objective assessment be attempted of boosters and boosted, denigrators and denigrated, not only in terms of institutions and individuals but of the most violently disputed therapies, so that much better than "rough justice" be arrived at.—I am, etc.,

Colchester, Essex. H. JACOBS.

Battered Baby Syndrome

SIR,—I would like to add another similar case to Professor Keith Simpson's account of the "battered baby" syndrome (6 February, p. 393). In this instance a young man, 21-year-old Christopher Noel Gallagher, was sentenced to five years' imprisonment for the manslaughter of Michael McCormack, aged 18 months.[1]

On 5 November 1964 Michael's body was brought to hospital by his mother and Gallagher, with whom she was then living. The child was said to have been found lying dead on the bedroom floor. The case was reported to the Coroner.

At post-mortem I found that the liver was ruptured on the inferior border, posteriorly in the caudate and quadrate lobes, and there was also a large laceration in the interior of the liver. There was a haemorrhage into the right suprarenal gland and a retroperitoneal haemorrhage. In addition there was a fracture of the shaft of the right humerus, and severe and extensive bruising of the right forearm, the dorsum of the left hand, and the dorsum of the right foot. There were many smaller superficial bruises, which varied in age, on the forehead, face, chest, abdomen, and all four limbs.

At the trial at the Leeds Assizes on 22 January it was reported that Gallagher had discovered that Michael's father (who was not the mother's husband) was coloured, and from then on he appeared to have ill-treated the child. Mr. P. Stanley-Price, Q.C., defending, is reported to have said that Gallagher had pleaded guilty because "in smacking the child because of its constant crying, he had lost his temper and head and struck Michael in the stomach, and that presumably was the striking which gave rise to the liver injuries." Mr. Stanley-Price questioned whether the child's mother had not been responsible for some of the bruises.—I am, etc.,

Department of Pathology, Royal Infirmary, Bradford 9, Yorks. W. M. EDGAR.

REFERENCE

1 *Yorkshire Post*, 23 January 1965.

Iatrogenic Vertebral Arteriovenous Fistula

SIR,—Dr. Hugh Garland and others in their Medical Memorandum (13 February, p. 429) record that following diagnostic vertebral arteriography their patient could tolerate her bruit more easily. It would be of interest to learn if this subjective improvement was born out by auscultatory findings.

In such a context I am reminded of a patient of my own,[1] a woman aged 52, also with a vertebral-artery abnormality, whose bruit was greatly diminished following on arteriography and had not again increased in volume over a three-year follow-up period. Krayenbühl's case,[2] a 60-year-old woman with an external-carotid-artery malformation, is recorded to have lost her bruit for three days following angiography. Faeth and Dueker's patient,[3] already quoted by the authors, showed a similar phenomenon, with the bruit completely abolished for an unrecorded length of time.

Hence, I would like to hear of any further instances of such "therapeutic" arteriograms.—I am, etc.,

London W.11. KLAUS HEYMANN.

REFERENCES

1 Heymann, K. G., *Brit. J. clin. Pract.*, 1964, **18**, 99.
2 Krayenbühl, H., *Münch. med. Wschr.*, 1961, **103**, 2185.
3 Faeth, W. H., and Dueker, H. W., *Neurology (Minneap.)*, 1961, **11**, 492.

Paterson–Kelly Syndrome in Adolescence

SIR,—The diagnosis of post-cricoid webs would have been more convincing in Dr. M. D'A. Crawfurd and his colleagues' patients (13 March, p. 693) had they been confirmed by direct inspection (hypopharyngoscopy). The notion that webs anywhere would disappear with medical treatment alone—that is, without dilatation and mechanical interruption—will be received with scepticism by surgeons who know from bitter experience how resistant post-cricoid webs are even to repeated dilatations combined with iron therapy.—I am, etc.,

Liverpool 1. FRANCIS BAUER.

Difficulties of Early Diagnosis

SIR,—The belief that earlier attendance at the surgery means earlier diagnosis is aired incessantly, not only by a growing number of politicians but also by many of our colleagues. That this concept is by no means always true is illustrated by the following cases from my practice:

Case I.—Female, aged 67 years. Hypertensive. Main complaint frequency of micturition. First attendance for this complaint 25 February 1963. Referred to surgeon 4 March 1963. No abnormalities found on full investigation. Eventually saw another surgeon who performed a laparotomy 15 July 1963. Extensive invasive carcinoma of descending colon found and resected. (Five months after first attendance.)

Case II.—Male, aged 38 years. Main complaint diarrhoea for 14 days. First attendance at surgery 22 February 1964. Referred to physician 7 March 1964. No abnormal signs found clinically or on investigation. Referred by physician to surgeon May, 1964; carcinoma of rectum diagnosed. Abdomino-perineal resection July 1964. (Five months after first attendance.)

I could point to a number of similar cases which have occurred in this practice in the past two years.

The purpose of writing this letter is to emphasize once again that early diagnosis may be impossible even if the necessary time and facilities for investigation are available. The average general practitioner in the present set-up has neither time nor diagnostic aids at his disposal. Is it, therefore, reasonable to exhort the public to visit the doctor "earlier" without ensuring that he has both these essential commodities?—I am, etc.,

Rainham, Essex. M. KEHR.

Palpation of Umbilical Cord Through Abdominal Wall

SIR,—Palpation of the umbilical cord through the abdominal wall during the course of labour is, I believe, a rare event and I have been unable to find a similar instance in the literature.

Mrs. A. B., aged 25 years, had two previous pregnancies, the first terminating in a lower-segment caesarean section for placenta praevia at 35 weeks. Three years later she experienced a full-term normal delivery. In the present pregnancy the membranes were ruptured artificially because of post-maturity at 42 weeks. A small quantity of clear liquor drained and four hours later weak uterine contractions began. An hour later the foetal heart was found to be down to 60 beats per minute, recovering to a normal rate during the course of the next three minutes.

During palpation of the abdomen at this time a pulsation was noted at the level, and to the left, of the umbilicus. This palpation could be traced over a linear course for 2–3 in. (5–7.5 cm.) in the sagittal plane. It felt quite superficial and was noted to be synchronous with the audible foetal heart and asynchronous with the maternal pulse. The pulsation was not obliterated during a contraction (these were weak), and the slowing of the foetal heart during each could be detected with the finger. Also, pressure over the pulsation between contractions for 15 seconds produced a foetal bradycardia. There was no clinical evidence of uterine rupture.

The patient was advised to have a caesarean section for the relief of foetal distress in early labour. A repeat lower-segment operation was performed. At this the pulsation was palpable through the uterine wall. A live child was delivered in good condition. The placenta was found on the posterior uterine wall and no deficiency was noted of the anterior uterine wall or of the abdominal wall. The umbilical cord was of normal proportions and was thought to have been lying between the foetal flank and uterine wall.

My purpose in writing is to inquire if any of your readers has had a similar experience.—I am, etc.,

LLOYD RANKIN.

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Screening Test for Urinary Amphetamine

SIR,—Recent correspondence has drawn attention to the great difficulty involved in the estimation of amphetamine in either blood or urine. A simple test is described below, which is a general one for ether-soluble aromatic amines (of which amphetamine is one). It is sensitive enough to detect a concentration as low as 1.0 μg. amphetamine per 1 ml. of urine, and therefore is positive with urine from patients on therapeutic doses of amphetamine. The test may well be useful as a rapid negative screening test to be used on urine obtained from patients suspected of being amphetamine addicts who have just been admitted to hospital for investigation. It is not useful in its present form if positive results are obtained, since other ether-soluble aromatic amines also give positive results.

Test.—50 ml. of urine is made alkaline to phenol-red with 10% sodium hydroxide and extracted with 20 ml. of diethyl-ether in a separating funnel for at least 1 minute (i.e., 100