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 South-wark, 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.,

J. L. CRAMMER

Chinnor, Oxon

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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C. J. GOOD

Department of Medicine,
Addington Hospital,
Durban,
S. Africa

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.,

R. H. GARDINER

Aylesbury Group of Hospitals,
Bucks

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.,

STANLEY C. RAW

Farnham Hospital,
Farnham, Surrey

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

orifice may become very sore and excoriated and even with modern adhesive appliances may become unpleasant for the patient, produce difficulties in nursing, and be a hindrance to further surgery if required.

Karaya gum used either as a powder or in a gelatin base as a washer helped considerably, but more recently Stomahesive (E. R. Squibb and Sons Ltd.) has been found of very great benefit. This was previously used by dental surgeons as Orahesive intra-oral bandage but is now produced in larger pieces, making it suitable for stomatherapy and the care of fistulae. No case of sensitivity has been noted thus far, and it remains intact when moist. Excoriated skin heals beneath it.

The squares of Stomahesive have an impermeable film backing on one side and a layer of release paper on the other. A hole or slit is cut in the centre of the square of a size which will fit closely round the stoma or fistula edges. The release paper is then removed and the contact surface is applied round the orifice and pressed down firmly. It is said that the skin should be moistened first, but the squares appear to adhere satisfactorily over either dry or moist skin. With the square in place, the appliance of choice is used in the ordinary way. The whole appliance—adhesive seal, flange, and bag—either may be assembled first and then placed over the square or each stage may be applied separately, first placing the adhesive seal on to the square, then the flange over it, and lastly applying the bag to the flange.

Stomaseal adhesive (3 M's) discs stick to the upper surface of the Stomahesive square more satisfactorily than many other adhesives, and it is generally possible to keep the square and appliance on for five to seven days. After this it starts to disintegrate.—We are, etc.,

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BARBARA SAUNDERS

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

Swimming for Asthmatics

SIR,—I was interested in the article on exercise-induced asthma (4 December, p. 577). I wondered whether this observation had been made in a chlorinated pool of salt or fresh water. There is a reference by Vedder,¹ reporting the success of treatment of acute and chronic bronchitis with choline gas, concentrations of 0.013–0.15 mg/l. in 1 hr. I wondered if this is relevant.—I am, etc.,

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London W.C.1

¹ Vedder, E. B., *Medical Aspects of Chemical Warfare*. Baltimore, Williams and Wilkins, 1925.

Hamster-hair Hypersensitivity

SIR,—I was interested to read Dr. K. H. Lim's suggestion (27 November, p. 560) that Case 2 of my series of hamster hair sensitive patients (6 November, p. 341) might have had asthma associated with Addison's disease. I am unable to give further laboratory evidence, particularly as the patient's death and necropsy occurred in another part of the country, but I believe

that the brevity of the clinical details in the report required by pressure of space may have led to misinterpretation, particularly of the man's terminal illness. His death, although sudden, should not be considered "unexpected".

The following details may clarify the issue. When he was first seen six weeks before his death he had no symptoms or signs of Addison's disease. He was not using corticosteroids at that time but had had short courses of prednisolone more than one month previously. He had not lost weight and was considered slightly overweight at 178 lb (80.7 kg); his height was not recorded.

Five weeks before his death he insisted on taking his family on holiday against advice, although at that time he had dyspnoea so severe that he was unable to walk more than a few steps, and had to be helped to and from his car. His orthopnoea prevented him from going to bed during this period. He became unconscious during an episode of severe dyspnoea, after being assisted from his car, when he had been driving for several hours on one occasion. He died within an hour despite medical assistance. According to his wife's account he was using more than 12 mg of triamcinolone daily in addition to bronchodilators during the last few weeks of his illness.

Necropsy showed mucus plugging of the bronchioles and a Cushingoid appearance in addition to adrenocortico-atrophy.—I am, etc.,

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The Liverpool Clinic,
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Intal and Intal Co.

SIR,—Your issue of 20 November contains the usual full-page colour advertisement, opposite page 490, for Intal Co. (disodium cromoglycate, isoprenaline sulphate, and lactose). Nowhere on this page is there any mention of the fact that plain Intal (disodium cromoglycate and lactose) can be obtained, nor that this is a form in which this useful drug can be prescribed. There are still too many patients using Intal Co. symptomatically, and this is a very expensive and wasteful way of using isoprenaline in inadequate doses.

It is high time that Messrs. Fisons changed their advertising policy for such an effective drug as this, and we would urge general practitioners to specify plain Intal on their prescriptions, and to instruct their patients to use it prophylactically.—We are, etc.,

J. B. WILKINSON

A. MITHAL

Central Lincolnshire Chest Unit,
Lincoln

Hyposensitization Treatment

SIR,—I wish to add my doubts to those of Dr. W. J. H. Leckie (6 November, p. 366) about the results of Dr. A. P. Smith (23 October, p. 204) and his reply (27 November, p. 561). Hyposensitization to house dust is a most difficult subject requiring more patients and a longer observation period. The condition of these patients greatly varies and condition "scores" by doctor and patients are not a reliable guide, even if the trial is strictly double blind. In this

trial, however, not even the degree of peak flow improvement and of corticoid decrease in the few patients in whom it occurred is given.—I am, etc.,

H. HERXHEIMER

London N.3

Urinary Infection and Jaundice

SIR,—Your leading article (4 September, p. 546) on urinary tract infection presenting as jaundice finds a good deal of support here. We would emphasize, however, that before jaundice can occur bacteraemia must be present. Asymptomatic urinary tract infection and lower urinary tract infection are confirmed by the presence of bacteriuria of significant degree in an acceptable specimen of urine and almost always leucocyturia. These cases respond easily to therapy and may even heal spontaneously. The condition occurs in about 1% of newborn at 6 days of age, and it is almost exclusively a male disorder. Congenital abnormalities are conspicuously absent. The blood culture is negative. Should spread occur to the renal parenchyma the kidney enlarges and is readily palpable, and the glomerular filtration rate decreases. If, as is probable at this stage, spread occurs to the blood stream jaundice or pallor or both result, with serum bilirubin levels of 4–20 mg/100 ml, and the blood culture is positive. Therapy here must be more vigorous, but recovery with intensive therapy is the rule. Relapses do not occur. Again, congenital abnormalities are conspicuous by their absence, and, again, it is almost exclusively a male disorder.—I am, etc.,

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Coronary Deaths

SIR,—Drs. P. G. F. Nixon and H. J. N. Bethell (20 November, p. 486) call nihilistic your leading article on "Coronary Deaths" (9 October, p. 64) because it ignores certain signs and symptoms which they proceed to describe. The pre-infarction phase of coronary artery disease is purported to be characterized by "a deterioration of general health, increasing fatigue Business efficiency deteriorates, tensions rise and irritability becomes more marked"

Most men today know that the commonest cause of death in the fifth decade in Britain is coronary artery disease. Most men of this age know of colleagues, neighbours, or relatives who have been suddenly struck down by heart attacks. Cardiac neurosis is understandably rife. Lassitude, irritability, and loss of concentration are cardinal symptoms of anxiety states. Many of us have spent most of our working lives reassuring patients with cardiac neuroses and trying to teach students how to distinguish between anxiety states and organic disease. Very occasionally a patient with a cardiac neurosis may die of a myocardial infarction because, unfortunately, there is no evidence that the fear of a heart attack prevents its occurrence.

If my views on preventing coronary artery disease due to autoimmune thyroiditis are found to be rubbish only my reputation will suffer. If medical students and paramedical