nodes. This may well link up with the work done by Hawley *et al.*[2] and Paile[5] suggesting that some patients may do better because their cellular immune mechanisms are putting up resistance to the primary, and they may do well even if some metastases have reached a few local nodes.

This is an important problem, because the surgeon at laparotomy who finds some palpable nodes near a resectable gastric tumour may well decide against radical local dissection on the basis of an apparently hopeless prognosis ("glandular metastases"). My study showed that where surgeons reported "malignant glands present," the histological findings in no less than 1:3 patients were of OX or LTH status (and therefore a better prognosis). In other words, there are two reasons to continue with radical lymphatic surgery, even with palpable nodes. Firstly, they may be benign, and secondly, they may represent the minimal invasion and quite good prognosis situation. For those who can stand awful doggerel this may be summarized:

"All that bulge are not maligne,
Even be some so, do not pyne."

May I also point out the fact that early diagnosis of gastric cancer, and greatly improved results in treatment, have been taken a stage further by the use of gastric cytology, with or without fibrescope collecting methods.[6 7]—I am, etc.,

E. G. CANTRELL

Medical Faculty,
University of Southampton

1 Pygott, F., *Gut*, 1964, **5**, 118.
2 Hawley, P. R., Westerholm, P., Morson, B. C., *British Journal of Surgery*, 1970, **57**, 877.
3 Pack, G. T., McNeer, G., *Surgery*, 1948, **24**, 769.
4 Cantrell, E. G., *British Journal of Surgery*, 1971, **58**, 384.
5 Paile, A., *Annales Chirurgiae et Gynaecologiae Fenniae*, 1971, **60**, Suppl. 175.
6 Cantrell, E. G., *Quarterly Journal of Medicine*, 1971, **40**, 239.
7 Kasugai, T., *Gastroenterology*, 1970, **58**, 429.

Antileprosy Drugs

SIR,—In "Today's Drugs" (17 July, p. 174) it is mentioned that it is doubtful if psychosis can be accepted as a toxic effect of dapsone. W. H. Jopling, to whom this statement is attributed,[1] was not in on the early treatment with dapsone in which high dosage was given to large numbers.

In 1950 I was in charge of Oji River Leprosarium, Nigeria. We treated all 15,000 patients with hydnocarpus oil and scarcely ever had any mental trouble. Within six months we changed the 1,800 settlement and 8,000 of the clinic patients to dapsone. Having been warned by the initial toxicity in a much smaller series under Dr. J. Lowe at Uzuakoli receiving a dose of 300 mg/day (1,800 mg/wk), we adopted a dose of 200 mg/day (1,200 mg/wk) in the settlement and 400 mg twice weekly in the clinics. Our idea of the lower dose in the clinics together with a slower induction was to minimize the serious reactions where fewer and less skilled staff were able to cope with the consequences.

We also induced treatment more slowly than at Uzuakoli (12 weeks instead of six weeks to reach the maximum), but still we were faced with many cases of acute psychosis with violence, delusions, and visual and auditory hallucinations together with two suicides within the first few months. Most of these were in the settlement where we had a higher dose and more rapid induction, so we soon changed our treatment to twice weekly, lowered the maximum, and induced more slowly. In addition, we were alerted to early signs of mental disturbance and took immediate action, thus reducing the rate of psychotic and other drug reactions to a much lower figure.

Dr. Jopling started treatment on much smaller numbers, used lower dosage, and increased more slowly. Modern low dosage treatment must also contribute to minimize this complication.

There was no statistically organized test but I believe the sudden outcrop of psychosis on dapsone treatment can be explained on no other hypothesis.—I am, etc.,

ARTHUR S. GARRETT

Reepham,
Norfolk

1 Joplin, W. H., *Handbook of Leprosy*, London, Heinemann, 1971.

Blood Flow in Ischaemic Feet

SIR,—We would like to respond to one or two points which arise in the letter from Dr. V. C. Roberts and others (9 October, p. 114) commenting on our recently published findings (24 July, p. 220).

They would doubtless agree that there is not necessarily a discrepancy between their observations in atherosclerotic subjects of a lower than normal total limb perfusion as measured in the great vessels and our observations of a higher than normal resting foot blood flow. There may well be a fundamental difference between proximal and peripheral perfusion under these pathological conditions. Our findings and those of Yao[1] indicate that there is a low systolic blood pressure and peripheral resistance in apparently ischaemic feet and therefore the level of femoral artery or vein blood flow is not necessarily a reliable indication of the level of foot blood flow in atherosclerotic subjects. There may, of course, be a simpler explanation for the difference between our findings and those of Dr. Roberts. Our measurements were made in controlled resting conditions where the normal exposed foot vasoconstricts in response to room temperature around 22°C. There is no information about environmental conditions in Dr. Roberts's letter and, therefore, it is difficult to comment on the relative significance of their observations. However, it is certain that both anaesthesia and warm operating theatre conditions would have completely altered our results.—We are, etc.,

A. J. MCEWAN
I. MCA. LEDINGHAM

University of Glasgow,
Department of Surgery,
Western Infirmary,
Glasgow W.1

1 Yao, S. T., *British Journal of Surgery*, 1970, 57, 761.

Predicting Fetal Maturity

SIR,—In their article (25 September, p. 736) Dr. Rosemary A. Underhill and others state that liquor studies were inexact when compared with ultrasound cephalometry and radiology. This is unfortunate. The scoring by Brosens and Gordon[1] should have attempted a two-week interval in the significant 34-38 weeks period of gestation. Had this been practised, liquor studies would have probably fared better by comparison. Ultrasound studies are more useful in the early stages of pregnancy and liquor studies in the last 6-8 weeks, when more critical decisions are imposed upon the obstetrician.

More recent experience with cytology[2-4] does suggest a better scoring system can be evaluated by utilizing not only the percentage of orange-staining cells but also the size of clusters, the presence of turbidity and debris, the existence of orange-staining globules, and unstained flakes. Not taking these into account may be responsible for certain spurious readings. As in other investigations, there is a tendency to give them a percentage of accuracy rating which may only reflect the need to improve the technique or interpretation thereof. We feel that in practice the clinician may utilize with benefit the augmented information resulting from a combination of investigations.—We are, etc.,

O. A. N. HUSAIN

Department of Cytology,

L. SINCLAIR

Department of Paediatrics,
St. Stephen's Hospital,
London S.W.10

1 Brosens, I., and Gordon, H., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1966, **73**, 88.
2 Sharma, S. D., and Trussell, R. R., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, **77**, 215.
3 Parkin, F. M., Lind, T., and Cheyne, G. A., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1969, **76**, 673.
4 Husain, O. A. N., and Sinclair, L., *Proceedings of the Royal Society of Medicine*, 1971, in press.

Fingerprint Changes in Dermatitis Herpetiformis

SIR,—Dr. T. J. David and colleagues (5 December 1970, p. 594) in a study mainly in adults reported the common occurrence of epidermal atrophy to actual loss of fingerprint patterns occurring on finger digits in coeliac disease, though one of us (Dr. J. Verbov, 2 January, p. 48) advised caution in interpretation of such fingerprint changes and Dr. W. M. McCrae and colleagues (10 July, p. 109) did not find ridge atrophy in six children with untreated coeliac disease.

The occurrence of jejunal mucosal abnormalities in dermatitis herpetiformis was first reported by Marks *et al.*,[1] and Shuster and Marks[2] found from published studies that two-thirds of patients with dermatitis herpetiformis have the enteropathy (coeliac syndrome) and in some cases there is intestinal malabsorption. More recently, Brow *et al.*,[3] using a multiple biopsy technique, have found the enteropathy to be almost invariably present. The enteropathy usually responds to a gluten-free diet.

Fingerprint changes in dermatitis herpetiformis are obviously of interest in view of the above and we report some preliminary findings. So far, fingers and fingerprints have been examined in 37 patients with dermatitis herpetiformis (12 women and 25 men). The age range of patients was 21-73 years and the mean age was 47·3 years. Intentionally, patients have been examined and prints analysed without prior knowledge of any jejunal biopsy findings. Minor degrees of ridge flattening with some white lines in prints were common, but did not appear to