known possible causes of atelectasis and complications representing a list of possible causes, though I attribute one reference under discussion to authors I should not have—namely, Kaneko in Prys-Roberts.

As to a mysterious further 116 patients. This is an error in editing on my part, and of course should have read 297 patients, being divided into a control group of 181 not given bicarbonate together with 116 receiving bicarbonate as stated in the summary. Fifty-two patients received halothane, but the importance of this is in the Table, which shows that these patients did not have a thiopentone induction unlike the other 235, so I thought it reasonable to separate them. The confusion between Venus and Astrup bicarbonate is only apparent because of the positioning of the table.

In conclusion, I should like to repeat how grateful I am for the criticisms of Drs. Conway and Leigh, and I hope this letter has helped to elucidate my paper for them and clear up some of their queries.—I am, etc.,

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Hepatic Carcinoma and Haemoperitoneum

SIR,—Dr. Marjorie L. Penwill's letter (17 October, p. 181) makes it sound as if haemoperitoneum in patients with malignant hepatoma is uncommon. In a series of 189 patients with primary hepatocellular carcinoma seen by us six patients presented as haemoperitoneum. Many of the patients with acute intrahepatic haemorrhage were not well enough to be transferred to us for treatment, so that the six patients mentioned form a very conservative estimate of the incidence of this presentation of the disease.

At post-mortem examination 15% of the patients treated by us were shown to have died of haemoperitoneum.—We are, etc.,

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Republic of South Africa.

Clofibrate and the Fibrinolytic System

SIR,—I agree with Dr. G. R. Fearnley (10 October, p. 114) that the action of clofibrate on fibrinolysis described in "Today's Drugs" (12 September, p. 632) requires qualification, but I do not agree with his comments.

A number of reports indicate that Atromid (clofibrate plus androsterone) or Atromid-S (clofibrate alone) increases fibrinolytic activity¹⁻⁵ and reduces raised levels of plasma fibrinogen^{3,4,6-8} in patients with ischaemic heart disease and hypercholesterolaemia. Both of these effects appear to be persistent. Statistically significant changes were apparent over a 9-month period of observation in patients treated with Atromid-S and over a 17-month period of observation in patients treated with Atromid.⁴ We have noted, however, that if an infective or thrombolytic episode occurs in patients receiving these preparations then

the temporary rise in fibrinogen and depression of fibrinolysis which results from these conditions still occurs. Similar observations were noted if patients receiving Atromid-S were subjected to surgical procedures. The pathways causing changes in these parameters following such stimuli probably differ from those producing changes in the chronic situation.⁹

As mentioned in "Today's Drugs" Atromid-S has no effect in reducing plasma fibrinogen or increasing fibrinolytic activity when these are in the normal range before treatment is instituted. This probably accounts for the results obtained by Sweet *et al.*,¹⁰ who obtained no effect on fibrinolysis or plasma fibrinogen levels in their patients treated with this preparation.

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REFERENCES

- 1 Srivastava, S. C., Smith, M. J., and Dewar, H. A., *Journal of Atherosclerosis Research*, 1963, 3, 640.
- 2 Hocking, E. D., Chakrabarti, R., Evans, J., and Fearnley, G. R., *Journal of Atherosclerosis Research*, 1967, 7, 121.
- 3 Gajewski, J., Skorykow, A., Ciszwicka-Sznajderman, M., Ignatowska, H., and Sznajderman, M., *Polskie Archiwum Medycyny Wewnętrznej*, 1964, 34, 1647.
- 4 Cotton, R. C., and Wade, E. G., *Lancet*, 1969, 1, 263.
- 5 Frandoli, G., Gibelli, A., and Giarola, P., *Clinica Terapeutica*, 1966, 38, 27.
- 6 Cotton, R. C., and Wade, E. G., *Journal of Atherosclerosis Research*, 1966, 6, 98.
- 7 Chakrabarti, R., Fearnley, G. R., and Evans, J. F., *Lancet*, 1968, 2, 1007.
- 8 Ogston, C. M., Ogston, D., and McAndrew, G. M., *Current Therapeutic Research*, 1965, 7, 437.
- 9 Thorp, J. M., Cotton, R. C., and Oliver, M. F., *Progress in Biochemical Pharmacology*, 1968, 4, 611.
- 10 Sweet, B., Rifkind, B. M., McNicol, G. P., and Gale, M., *Journal of Atherosclerosis Research* 1965, 5, 347.

Problems of Rectal Prolapse

SIR,—In the leading article on the management of prolapse of the rectum (14 November, p. 381) I was surprised to see no reference to the anal stimulator described by Hopkinson and Lightwood.¹

In my experience this device has become the treatment of choice in the first instance for all patients suffering from rectal prolapse. When it is effective it controls both the prolapse and the incontinence that goes with it. It is a very simple treatment and inexpensive. Even if it is not successful it is difficult to see how it could ever be harmful. Since this invention was described I have not had to subject any patient to surgery for rectal prolapse.

I regard the stimulator as a most excellent device and feel that it should be brought to the attention of your readers.—I am, etc.,

PETER H. LORD.

London W.1.

REFERENCE

- 1 Hopkinson, B. R., and Lightwood, R., *Lancet*, 1966, 1, 297.

Problems of Rectal Prolapse

SIR,—I would take issue with the writer of your leading article on rectal prolapse (14 November, p. 381) on two counts. In the first place, the evidence that rectal prolapse is really an intussusception starting at the

rectosigmoid junction is certainly not conclusive. A fundamental feature of any intussusception is that the precise site of origin of the intussusception becomes the leading point of the intussusception and remains so as the condition advances. In rectal prolapse in children, on the other hand, as the condition advances from a prolapse of about 1 cm. to perhaps 5 or 6 cm. the leading point becomes progressively a more proximal part of the rectum.

Secondly, I think a review of the surgical management of rectal prolapse is incomplete without reference to the injection of a sclerosing solution, such as saturated saline, into the pararectal tissues.¹ While it remains true that most cases of rectal prolapse in children settle down spontaneously with simple conservative measures such as strapping, there is undoubtedly a group which needs something more, and I would strongly recommend the injection of saturated saline into the pararectal tissues before proceeding to other surgical methods. The precise site of injection is of fundamental importance. A lumbar puncture needle is introduced about 5 cm. from the anal margin and is passed upwards until it can be felt by an index finger in the rectum to lie very close to the rectal wall. About 5 ml. of saturated saline is injected at each side and also posteriorly, and it is of the utmost importance to make sure that the injection does not raise a bleb under the finger which might lead to necrosis of the overlying mucosa. If such a bleb is felt, the needle is withdrawn slightly and the bleb massaged away at once before injecting more saline slightly further away from the finger in the rectum.—I am, etc.,

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REFERENCE

- 1 Kay, N. R. M., and Zachary, R. B., *Journal of Pediatric Surgery*, 1970, 5, 334.

Estimation of Immunoglobulin E (IgE)

SIR,—It is now established that reaginic antibodies belong to the class of immunoglobulins designated as IgE. These antibodies become fixed to the surface of mast cells in various tissues. When the allergen becomes attached to the antibodies, histamine and other amines are liberated from the mast cells giving rise to the allergic reaction (Type I allergy).

Furthermore, these antibodies have been characterized as being heat-labile, non-precipitating, and non-complement binding. Because of their non-precipitating nature several methods have been described to detect them: inhibition of the Prausnitz-Kustner reaction,¹ the red cell-linked-antigen-antiglobulin-reaction,² radioactive methods of Rowe³ and Wide *et al.*⁴

Micromethods of diffusion in agar gels are now routinely used for quantitative measurements of immunoglobulins, and we have recently developed a technique of immunodiffusion in agar gel which demonstrates that IgE forms a visible precipitate (Fig.) given certain optimum conditions, which may be used as a quantitative measurement of IgE levels.—We are, etc.,

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REFERENCES

- 1 Stanworth, D. R., Humphrey, J. H., Bennich, H., and Johansson, S. G. O., *Lancet*, 1967, 2, 330.
- 2 Coombs, R. R. A., *et al. Lancet*, 1968, 1, 1115.
- 3 Rowe, D. S., *Bulletin of the World Health Organization*, 1969, 40, 613.
- 4 Wide, L., Bennich, H., and Johansson, S. G. O., *Lancet*, 1967, 2, 1105.

Nifuratel (Magmilor) in the Treatment of Trichomoniasis

SIR,—Contrasting opinions on the relative value of nifuratel and metronidazole have recently been expressed by Drs. B. A. Evans and R. D. Catterall (9 May, p. 335).

In my personal experience nifuratel produces higher cure rates than metronidazole, is effective in cases resistant to this drug, and is better tolerated.^{1,2} Other Polish authors³ have expressed similar opinions on nifuratel as compared with metronidazole.

At the congresses of the Polish Society of Parasitology (Katowice 1967 and Zakopane 1968) various clinicians spoke of nifuratel as the drug of choice in the treatment of vulvovaginal infections because of its activity against *Trichomonas*, *Candida*, and bacteria.—I am, etc.,

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REFERENCES

- 1 Baron, A., and Gorzedowska, E., *Rivista d'Obstetrica e Ginecologia Pratica*, 1968, 10, 946.
- 2 Baron, A., *Minerva Ginecologica*, 1970, 22, 269.
- 3 Kurnatowska, A., and Bartoszewski, A., Ninth Congress of the Polish Society of Parasitology, Lublin, 1967.

Other Side of Table Mountain

SIR,—As an ex-colleague I was not anxious to join the correspondence that followed Professor W. P. U. Jackson's Personal View (1 August, p. 281). I feel the issues have become confused and would like to make two points.

No one would deny the value of the work done by Professor Jackson in South Africa—this is not the issue, and those who sprang to his defence are merely camouflaging the facts. Many people here took exception to the fact that he chose to introduce a political "plug" into an otherwise entertainingly-written article. If this was his "Personal

View," he must not object when others express their personal views.

I understand the resentment some South Africans feel when they encounter criticism from abroad, especially when it stems from expatriates. I even sympathize with those who feel they are making a real, positive contribution by staying there to help alleviate non-White suffering. Their judgement of their ex-compatriots should be tempered by the realization that some of them left by force of Government action, others because they could no longer continue without protest to provide patchwork medical care for diseases which should have been prevented. Malnutrition and infectious diseases like tuberculosis, tetanus, smallpox, and typhoid would largely be eliminated if true concern was shown by the Government for the health of *all* its people. The fact that these diseases are so prevalent among non-Whites is a reflection of political and economic discrimination.

Those who remain in Southern Africa have this fact thrust in front of their eyes every day. If they cannot—or will not—protest from within, they must accept that others will make the truth known from without.—I am, etc.,

R. HOFFENBERG.

Great Gaddesden,
Herts.

Race and Commonwealth

SIR,—Born in Ireland, reared with an abhorrence of oppression, trained in the liberal medical world of London, and having spent 20 years practising medicine in that tradition among both black and white patients in Rhodesia, I confess to occasional inner conflicts.

Four recent contributions to the *B.M.J.* point the marked differences of opinion which occur when medicine becomes mixed with politics. I refer to Professor W. P. U. Jackson's Personal View (1 August, p. 281), the ill-informed criticism of this view by Dr. Joyce E. Leeson (12 September, p. 648), the reasoned statement of the true position by Dr. G. W. Gale (19 September, p. 705), and the excellent short letter from Dr. V. Russell (19 September, p. 706).

I believe that Dr. Russell's letter expresses the views and hopes of the majority of my colleagues in both Rhodesia and the Republic of South Africa. You, Sir, used the phrase "Civis Medicus Sum" in a different connotation some time ago, but in its Pauline sense, and in parallel with the Hippocratic oath, surely this should be the guiding principle of all doctors and medical associations, whether British, Commonwealth, or World, whether one's skin is pigmented or not.

It is futile for those who have not lived with a problem and seen the practical difficulties of solving it to propound simple and apparently obvious solutions which just would not work. There is, on a practical level, as much apartheid in Georgia and Mississippi, in Birmingham and Notting Hill, as there is in Africa south of the Zambezi. And the problems of Northern Ireland show that colour is not the most important factor. It is therefore just as foolish for me to say how those problems must be solved as for the critics of Southern Africa to tell us here how to solve ours.

To all those who criticize South Africa, I

say "come and see for yourselves." Here in Rhodesia all doctors in salaried service receive the same rates of pay for their particular grade whatever their nationality. This applies also to nursing staff and to many other professions and trades. Membership of the Rhodesian Medical Association is open to all resident qualified medical practitioners, whatever their race.

While the shortage of doctors here is not so great as in many other countries there is plenty of room for our critics to come and work among us, to see and feel our problems, and to help us in a practical way to solve them. Such action would bring much greater results much more quickly than the sterile policy of "medical sanctions."—I am, etc.,

WILLIAM HOUSTON.

Bulawayo,
Rhodesia.

Progress in Physiotherapy

SIR,—May I draw your attention to a mistake in your interesting leading article entitled "Progress in Physiotherapy" (14 November, p. 383) in which it is said that the Chartered Society supervises training, examination, and registration. Registration, in fact, is the responsibility of the Physiotherapists Board set up under the Professions Supplementary to Medicine Act, 1960. The Board, which consists of physiotherapists, doctors, an educationalist, and a physicist, is a statutory body completely independent of the Chartered Society.

Among its other duties, the Board must approve courses of training and examinations and schools where the courses are conducted. For this purpose it can and does visit schools to ensure that they are properly organized and equipped for the purpose. The Board has approved for registration the qualifications of the Chartered Society and many other qualifications granted outside the United Kingdom.

This work is done under the general co-ordination of the Council for the Professions. The Council has just published a report on the remedial professions which, with a report published by the Board in 1968, covers many of the matters referred to in your article.—I am, etc.,

J. S. TAPSFIELD,

Registrar,
Council for Professions
Supplementary to Medicine.

London S.E.1.

SIR,—The writer in your leading article on this subject (14 November, p. 383) rightly deplores the shortage of physiotherapists. The back pages of *Physiotherapy* prove his point; for there are always far more vacancies advertised than graduates to fill them. But I should like to remind readers of Sir Reginald Watson Jones's cogent letter in *The Times* in 1962.¹ What was needed, so he maintained, was far fewer physiotherapists, but better