is 2:1 is either very naive or hypocritical. I think they ought to make a proper analysis in terms of work loads and available persons, trained or otherwise; that ratio stuff is just the bureaucrat's trick to bewilder innocent nurses.

This is not to say that the H.A.S. teams are not doing good. Their arrival provokes valuable self-criticism; they may bring to light gross failures; they may sometimes draw attention to useful experience at another hospital. Their reports carry much more weight with administrators than similar advice from an internal hospital committee. But I think they would do much better work for us, for the N.H.S., and for patient-care if they had less dogma and more objectivity. I would like them, and Dr. Baker, to remember that people have different gifts and need to express them in their work. One standard, rigid plan, hatched in Southwark, is not likely to suit everybody or every local circumstance. The H.A.S. could be helping to introduce a little flexibility.

Others have experienced the H.A.S. in action. What do they think?—I am, etc.,

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- ¹ Baker, A. A., *Health Trends*, 1971, 3, 51.
² Local Authority and Allied Personal Services, Report, Cmnd. 3703. London, H.M.S.O., 1968.

Starch Granulomatosis of the Peritoneum

SIR,—We read with interest the article by Mr. J. Neely and Dr. J. Douglas Davies on starch granulomatosis of the peritoneum (11 September, p. 625).

We have encountered three patients with this condition, all presenting with abdominal pain after surgery. Our patients were women aged 45, 67, and 72 years, who presented between 4 and 7 weeks after appendicectomy in one case and cholecystectomy in the other two. Starch granulomata were the only findings.

Review of the literature¹ shows that presentations are similar with several features emerging. The condition usually presents between 2 and 6 weeks postoperatively (although a 4-year interval has been described).² Generalized abdominal pain, tenderness, and distension are present with the absence of specific clinical and radiological findings. An abdominal mass may be palpable. The E.S.R. is usually raised in the presence of a normal white blood count. (Our results ranged between 55 and 109 in the first hour).

At laparotomy, one or more of the following features are noted: (1) Free ascitic fluid; (2) multiple peritoneal nodules resembling tuberculosis or disseminated carcinoma; (3) dense indurated mass involving the omentum and dense adhesions.

We would like to stress these clinical features, the observation of which led to the correct diagnosis in our third case before laparotomy.

We agree with the histological findings described by Mr. Neely and Dr. Douglas Davies except in two respects. Firstly, we believe that the presence of intracytoplasmic granules of starch in the macrophages or giant cells is essential for the diagnosis of the disease, in view of the contamination of the tissue with powder subsequent to surgery. This casts doubt on the significance of starch granules in the lymphatic vessels

and afferent sinuses of lymph nodes, where they are uninvolved in the inflammatory process. We have noted experimentally that starch is absorbed into such vessels and other tissue spaces during the routine processing of tissue for histological examination.

Secondly, according to Lee *et al.*,^{3,4} there is no evidence that starch granules are mobilized to the lymph nodes. Mr. Neely and Dr. Davies's finding of starch granules in lymph node histiocytes is the first report of this feature.

We have encountered one interesting case in a patient with abdominal carcinomatosis. The starch in ascitic fluid drained some days following laparotomy was phagocytosed by neutrophil polymorphs. Starch in granulomata on the other hand is ingested by macrophages and giant cells.—We are, etc.,

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- ¹ McNaught, G. H. D., *British Journal of Surgery*, 1964, 51, 845.
² Fegan, W. G., and Beesley, W. H., *Irish Journal of Medical Science*, 1965, 6, 335.
³ Lee, C. M., and Lehman, E. P., *Surgery, Gynecology and Obstetrics*, 1947, 84, 689.
⁴ Lee, C. M., Collins, W. T., and Largen, T. L., *Surgery, Gynecology and Obstetrics*, 1952, 95, 725.

Glaucoma and Systemic Lupus Erythematosus

SIR,—A 28-year-old European woman was admitted to hospital with exacerbation of systemic lupus erythematosus. She had been diagnosed in 1966 and had been treated with prednisolone, 5 to 30 mg daily, ever since. Glaucoma was diagnosed in the autumn of 1970 and she was treated with pilocarpine eyedrops. There was no history of glaucoma or serious illness in the family. On admission the intraocular pressure was so high that an operation on the left eye was indicated. She made an uneventful recovery.

The patient's open-angle glaucoma may have been aggravated by systemic corticosteroid drugs. W. M. Grant¹ states that repeated topical application of corticosteroids to the eye is well known to raise the intraocular pressure and frequently to induce severe open-angle glaucoma. However, systemically administered corticosteroids have comparatively little tendency to induce glaucoma, except in cases complicated by uveitis or other intraocular inflammation in which the intraocular pressure increases after beginning treatment with corticosteroids either topically or systemically.² At no time did our patient have uveitis or intraocular inflammation or receive topical corticosteroids.

In open-angle glaucoma excessive resistance to outflow is caused by changes within the outflow channels themselves, mainly within the trabecular meshwork, independent of the size of the pupil. We know of no reports of glaucoma associated with systemic lupus erythematosus, and we can only speculate that an inflammatory connective tissue disorder such as systemic lupus erythematosus had occurred in this case within the outflow channels and resulted in glaucoma. A diagnosis can be made only at necropsy, and even then with

difficulty. These unfortunate people may have a multitude of complaints, and glaucoma is easily missed.—We are, etc.,

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- ¹ Grant, W. M., *Journal of the American Medical Association*, 1969, 207, 2089.
² Grant, W. M., in *Ocular Therapy, Complications and Management*, ed. I. M. Leopold, vol. 3, chapter 5. St. Louis, Mosby, 1968.

Hospital Waiting Lists

SIR,—Having used an almost identical method for the admission of my surgical patients as Mr. N. H. Harris (27 November, p. 554) for the past four years, I can heartily endorse all he has to say.

This method of dealing with the admission of cases (together with other ways and means of ensuring the full use of beds and of avoiding bed wastage) is fully described in the article by myself and M. H. Moreny on "The Reduction of the Surgical Waiting List."¹ I succeeded in clearing a backlog of 339 cases and since then have not had to re-open a waiting list, so I can thoroughly commend the methods to others willing to try them out.—I am, etc.,

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- ¹ Gardiner, R. H., and Moreny M. H., *Health Trends*, 1970, 2, 49.

SIR,—I read with great interest Mr. N. H. Harris's (27 November, p. 554) experience of booking the admissions of orthopaedic cases at the time they are first seen as outpatients.

I wrote on very similar lines as a general surgeon some eight years ago.¹ I have been able to avoid a waiting list by operating upon suitable cases in two cottage hospitals; by doing almost all investigations including radiology, as outpatients; and by avoiding booking patients for operation of doubtful or minimal value. It is of course necessary to see some patients again after an interval of months for review—for example, lumps in the breast in young women or when there has been a previous biopsy on the other side. Further help can be obtained by operating on outpatients, and by early discharge. The advantages to the patient and the family cannot be exaggerated, as a long experience has shown me. Mr. Harris is perfectly right in stressing that these bookings must be done by the consultant himself. The system may break down if the pressure of work gets excessive, but this method covers at any rate the number of outpatients that one surgeon can reasonably deal with adequately.—I am, etc.,

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- ¹ Raw, S. C., *British Medical Journal*, 1967, 1, 424.

Care of Fistulous Stomata

SIR,—From time to time all surgeons are faced with the problem of an unwanted intestinal fistula. The skin around such an