intense emotional significance. He develops symptoms in relation to his employer, his wife, or his mother, and not, as is so often asserted, primarily as an anxiety response to being told that his blood pressure is high.

(3) There is evidence of a direct correlation between the level of diastolic blood pressure and a current emotional situation (Hambling, J., *Brit. J. med. Psychol.*, 1952, **25**, 39). Under certain conditions of interview it is possible to map out the "pressor areas" in the patient's emotional life by the fluctuations that occur in his diastolic blood pressure during his account of himself. This can happen with patients in each of the three phases of hypertension—i.e., "diastolic reaction," benign hypertension, malignant hypertension—and applies to asymptomatic as much as to symptomful cases.

(4) There is suggestive evidence, as yet unpublished, that lack of affection, severity of treatment, and violence between parents may be the childhood background to the character difficulties described in the literature.

Questions of ultimate aetiology apart, it will be right to explore fully the characterology and psychosocial situation of the hypertensive, because it promises to lead to advances in management directed towards minimizing the pressor effect of the environment. It may be eventually found that young diastolic reactors can be "desensitized" so that they no longer react. Eventually, if the childhood situation turns out to be a significant factor, then the therapy of hypertension enters the field of general preventive medicine in the sector of the mental hygiene of the family group.—I am, etc.,

London, W.1. JOHN HAMBLING.

Congenital Absence of Rectum

SIR,—While agreeing with most of Dr. Isabella Forshall's remarks (April 5, p. 762), I cannot agree that gas will be seen in the terminal hind gut on radiography within six hours of birth. In most cases almost 24 hours must elapse before gas passes through the sticky green-black meconium in the terminal gut. If the radiographic appearances at six hours are taken as indicating accurately the termination of the hind gut, not only will the abdomino-perineal approach be used needlessly in cases in which only a thin diaphragm separates the hind gut from the surface, but the operator will find himself in considerable difficulty in attempting to follow the hind gut below the peritoneum in the diminutive pelvis of the infant. Admittedly a fistulous connexion with the urinary tract may be found and divided.

As Miss Forshall suggests, the combined abdomino-perineal approach for high rectal atresia is practised in other centres—for the past three years in the Royal Hospital for Sick Children, Glasgow. The mortality in this apparently "major" procedure performed during the first few days of life is considerably lower than the mortality following a "simple" colostomy performed in the newborn. With the exception of the case with recto-vaginal fistula, colostomy should rarely be required in this condition. A high mortality in this condition is related either to delay in sending patients to a suitable centre of paediatric surgery or to other associated severe congenital defects.—I am, etc.,

Glasgow. W. M. DENNISON.

Is Latin Dead?

SIR,—The following story is taken from *The Last Serjeant*, by Serjeant A. M. Sullivan, Q.C. There was a judge much given to Latinity who once asked counsel: "Has your client never heard, *Sic utere tuo ut alienum non laedas*?" To which counsel answered: "Not a day passes, your Honour, on which he does not hear it. It is the sole topic of conversation where he lives at the top of Mushera Mountain."—I am, etc.,

Bristol. WALTER SIMPSON.

SIR,—Dr. J. Lawrence Henry (April 26, p. 924) pleads for a continued use of Latin in medicine, but, while the study of Latin at school is a stimulating mental process, the reading, writing, and, most of all, the speaking of it demand great erudition. A medical student cannot reasonably be expected to do justice to the majestic Latin tongue any more than an itinerant musician could be expected to play the Caprices of Paganini on a tin whistle.

Actually, English is taking the place of Latin as the international language. In Europe and the Scandinavian countries English is a compulsory school subject, and it is taught in such a way that pupils are eventually able to speak it intelligibly and understand it when it is spoken. In this country the acquisition of a working knowledge of foreign languages is grievously hindered by the waste of valuable time on the study of the minutest details of grammar and syntax, and after years of drudgery at school little practical progress is made.

I make bold to say that foreign doctors would prefer good English to bad Latin. Let us use English, therefore, lest we make Cicero and Virgil stir uneasily in their graves.—I am, etc.,

Strichen, Aberdeenshire. WILLIAM HARKINS.

SIR,—May I as a British bilingual practitioner with British and Continental qualifications support the plea of Dr. J. Lawrence Henry (April 26, p. 924) for the revival of the Latin language among medical men? While in most other languages, in particular German, practically all anatomical and medical terms have indigenous equivalents which are commonly used among the lay population, and only medical men use an unadulterated Latin or Greek nomenclature in their professional language, the English language is unique in that it lacks Anglo-Saxon terms for many of these, and anglicized Latin or Greek expressions, always pronounced according to English phonetics, are used equally by laymen and professionals. Larynx, duodenum, diabetes, pleurisy, are only four examples of a big list of terms without accepted native equivalents, while gullet, the English name for oesophagus, is unfamiliar, and the midriff means to the modern layman not the diaphragm but the unclothed portion of the dancer's or artiste's body between blouse and skirt. A limited knowledge at least of Latin and Greek (most medical terms are derived from the latter rather), by no means a scholastic delving into the writings of Hippocrates and Galen, will always stimulate the scientific interest and insight of the medical man lest he forget that medicine is not only the most realistic, but also the most humanistic of all sciences. He will then do justice to the popular appraisal of his art and learning, which accords him alone among the professions the noble title "doctor"—i.e., wise man—without implying an academic distinction.

I much regret, however, Dr. Lawrence Henry's disparaging remarks about the metric system. Surely this is not advocated to help foreign readers, but to bring medicine and pharmacy in line with all the other sciences, which have long ago abandoned the foot-pound-duodecimal for the centimetre-gramme-decimal system. The medical profession here lags sadly behind, and might be accused of playing down to popular tradition at the expense of scientific accuracy. The grain and minim should be entirely abandoned in favour of the gramme and cubic centimetre.—I am, etc.,

Leicester. A. K. GRAF.

POINTS FROM LETTERS

Debauchery of Honest Words

Dr. WILLIAM FOSBERY (Batheaston) writes: I trust that Dr. C. W. M. Whitty (April 5, p. 762) would not advocate the use of such neologisms and new-coined phrases as the following, which I saw recently in the U.S.A.: "The basement is closed tonite, as it is being groceteriarised."

Correction

Mr. C. LANGTON HEWER writes to point out that in his letter on succinylcholine (May 3, p. 971) the dose of succinylcholine recommended by the makers for a large adult should have read 100 mg.