boy of average height during a current survey; the fact remains that this boy was of average height at the time of our survey. Had we concentrated on boys of above average height (as is often the case in studies involving XYY individuals), this boy would not have been spotted.

(2) As our survey is still in progress we deliberately did not extrapolate his height for two reasons: (a) the boy is still under observation and we are hoping to be able to follow his growth as long as possible; (b) we supplied the two measurements in our paper to enable interested readers to do their own extrapolating.—We are, etc.,

J. KAHN

Institute of Psychiatry,
London S.E.5

T. COATES

Reed International Ltd.,
Larkfield, Kent

Starch Granulomatosis of the Peritoneum

SIR,—I was interested to read the article by Mr. Julian Neely and Dr. J. Douglas Davies (11 September, p. 625) on starch granulomatosis of the peritoneum and agree that this condition is much more common than is generally realized. I have seen two such cases during the last year. The first was found to have multiple peritoneal nodules at laparotomy after a previous resection of colon. The second was an incidental finding on the surface of an oophorectomy specimen, this patient having had a laparotomy some months before.

While the diagnosis, once thought of, is easy to make in those cases in which there are well marked granulomata with giant cells incorporating starch grains, this is not always so. There is considerable difficulty in distinguishing between contamination of pre-existing adhesions and true starch-induced granulomata. Contamination by glove powder of routine biopsy material is very common. In a series of 100 appendices and 200 fallopian tubes that Dr. Laverty and I have been studying we found contamination in 86%. We believe this to have occurred at operation as the starch is often enmeshed within fibrin, but the possibility of the contamination from the pathologist's gloves during the "cut up" of specimens should be remembered.

During our study of these cases we have come across several lesions in previously non-operated patients (both male and female) which we believe to resemble those that others¹ have described as starch granu-

lomata. These consisted of inflammatory cells, mostly mononuclear, in a fibrous or fibrinous background with starch granules showing under polarized light. No giant cells were present. An example is shown in the Figure taken under polarized light. With the aid of collagen and fibrin stains one can see that this is not a starch granuloma but a folded fibrous adhesion with fibrin enmeshed starch granules on its surface.

Except in those cases such as Mr. Neely and Dr. Davies have described, in which there are clear foreign body giant cells with starch granules, care should be taken in ascribing granulomatous lesions in patients who have had previous surgery to starch glove powder rather than infection or surgical trauma.—I am, etc.,

G. R. SWINGLER

Department of Pathology,
St. Mary's Hospital,
Manchester

1 Paine, C. G., and Smith, P., *Journal of Clinical Pathology*, 1957, 10, 51.

Nitroprusside Revisited

SIR,—Though we agree that sodium nitroprusside is a simple, speedy, and effective hypotensive agent, especially of value when other agents have failed, we do not think it is necessarily as innocuous as Dr. M. K. Mani claims (14 August, p. 407).

We have investigated the degradation of nitroprusside both in vivo and in vitro and have shown that the formation of cyanide and thence thiocyanate from nitroprusside occurs more quickly than earlier studies using less sensitive techniques suggested.¹ Even though the pharmacological effects of nitroprusside may not be due to cyanide per se,² the release of cyanide may constitute a hazard to certain patients who are especially vulnerable to its effects—namely, B₁₂-deficient,³ those with hereditary optic atrophy,⁴ and the malnourished.^{6,7}

The results of our studies will be published shortly.—We are, etc.,

J. WILSON

M.R.C. Clinical Genetics Research Unit,
Institute of Child Health and Institute of Neurology,
London W.C.1

C. J. VESEY

M.R.C. Clinical Genetics Research Unit,
National Hospital,
London W.C.1

P. V. COLE

St. Bartholomew's Hospital,
London E.C.1

1 Hill, H. E., *Australian Chemical Institute Journal and Proceedings*, 1942, 9, 89.

2 Page, I. H., Corcoran, A. C., Dustan, H. P., and Koppányi, T., *Circulation*, 1955, 11, 188.

3 Wilson, J., and Langman, M. J. S., *Nature (London)*, 1966, 212, 787.

4 Wilson, J., *Clinical Science*, 1965, 29, 505.

5 Wilson, J., Linnell, J. C., and Matthews, D. M., *Lancet*, 1971, 1, 259.

6 Monekosso, G. L., and Wilson, J., *Lancet*, 1966, 1, 1062.

7 Osuntokun, B. O., Monekosso, G. L., and Wilson, J., *British Medical Journal*, 1969, 1, 547.

Predicting Fetal Maturity

SIR,—It would be a pity if the conclusions of Miss Rosemary A. Underhill and others (25 September, p. 736) led readers to conclude that useful estimates of the length of gestation cannot be made from examination of amniotic fluid.

They based their conclusions on the appearance of amniotic fluid cells stained with

Nile blue sulphate and "in some samples" also on the determination of creatinine by an unspecified method for which a paper from this unit¹ is quoted as a basis. We have subsequently pointed out² that the laboratory method of measuring creatinine is of considerable importance; and while staining with Nile blue sulphate, introduced by Kittrich in 1963,³ was an important historical landmark, it is now generally recognized as of no value to precise diagnosis.

We recently described a scoring system based on the appearance of cells stained with haematoxylin and eosin or with Papanicolaou's stain, and the "true" creatinine and urea contents of amniotic fluid and maternal plasma.⁴ This system enabled length of gestation to be predicted with an accuracy that is certainly of clinical value. Comparisons are difficult since Miss Underhill and colleagues predicted the expected date of confinement (E.D.C.) in cases of unknown gestational age, whereas we estimated length of gestation. It would seem, however, that our scoring system gives results at least as useful as those reported for ultrasound; moreover it can be used with a single sample taken at any time after 30 weeks' gestation and does not need sophisticated equipment.

And it is perhaps relevant to ask whether a predicted E.D.C. is what the obstetrician wants to know. Is it helpful, for example, in deciding whether or not to deliver a woman, to know that she would deliver normally in eight weeks? Is she eight weeks from 38 weeks or 42 weeks? It makes a difference.—I am, etc.,

T. LIND

M.R.C. Reproduction and Growth Unit,
Princess Mary Maternity Hospital,
Newcastle upon Tyne

1 Lind, T., Parkin, F. M., and Cheyne, G. A., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1969, 76, 673.

2 Lind, T., Billewicz, W. Z., and Cheyne, G. A., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1971, 78, 505.

3 Kittrich, M., *Geburtshilfe und Frauenheilkunde*, 1963, 23, 156.

4 Lind, T. and Billewicz, W. Z., *British Journal of Hospital Medicine*, 1971, 5, 681.

Bullous Lesions in Poisoning

SIR,—I was interested to read Dr. C. M. Ridley's recent report (3 July, p. 28) and the subsequent correspondence (7 August, pp. 371, 372). In my original paper¹ we merely stated that these blisters were "sufficiently characteristic to suggest strongly the possibility of barbiturate poisoning." Carbon monoxide had been previously implicated and since then a number of other drugs (methadone, hydrocodone bitartrate, meprobamate, imipramine, and glutethimide) have occasionally been reported as causing blisters. It is still the experience, however, of the Regional Poisoning Treatment Centre, the Royal Infirmary, Edinburgh, with over 1,000 admissions annually, that the drugs which most frequently produce blisters are the barbiturates despite the declining incidence of overdosage from this drug (H. J. S. Matthew, personal communication).

The mode of production of these fascinating blisters in drug-induced coma is still open to speculation, as I indicated in a recent review on the skin in acute barbiturate poisoning.² While I would agree that pressure and possibly hypoxia owing to circulatory changes are factors in the production of these blisters, I do not think as