Mechanism of Gouty Inflammation

SIR,—In your leading article on this subject (20 October, p. 125) you emphasize the occurrence of leucotaxis after ingestion of sodium urate crystals by leucocytes. You might also have mentioned the elegant work of Naff and his colleagues,^{1,2} which showed that sodium urate crystals (but not calcium pyrophosphate) are capable of activating complement with release of chemotactic factors directly, without ingestion by cells. This mechanism may operate in acute gouty arthropathy as well, and contribute to the exudate. Complement depletion in animals inhibits uric acid crystal-induced inflammation.³—I am, etc.,

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- ¹ Naff, G. B., and Byers, P. H., *Journal of Laboratory and Clinical Medicine*, 1973, **81**, 747.
- ² Byers, P. H., Ward, P. A., Kellermeyer, R. W., and Naff, G. B., *Journal of Laboratory and Clinical Medicine*, 1973, **81**, 761.
- ³ Webster, M. E., Maling, H. M., Zweig, M. H., Williams, M. A., and Anderson, W., *Immunological Communications*, 1972, **1**, 185.

Intratracheal Anaesthesia

SIR,—In defence of the allusion in your leading article on "Post-intubation Granuloma" (10 November, p. 313) to endotracheal anaesthesia, it is nowadays perhaps necessary to comment on the considerable distinction between the insufflation method adopted by Mr. R. E. Kelly in Liverpool before the first World War and later developments. The former was by custom always referred to by the hybrid term "intratracheal" intubation, and entailed the insufflation of a relatively small flow of oxygen and ether vapour through a narrow gum-elastic catheter passed down to the region of the tracheal bifurcation, leaving most of the tracheal lumen available for normal to-and-fro breathing of atmospheric air. Like Dr. C. Langron Hewer (1 December, p. 551), I also (in Liverpool) had the fortune to be present at many operations in which this method was used in the 1920s. The improvement it constituted on previous "open" methods had to be seen to be believed. The narrow tube caused no pressure, friction, or distension on surrounding structures, and so far as I know no granulomas were then caused.

It was the "endotracheal" intubation with a wide-bore tube designed to carry the whole respiratory exchange which was widely adopted in the 1930s, and it was then that granulomas started to be reported.¹ The wider-bore tube was quite capable of causing laryngeal trauma, and one would assume that it is this practice which was alluded to in your article.—I am, etc.,

R. L. WYNNE

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- ¹ Moulden, G. A., and Wynne, R. L., *British Journal of Anaesthesia*, 1951, **23**, 92.

SIR,—Sir Ivan Macgill (1 December, p. 551) asks whether the old art of anaesthesia has been lost entirely. This must be a purely rhetorical question because he well knows that the "old art" depended mainly on the skilful administration of toxic volatile vapours.

The majority of the modern generation

of anaesthetists have never used chloroform and an increasing number are becoming unfamiliar with ether. But the "old art" has been replaced by a new art in the handling and administration of intravenous drugs for sleep, tranquillity, analgesia, and muscular relaxation against a background of non-toxic or mildly toxic gases delivered by a ventilating apparatus through "the tube" which "Maggie" showed us how to use.

My generation, and I hope the younger generations also, know that it was Sir Ivan's pioneering and inspiring skill which started raising anaesthesia from a minor specialty to its present high status level.—I am, etc.,

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Forms of Colitis

SIR,—I was interested in your leading article on this subject (17 November, p. 370) and would like to comment on two aspects mentioned therein.

Firstly, I was surprised that you stated that "Crohn's disease has had a more precise historical passage" than ulcerative colitis. The disease process may have been first described by Morgagni as long ago as 1769.¹ Descriptions of the disease affecting the small intestine appeared in England and in Scotland in 1813 and 1828³ respectively. Moynihan described six patients with large-bowel disease in 1907⁴ and Robson three patients (one large-bowel and two small-bowel disease) in 1908,⁵ though neither author appeared aware of the significance of his contribution. Heinrich Braun in 1909⁶ showed a deeper histological understanding of the disease.

The best landmark in the history of the disease came, to my mind, in 1913, when Dr. T. K. Dalziel published his paper on "Chronic Intestinal Enteritis" in the *B.M.J.*⁷ He gave an accurate clinical, macroscopic, and histological account of the disease as it affected the small and/or the large intestine. He even suggested a mycobacterial (*M. johnei*) aetiology for the condition. In America Moschowitz and Wilensky (Mount Sinai Hospital, New York) reported the disease as it affected both the large (1923)⁸ and small (1927)⁹ intestine. This much abbreviated historical review should help to put your editorial landmarks into perspective.

I was also disappointed that the clinical differences between ulcerative colitis and Crohn's disease of the large intestine alone were mentioned so briefly. The history is often helpful. In ulcerative colitis the essence, by the time the patient sees the doctor, is the bloody nature of the diarrhoea; in Crohn's colitis the patient usually complains of diarrhoea which on questioning may or may not have been noticed to have contained blood. On examination finger clubbing favours a diagnosis of Crohn's colitis.^{10,11} Absence of perianal disease strongly favours a diagnosis of ulcerative colitis, whereas the presence of gross perianal disease equally strongly favours a diagnosis of Crohn's disease.¹²—I am, etc.,

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- ¹ Morgagni, J. B., *The Seats and Causes of Disease*, trans. Alexander. Vol. 2, p. 75. London, Millar and Cadell, 1769.
- ² Combe, C., and Saunders, W., *Medical Transactions of the Royal College of Physicians of London*, 1813, **4**, 16.

- ³ Abercrombie, J., *Pathological and Practical Researches on Diseases of the Stomach, the Intestinal Canal and Other Viscera of the Abdomen*, p. 238. Edinburgh, Waugh and Innes, 1828.
- ⁴ Moynihan, B. G. A., *Edinburgh Medical Journal*, 1907, **21**, 223.
- ⁵ Robson, A. W. M., *British Medical Journal*, 1908, **1**, 425.
- ⁶ Braun, H., *Deutsche Zeitschrift für Chirurgie*, 1909, **100**, 1.
- ⁷ Dalziel, T. K., *British Medical Journal*, 1913, **2**, 1068.
- ⁸ Moschowitz, E., and Wilensky, A. D., *American Journal of the Medical Sciences*, 1923, **166**, 48.
- ⁹ Wilensky, A. D., and Moschowitz, E., *American Journal of the Medical Sciences*, 1927, **173**, 374.
- ¹⁰ Fielding, J. F., and Cooke, W. T., *Gut*, 1971, **12**, 442.
- ¹¹ Jalan, K. L., et al., *Gut*, 1970, **11**, 748.
- ¹² Fielding, J. F., *Journal of the Royal College of Surgeons, of Edinburgh*, 1972, **17**, 32.

Exsanguinating Digital Tourniquet

SIR,—I have read with interest the recent correspondence on the dangers of using exsanguinating digital ring tourniquets (30 June, p. 779; 4 August, p. 293; and 20 October, p. 174).

These rings have been available for the past 10 years, since I first described the device.¹ The original rings were individually made from latex and were difficult to standardize in terms of thickness. Some surgeons also complained that the rings sometimes contained bubbles of air. About four years ago the manufacturers changed over to silicone rubber for these technical reasons and also because there was insufficient skilled labour to cope with large demand. The silicone rubber rings have the benefit of being of standard thickness and elasticity but are rather more difficult to apply and, as has been pointed out, are difficult to detect against skin. The distributors tell me that in 1972 almost 9,000 tourniquet rings were supplied and that the demand this year appears to have increased over last year.

There is, of course, a risk inherent in the use of any tourniquet and, as has been pointed out by your correspondents, digital tourniquets can very easily be left in place accidentally. For this reason I would not encourage the routine use of these rings in a casualty department where a doctor can so easily be called away just as he is about to take off the tourniquet ring. It seems to me that the tourniquet rings are more useful in formal operations on digits, where the surgeon is unhurried and has time to take off the tourniquet himself, before the dressing is applied.—I am, etc.,

GAVIN D. SMELLIE

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- ¹ Smellie, G. P., *Lancet*, 1962, **2**, 78.

Schönlein versus Henoch

SIR,—In articles on the nephritis associated with Henoch-Schönlein (or Schönlein-Henoch) purpura^{1,2} it is customary to make a double obeisance to the eponymous originators of the disease. It is usually stated that while Schönlein in 1837³ first described the association of purpura with joint manifestations, it was not until 1852 that Sir George Johnson⁴ noted the occurrence of kidney disease in purpura. Johnson certainly states: "Disease of the kidney, with albuminous urine is very common in connexion with purpura." However, the patient whom he describes (Charles Fox, p. 152⁴) was

certainly not suffering from "purpura rheumatica"—indeed the skin lesions described ("the eruption . . . consisted of irregular diffused patches, somewhat raised, and of a bright red colour; they were chiefly on the outside of the calf, as low down as the ankle") are typical of erythema nodosum. Johnson describes this as "a purpuric eruption." I cannot find, in the 34 other cases which Johnson carefully describes, any features suggestive of kidney disease associated with purpura rheumatica.

Schönlein,³ on the other hand, clearly did recognize urinary abnormalities in purpura rheumatica. The bibliographical details of his *Allgemeine und speciële Pathologie und Therapie* are a little obscure, since it appears to have been compiled by students from lecture notes without his authorization. At least one of the editions was disowned by him.⁵ However, in all the editions which I have been able to consult the description of "peliosis rheumatica" (= purpura rheumatica) contains the phrase: "Nicht selten Ausscheidungen im Harne" ("frequently precipitates [occur] in the urine"). The contribution of Henoch is less in doubt. In 1868⁶ (not in 1874, as quoted by Meadow *et al.*) he first drew attention to the gastrointestinal manifestations of purpura rheumatica. Meadow *et al.* draw attention to a boy described by Heberden in the posthumously published "Commentaries" of 1801⁸ (not 1806), which clearly illustrates the same disease.

There are two conclusions to be drawn. The first is that Schönlein has a better case than Johnson to be considered the first to describe renal involvement in purpura rheumatica. Johnson, in fact, used "purpura" to describe lesions which would certainly not be considered purpuric today. The second conclusion is that those who write historical introductions to their articles might find it entertaining, and even, occasionally, useful, to spend a little time reading the authors to whom they refer.—I am, etc.,

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- ¹ Hamburger, J., *et al.*, *Nephrology*, p. 858. Philadelphia, Saunders, 1968.
- ² Berlyne, G. M., in *Renal Disease*, ed. D. Black, chap. 20. Oxford, Blackwell, 1973.
- ³ Schönlein, J. L., *Allgemeine und speciële Pathologie und Therapie*, p. 41. Wurzburg, Etlinger, 1832.
- ⁴ Johnson, G., *On the Diseases of the Kidney*. London, Parker and Son, 1852.
- ⁵ Ackerknecht, E. H., *Journal of the History of Medicine*, 1964, 19, 131.
- ⁶ Henoch, E., *Berliner Klinische Wochenschrift*, 1868, 5, 517.
- ⁷ Meadow, S. R., *et al.*, *Quarterly Journal of Medicine*, 1972, 41, 241.
- ⁸ Heberden, W., *Commentarii de Morborum Historia et Curatione*, chap. 78. London, T. Payne, 1802.

Diabetic Pregnancy

SIR,—In commenting on our paper on diabetic pregnancy (13 October, p. 89) Dr. M. I. Drury (10 November, p. 358) asks: (1) how many terminations of pregnancy were performed on our patients and (2) why our series included fewer cases of diabetes diagnosed during pregnancy than his own and others.

(1) In 1971-2, when 77 diabetic women were delivered at this hospital, there were four terminations of pregnancy in diabetics. Two of the women, aged 16 and 20, were unmarried and pregnancy was ter-

minated for social reasons. The third, also unmarried, had chronic active hepatitis treated with prednisone and azathioprine. She later married and had a successful pregnancy. The fourth, a Jamaican woman aged 39 with mild diabetes treated with chlorpropamide, had had four children and suffered from depression. All asked for termination; in none was there any diabetic complication.

(2) As explained in our article we use a 50-g glucose load in the oral glucose tolerance test and the criteria of the British Diabetic Association in making the diagnosis of diabetes. In 1971-2 we found diabetes in 0.2% of all pregnant women seen at King's compared with the figure of 1% reported by Dr. Drury.¹ The difference may be partly due to the fact that Dr. Drury uses a 100-g glucose load. It is likely that fetal loss in gestational diabetes is less, or at least no more, than in established cases and it was presumably for this reason that Dr. Drury concluded that it was "imperative to exclude such cases from statistics purporting to show the results of various regimens in the management of pregnancy in the diabetic."¹ If our series had included a larger number of gestational diabetics the results in terms of fetal survival would presumably have been no worse than they actually were. We think therefore that we were justified in our tentative conclusion: "In managing pregnant diabetics it is notoriously easy to be deceived by a run of successes. Nevertheless, other centres too are getting better results than previously, and we think therefore that we are seeing a real improvement."—We are, etc.,

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¹ Drury, M. I., and Timoney, F. J., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, 77, 24.

Profound Hypothermia with Cardiac Arrest after Immersion

SIR,—In the case reported by Dr. E. Dominguez de Villota and others (17 November, p. 394) the cardiac asystole and the apparently minimal inhalation of water may have been due to stimulation of a vagal reflex with instantaneous cardiac and respiratory arrest when water entered the nose and/or ears of the child as he fell into the pool, as in the "brides in the bath" murder case of 1915.¹—I am, etc.,

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¹ Browne, D. G., and Tullett, E. V., *Bernard Spilsbury. His Life and Cases*, p. 70. London, Harrap, 1952.

General-practitioner Surgeons

SIR,—Between the 1870s and the formation of the N.H.S. in 1948 a high percentage of the major surgery in this country was performed not in the large centres, but by general practitioners in their capacity as honorary surgeons in their local hospitals. While they depended on their general practice for their livelihood, many hours of their working week were devoted to their unpaid hospital work. They had little clerical

assistance—there were dispensers, not secretaries, in those days—and with their double duties they had little time to write papers so that their work has gone largely unrecorded.

Many of them had higher qualifications and were men of considerable intelligence and surgical ability, who for family, financial, or other reasons were unable to apply for the posts that their ability deserved. Consequently, as I know from my own observations, many patients in the smaller industrial towns (particularly in the north) benefited from surgery of a very high standard. Among them there were as many "characters" as there were among the surgical giants of their time, but their audiences were small and few people saw their work.

The only paper on this subject that I have found in the literature was a plea for cottage-table surgery written in 1914, but I feel that there must be other records, either in the histories of local hospitals or in stories remembered about the "characters," maybe some of them by now apocryphal. I feel that the labours of those devoted men should be recorded before they are entirely forgotten and would be grateful for any help with memories, hospital histories, or other papers which would assist. Any papers forwarded would, of course, be returned as soon as possible.—I am, etc.,

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M.P. Pressure

SIR,—I read Mr. D. F. Thomas's interesting letter (17 November, p. 427) on the subject of M.P. pressure and if it is any comfort to him I can assure him that he is certainly not alone in his experiences. I would also add to M.P.s, local councillors.—I am, etc.,

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Notional Rent

SIR,—I wonder if many doctors are having similar problems to mine with the assessment of notional rent for surgeries which are within the doctor's residence.

Two years ago I obtained an independent opinion on the rental value of my surgery. This was assessed at £750 per year. As a result of the new method of reimbursement which came into force on 1 April of this year my notional rent has been assessed at £700 per year. As this has to stand for the next five years, I will still be obtaining only £700 per year reimbursement some seven years after the rent was assessed at £750 per year. It would seem to me that I am being asked to subsidize the Health Service out of my own pocket.—I am, etc.,

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Transfer of Registrars

SIR,—The discussion on the redistribution of registrars in your leading article (17 November, p. 369) produced the statement that more emergency work will be done by