preventing the escape of gas. An enema administered in the supine position may occasionally force fluid into the loop, but gas will be unable to escape. In the early stages of the obstruction, peristaltic contractions in the gut proximal to the distended loop may also have a similar effect. However, if the patient is placed in the prone position the fluid–gas relationship will be reversed, thereby providing a more favourable situation for the escape of gas from the distended loop. In a small number of patients a simple enema administered in the prone position has been successful in relieving a colonic volvulus, and it would certainly seem worth trying this procedure in the early stage of a suspected volvulus. Moreover, this simple technique is also applicable to volvulus of the splenic flexure, which is out of reach of the sigmoidoscope,—I am, etc.,

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Systemic Sclerosis

Sir,—Readers of the article by Drs. A. W. Delliopiani and M. George (11 November, p. 334) may be led to believe that a syndrome of scleroderma, calcinosis, Raynaud's phenomenon, and telangiectasia is generally accepted. Certainly they seem to have convinced Drs. Stephanie A. Davies and F. J. Woodruffe (30 December, p. 804). The evidence, however, indicates that patients with this combination of features are, in fact, suffering from progressive systemic sclerosis. The term "CRST syndrome," used by Winterbauer,1 should never have been coined. Winterbauer also confused the issue by stating that the telangiectases exactly mimic those found in hereditary haemorrhagic telangiectasia, but in my experience there is little likelihood of clinical confusion. He also stated that telangiectases do not occur in sclerodermatous skin. This is untrue.

In a personal series of 51 patients with systemic sclerosis only one patient did not have cutaneous changes and another did not have Raynaud's phenomenon. Telangiectasia was found in 71%, and calcinosis in 24%. Seven patients (14%) had all four features. These are summarized in the Table. All had systemic involvement and their clinical course was similar to that of the remainder of the series. The alleged benign nature of this artificial subgroup is not supported, and one patient died from malignant hypertension, which is a well-recognized terminal event in systemic sclerosis.

I see no reason to perpetuate the separation of these patients as a separate syndrome. Systemic sclerosis has many manifestations, which are not present in all cases. As the course is extremely variable, I prefer to omit the term "progressive" from the name.

Detailed investigation is required to reveal the degree of organ involvement in any case. Davies and Woodruffe did not even find fluid in a survey of 100 cases because there was no dysphagia. In my series, 71% of patients had radiological changes in the oesophagus, though only 52% had symptoms. Symptoms of oesophageal reflux (46%) were more than twice as frequent as dysphagia (22%).—I am, etc.,

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REFERENCE


Transpidermal Water Loss

Sir,—We are of course very familiar with the excellent work of Drs. E. M. Malten and D. Spruit (20 January, p. 180, and 3 February, p. 315) and others of the Nijmegen School.

It is possible that some confusion may result from the terms in use. By transpidermal water loss we mean the passive diffusion of water across the epidermis in the total absence of sweating. Unless great care is taken to eliminate all possibility of sweating, measurements of skin water loss may include a contribution from sweat glands which is not clinically appreciable. The term "insensible perspiration" has been applied to the water loss which is invisible to the naked eye. Since, as we understand, Drs. Malten and Spruit did not expressly eliminate sweating, we wonder whether the figures they gave for "insensible perspiration" may include a contribution from the sweat glands. Their mention of a mosaic pattern on the forearm changing from day to day is very suggestive of sweat gland activity.

It is well known that sweat secretion is reduced in patches of active psoriasis and one may therefore expect that on the uninvolved skin sweating may be somewhat increased to compensate for this. We wondered if this might not account for "insensible perspiration" reported by the Dutch authors.—We are, etc.,

F. R. BETTELEY.

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REFERENCE


Using Computers

Sir,—I can hardly be expected to let Dr. E. D. Acheson's and Mrs. Sheelagh P. Watts's letter (3 February, p. 316) go unanswered. I will not, however, be tempted to join in a semantic squabble about the difference between a "computer method" (sic) and the computer implementation of a mechanism for free record matching procedure. I react strongly, and am likely to continue to do so, against the current habit of using the terms "computer," "computer-assisted," or "analysed by computer" as adding additional qualify or respectability to the basic data (which are of course unaffected) or as adding something basically new to what may in fact be well-established procedure. In the present instance what was important was the linkage of records; how it was achieved—that is, manually, mechanically, or electronically—was of secondary importance.

I agree entirely with Dr. Acheson's objective: to "have the option to produce either type of statistic" (spells or persons). I also agree with Dr. Acheson that linkage, whether retrospective or prospective (as I prefer), is likely to be greatly simplified by a universal numbering system (for example, the N.H.S. number) and I will join with anyone in working to that end.

I disagree with Dr. Acheson about the next steps. I have never referred to a "massive series of computer-held cumulative health files" or to "20 years of education" or to "£100m in capital for equipment". This is colourful language, frightening to the timid administrator. But I am a practical man, and I believe not only that dreams are useless unless you begin to move toward them, but also that quite small steps are often enough to start the irresistible move forward.

The costs of Dr. Acheson's unit at Oxford, which exists apart from the regional hospital board's statistics department, are not inconsiderable and they have been supported by special Ministry funds—that is, they are additional to normal hospital service costs. If extended on a national scale his unit would involve a very large addition to hospital costs. For it is not linkage itself that costs money in the retrospective record but the amassing and maintenance of duplicates of original records. For much less there could be a few feasibility studies of the cumulative method, which avoids duplication of records, both to develop methodology and to establish the true likely costs. Then a rational decision about further steps could be made. Storage and retrieval techniques have