Having been born in the 1930s, my own life expectancy is still a fairly long one, but, Sir, I assure you I shall even now take the precaution of withdrawing my B.M.A. membership if you start telling all and sundry among our colleagues in the Association of the causes of our deaths.—I am, etc.,

Farnham, Surrey. WENDY WRIGHT.

SIR,—I wish to express strong dissent from the proposal to publish the cause of death in obituary notices of doctors (30 December, p. 806).

I have always found the American practice repugnant. This last privacy should be respected. Neither the intimation of mortality nor the cause of truth would be furthered in any way by adoption of the procedure.—I am, etc.,

Milngavie, Nr. Glasgow. IAN D. RILEY.

Fibrin Degradation Products

SIR,—We regret that Table III of our paper on "Fibrin Degradation Products in Sera of Normal Subjects" (23 December, p. 718) contained a number of errors which arose during the typing. The correct figures are shown in the Table below.

TABLE III.—*Serum F.D.P. Levels Before and After a Moderate Exercise and Intravenous Adrenaline Procedure*

Exercise			Adrenaline		
Subject No.	Serum F.D.P. (μg./ml.)		Subject No.	Serum F.D.P. (μg./ml.)	
	Before	After		Before	After
1	3·7	7·4	1	3·7	11·0
2	1·9	3·7	2	6·5	14·9
3	1·9	7·4	3	1·9	7·5
4	1·0	3·7	4	1·0	3·7
5	3·7	8·4	5	3·4	8·4
6	3·7	11·0			
7	1·9	3·7			
8	3·7	11·0			
9	1·9	3·7			
10	1·5	8·8			
11	3·4	10·1			
12	3·6	4·8			
13	2·4	5·5			
14	5·2	6·8			
15	3·0	6·1			
16	2·2	5·2			
17	3·0	5·2			
18	4·3	7·3			
19	3·2	4·9			
20	4·5	8·2			
21	4·1	6·7			
22	3·4	7·3			
23	4·1	6·1			
24	5·3	8·1			
25	6·0	8·2			
26	4·1	6·0			
Mean	3·3	6·7	Mean	3·3	9·1

—We are, etc.,

J. D. CASH.
P. C. DAS.
A. G. E. ALLAN.
D. G. WOODFIELD.

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Haemorrhagic Necrosis of the Intestine

SIR,—It was with great interest that I read the article by Drs. J. S. McKinnell and M. S. Kearney on haemorrhagic necrosis of the intestine (25 November, p. 460). Their report once again emphasizes what we had noted earlier in a comprehensive review of the subject,[1] that not only is this a distinct clinicopathological entity but also it had a fatal termination in the vast majority of cases reported in the literature, including our series.

It is for these reasons that we suggested a distinct name for this entity—that is, "terminal haemorrhagic necrotizing enteropathy"—be substituted for various confusing titles used in the literature, such as haemorrhagic enterocolitis, intestinal gangrene,[2 3] and infarction without occlusion.[4] We believe that by emphasizing the fatal termination of the disease it would excite enough interest of the clinicians to be diagnosed antemortem. Not infrequently it is mistaken for various acute surgical diseases of the intestines. We defined terminal haemorrhagic necrotizing enteropathy as a distinct clinicopathological entity characterized by:

(1) Its almost exclusive occurrence in elderly persons with significant heart disease, often complicated by heart failure or various cardiac arrhythmias;

(2) Extensive haemorrhagic necrosis of the gastrointestinal tract, usually within the distribution range of the superior mesenteric artery and unassociated with mesenteric vascular occlusion or significant stenosis, mechanical interference with mesenteric vasculature, or primary arterial disease;

(3) Most frequent association clinically with an episode of persistent hypotension and varied acute abdominal symptoms;

(4) Rather characteristic gross and microscopic appearance of the affected part of the gastrointestinal tract;

(5) Probable functional vascular aetiologic basis influenced by poorly understood mechanisms leading to self-perpetuating vicious circles; and

(6) Usual fatal termination.—I am, etc.,

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Sarcoid Myopathy

SIR,—In spite of my admiration for the great English polymath Jonathan Hutchinson I doubt whether, as Dr. D. G. James (23 December, p. 743) suggests, he can legitimately be credited with the first description of a case recognizable in retrospect as sarcoidosis of the skin. The resemblance of the skin eruption he described in 1877[1] as "livid papillary psoriasis," and thought to be associated with gout, to any of the skin lesions of sarcoidosis is not very convincing, though I suppose that it might be imagined to resemble lupus pernio localized to the backs of the hands and fingers. Moreover, neither in relation to this case, nor to "Mortimer's malady," which he described in 1898,[2] was there any histological evidence. Mortimer's malady can legitimately be accepted as skin sarcoidosis because of its close resemblance to the "benign miliary sarkoid" of which Boeck described both clinical features and histology in 1899.[3]

The first recorded case of skin sarcoidosis which can be accepted unquestioningly is that described as lupus pernio in 1889 by the Frenchman, Besnier.[4] This case was not studied histologically, but the histology of a similar case was described in 1892.[5] Besnier appears to have made no further contribution to the development of knowledge about sarcoidosis. Boeck, on the other hand, maintained a lively interest in the disease for many years, perceived the probable identity of lupus pernio with "multiple benign sarkoids," and recognized the importance of non-cutaneous manifestations.

Thus, although I agree with Dr. James that Dr. Talbot (25 November, p. 465) is not strictly correct in attributing the first description of the skin lesions of sarcoidosis to Boeck, I consider that Besnier, rather than Hutchinson, should be credited with this. But if anyone's name is to be associated with the early development of knowledge about sarcoidosis I think it should be that of the Norwegian, Caesar Boeck.—I am, etc.,

Institute of Diseases of the Chest, London. J. G. SCADDING.

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Australia Next?

SIR,—May I say how much those of us now living in the antipodes appreciate the Australian printing of the *B.M.J.*. The speed with which this reaches us each week is remarkable, and we are thus able to keep in close touch with B.M.A. affairs. I feel that all concerned with this venture are to be congratulated.

The recent correspondence in your columns concerning the Ministry of Health recruiting team's visit to Canada has shown this to be the pathetic venture that many of us predicted it would be, and we await with interest the report of this committee informing us of the results of their North American vacation.

Flushed with the success of their failure in Canada, it now seems possible that the men from the Ministry will turn their rose-tinted spectacles on to this country, which contains a veritable army of us refugees from that crumbling socialist edifice—the British N.H.S. We shall welcome them with open arms, but cannot promise any greater degree of success than that which they have already achieved elsewhere; at any rate in this State, which contains a larger number of British doctors in proportion to the population than any of the other five Australian States.

Since arriving in Australia I have been fortunate in visiting a large variety of practices and meeting immigrant doctors throughout Victoria. There is simply no comparison between the conditions under which they are now practising and those which they, like me, endured under the N.H.S. An infinitely higher standard of medicine, complete clinical freedom, excellent facilities, immense professional respect and satisfaction, and adequate financial reward are some of the reasons why it is hard to see how these men and women could be persuaded to return to Great Britain—and these in addition to the other non-medical advantages that this country has to offer. No country is perfect, either in its medical services or as a place to live and bring up one's family, but the Ministry must be