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.,

IAN P. TODD

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

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.,

C. O. KENNEDY

Royal London Homœopathic Hospital,
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.,

J. A. WILSON

The Liverpool Clinic,
Allergy Unit,
Liverpool 1

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.,

SHEAMUS DUNDON

Renal and Diabetic Unit,
Our Lady's Hospital for Sick Children,
Crumlin,
Dublin 12

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