lotion (a solution containing the malic acid ester of propylene glycol 1.05%, malic acid 1.55%, benzoic acid 0.15%, salicylic acid 0.03%), and 29 patients were treated with Aserbine cream (a cream containing the malic acid ester of propylene glycol 0.16%, malic acid 0.25%, benzoic acid 0.025%, salicylic acid 0.005%). The numbers are small and the lesions are so varied in extent, degree, and site that no attempt can be made to compare the methods statistically. Four (21%) of the 19 patients treated with Aserbine lotion and seven (24%) of the 29 patients treated with Aserbine cream developed clinical evidence of infection.

Most of the patients in the series are in the "toddler" age group (mean age 2 years 7 months), and the exposure method at this age requires the use of restrainers. Because of this, the method was used to treat burns of face and buttocks only, where dressings have obvious disadvantages. Twenty-seven were treated in this way and only one developed evidence of infection, but they were a specially selected group who all suffered from superficial burns involving a small surface area.

The rationale of antiseptic methods in the treatment of patients with burns in a general ward is that contamination of the environment is accepted, but by frequent application

of antiseptics to the dressings the organisms are prevented from getting access to the lesions. Until a non-toxic antibiotic is discovered to which all common contaminants of a burn are sensitive, the antiseptic method would seem to be the one of choice. In this series the infection rate was higher with Aserbine than with Hibitane, though the numbers treated were too small to make the findings significant. Sloughs, however, separated more quickly with Aserbine, but the method was discontinued because the application of the lotion caused considerable stinging. Two patients who were treated with Hibitane lotion developed skin reactions, but the reaction was not severe enough to require the method to be discontinued.

The use of Aserbine cream was discontinued because of the higher rate of infection. This may have been because the dressings were changed once a day only, and the antibacterial properties of the Aserbine were not retained for that length of time. The scraping off and the reapplication of cream to the lesion more often was not considered practicable. The method using Hibitane solution was reintroduced following the trial with Aserbine lotion and cream, and continues to give what are considered to be satisfactory results.—I am, etc.,

Stobhill General Hospital,
Glasgow N.1.

J. C. GRANT.

REFERENCE

- Grant, J. C., and Findlay, J. C., *Lancet*, 1957, 1, 862.

Bladder Distension and Leg Oedema

SIR,—The account by Mr. Haziq-ul-Yaqin (9 November, p. 369) of a patient who suffered from oedema of the lower limbs caused by a distended bladder interested me. All experienced urologists see occasional cases of gross bladder distension causing oedema of the lower limbs by pressure on the iliac veins. The paucity of such reports in the literature is no real measure of their frequency. As in the case reported, the remarkable feature is how distended the bladder can be without the patient's or even his general practitioner's knowledge. The commonest pelvic swelling in a male is a distended bladder, and in a female a pregnant uterus: a clinical rule which is now so frequently forgotten, often with disastrous results. It is difficult to believe that such patients are sometimes explored as cases of pelvic tumour.

The mechanism of the oedema in this case is doubtful. We are told the bladder is atonic. If the pressure in the bladder is low it is difficult to understand how it can cause obstruction of the venous return, although no doubt it may cause a lymphatic obstruction. Everyone interested in the treatment of vesical atony remaining after the cure of bladder neck obstruction will be interested in the excellent results reported after bladder capacity reduction operation recently devised by Hamilton Stewart,¹ although we would like to know a little more about the final state, particularly how much residual urine remains.—I am, etc.,

Department of Urology,
Manchester Royal
Infirmary.

THOMAS MOORE.

REFERENCE

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