their turn comes. The ideal, of course, is to judge each request on its own merit, but unfortunately few units can cope with the ever-increasing demand. I think the following proposals would facilitate the working of an "on merit" system.

The geriatrician should first be asked to assess the patient. After this a consultation would be arranged between the staff of the geriatric and requesting firms, headed by the consultants and including the junior medical staff, ward sisters, social workers, and physio- and occupational therapists. Satisfactory working of the system would depend on the widest possible attendance, so that practically every aspect of social, medical, and nursing needs could be dealt with. The relatives of the patient would also be notified about the consultation so that their views could be taken into consideration.

This system would be of considerable benefit to the patient's future care. It would enable the geriatric firm to keep in touch with the acute or specialized units. It would enable members of the requesting firm to gain insight into clinical geriatrics, of which they are often quite unaware. Last, but not least, it could bring a more "personal touch" into an administrative procedure which is often emotionally quite upsetting both to the patient and to the staff concerned. The scheme might sound naive, too complex, or bureaucratic, but I think those engaged in clinical geriatrics will recognize its advantages and the practical benefits that could derive from it.—I am, etc.,

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Rifamide in Acute Cholecystitis and Biliary Surgery

SIR,—We were most interested in the paper by Mr. P. G. Bevan and Dr. J. D. Williams (31 July, p. 284).

We noticed that they quoted the biliary levels published by ourselves in the *Medical Journal of Australia*,¹ but have taken the original idea of using rifamide in such patients upon themselves.

We find it very hard indeed to understand why they had not read the second paper in the same journal² where on page seven is reported under one of our names (B.C.S.) "The Treatment of Acute Cholecystitis and Other Diseases with Rifamycin Diethylamide (Rifamide)." To the best of our knowledge the 38 cases of biliary disease reported in this paper were the first printed record of the use of this drug.—We are, etc.,

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¹ Stratford, B. C., and Dixon, S., *Medical Journal of Australia*, 1966, 1, 1.

² Stratford, B. C., *Medical Journal of Australia*, 1966, 1, 7.

** We have shown the above letter to Mr. Bevan and Dr. Williams, who reply: "Nowhere in our paper did we claim that this was the first use of rifamide in biliary tract disease. The compound was widely used in continental Europe for some years prior to its use in England. With regard to priority of publication one might in fairness quote

Gaetini, A. M., and Dei Poli, M., *Bollettino e Memorie della Società piemontese di Chirurgia*, 1965, 35, 1.—Ed., B.M.J.

Availability of Cadaveric Kidneys

SIR,—Mr. J. S. Garfield's letter (4 December, p. 622) supports our finding (13 November, p. 401) that the persistent shortage of cadaveric donor kidneys results mainly from inadequate communication between clinicians caring for potential donors and surgeons working in kidney transplant units. It is, of course, entirely understandable that an overburdened clinical staff, preoccupied with their efforts to save the lives of dying patients, should frequently overlook the possibility of cadaveric kidney transplantation. However, one trusts that Mr. Garfield does not imply that in some hospitals, as a matter of policy, the removal of cadaveric donor kidneys is not being considered because of staff shortages and over-stretched facilities. It must surely be possible for the medical staff of an acute hospital to come to some sympathetic arrangement with the staff of the nearest kidney transplant unit, whereby the latter understand the need to relieve the donor hospital of most of the extra work that results.

Unless this communication problem can be resolved, it seems inevitable that considerable numbers of healthy donor kidneys will continue to be cremated or buried, despite the urgent need of these by increasing numbers of potential recipients. Indeed, it seems plain that kidney transplant units will prove able to undertake a regional service only to the extent that the supply of donor kidneys can be improved.—I am, etc.,

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Painless Acute Glaucoma

SIR,—During the acute glaucoma season tragedy inevitably appears. May I emphasize an unpublished point in which urgent treatment can avert blindness.

Patients from country areas often do not have the expected severe pain though the cornea is usually cloudy. Thus, if a patient complains of sudden visual deterioration, particularly with a cloudy cornea, an immediate hospital visit is essential.—I am, etc.,

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Lymphocyte Transformation

SIR,—We were interested in the paper by Dr. Lindsay H. Jones and his colleagues (6 November, p. 329) and, in particular, their failure to demonstrate that treatment with methotrexate alters the response of lymphocytes to phytohaemagglutinin (P.H.A.). We have recently studied the effect of prednisolone, and azathioprine and prednisolone, on lymphocyte transformation provoked by P.H.A. and by *Candida* antigen.¹ It appears that both drugs suppressed the transformation produced by P.H.A. This suggests that the effect of P.H.A. and antigen may differ and that the effect of cytotoxic agents can be selective

in terms of suppression of lymphocyte transformation.

It would be useful to know what results would be obtained if antigen were used in the context of Dr. Lindsay H. Jones's investigation.—We are, etc.,

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¹ Folb, P. I., and Trounce, J. R., *Lancet*, 1971, 2, 221.

Wegener's Granulomatosis

SIR,—Your leading article on "Wegener's Granulomatosis" (21 August, p. 446) is a fine portrayal of the pathological aspects of this disease, but I wonder why a medical journal would not also include recent therapeutic advances in the palliation of this fatal disease. To solely mention the palliative effect of prednisone leaves the medical practitioner with a limited comprehension of therapeutic advancements. Such drugs as methotrexate,¹ azathioprine,² adrenal steroids,^{3,4} alkylating agents,^{5,6} and various combinations of the above^{7,8} have been shown to produce significant remission of disease.—I am, etc.,

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¹ Capizzi, R. L., and Bertino, J. R., *Annals of Internal Medicine*, 1971, 74, 74.

² Peermohamed, A. R., and Shafar, J., *British Medical Journal*, 1969, 4, 600.

³ Hagens, E. W., *Archives of Otolaryngology*, 1962, 76, 183.

⁴ Evans, D. W., and Haley, J. B. W., *Journal of Clinical Pathology*, 1963, 16, 215.

⁵ McIlvanie, S. K., *Journal of the American Medical Association*, 1966, 197, 90.

⁶ Hollander, D., and Manning, R. T., *Annals of Internal Medicine*, 1967, 67, 393.

⁷ Kaplan, S. R., Hayslett, J., and Calabresi, P., *New England Journal of Medicine*, 1968, 278, 239.

⁸ Raitt, J. W., *Annals of Internal Medicine*, 1971, 74, 344.

Cot Deaths

SIR,—The suggestion by Dr. O. Englander (4 December, p. 625) that cot deaths in infants are due to atlantoid dislocation is an intriguing one but what evidence that we have at the moment is a little against it.

It has been our practice for many years to explore the back of the neck at necropsy and to dissect the area of the foramen magnum. Also a deliberate dissection of the nasopharynx has been carried out in all cot deaths. In a series of at least 300 cot deaths examined in this way, I have found no evidence of a dislocation, as postulated by Dr. Englander. The possibility remains that pressure on the cord could occur due to abnormal laxity of ligaments in particular children, but we have found no evidence of haemorrhage or trauma to the cervical cord to suggest that this has occurred.

It is hoped that Dr. Englander will produce some evidence on the variability of laxity of atlantoid ligaments in infants which may help us in assessing the possibility of there having been an evanescent pressure effect on the cord, as it is possible that such