

(tetracycline and nystatin) was prescribed. The pain subsided, but the right scrotum started to swell.

On arrival at hospital the boy did not complain of any pain in the scrotum. There was no history of any urinary trouble. His pulse was normal and his temperature 99.8° F. (37.7° C.). There was oedema of the right half of the scrotum, extending to the left side. The scrotum was extremely tender. The right testis was higher in the scrotum and no distinction could be made out between it and the epididymis. The urine was normal chemically.

A diagnosis of torsion was made and immediate operation carried out. Through a scrotal incision the testis was exposed and was found to be dark blue. There was high investment of the tunica vaginalis and torsion was intravaginal. As the testis did not improve after release of torsion, orchidectomy was done. The left testis was exposed at the same operation and high investment of the tunica vaginalis was found on this side too; therefore orchidopexy was done.

A histological report showed haemorrhagic infarct and necrotic spermatid tubules.

To prevent the loss of a testis in young patients the results of investigations by Barker and Raper<sup>1</sup> need more publicity. They did not find a single case of epididymo-orchitis under the age of 18 in a series of 129 cases. Infrequency of orchitis and difficulty in differentiating from acute epididymo-orchitis make compelling reasons for early exploration. The earlier the operation is carried out the better, for in 50 cases Allan and Brown<sup>2</sup> found 100% testicular survival in those cases operated within 10 hours and no testicular salvage after 20 hours. Moreover, experiments on dogs by Smith<sup>3</sup> have shown loss of spermatogenesis after six hours of the loss of blood supply to testis. Orchidopexy must be done on the other side at the same time, as in 50% of cases the anomaly is bilateral.

I wish to thank Sir John Nicholson and Mr. M. D. Staunton for their advice and for allowing me to report this case.

—I am, etc.,

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#### REFERENCES

- 1 Barker, K., and Raper, F. P., *Brit. J. Urol.*, 1964, **36**, 35.
- 2 Allan, W. R., and Brown, R. B., *Brit. med. J.*, 1966, **1**, 1396.
- 3 Smith, G. I., *J. Urol. (Baltimore)*, 1955, **73**, 355.

### Communication and Kindness in Hospital

SIR,—Dr. David Kyle's Personal View (25 January, p. 246) reminded me of the first surgical patient I clerked as a clinical student. He was a man in his 50s with a supposedly benign gastric ulcer; at operation the ulcer was clearly malignant. Immediate post-operative recovery was uneventful and on the third day the patient asked me if I would see his wife, who was, he said, worried about him—could I reassure her? He told me that she had already seen the houseman. The patient's wife wanted a private word with me, and tearfully told me that the houseman had told her that her husband had cancer, and he then had rushed off saying he was busy. She was under the impression that her husband would not leave the hospital alive, and was immensely relieved when I told her that he almost certainly would. Over the next few days I saw her several times, answering questions about prognosis, future work, food, and other small matters—

after I had looked them up or asked the houseman.

The patient then developed every post-operative complication in the surgical textbook and was placed on the danger list. The wife was informed of his condition by sister. Three days later he was off the list, but a week later the patient's wife again asked to see me and asked if her husband was really dangerously ill, for he looked so well. Being a zealous young student I proceeded to reprimand sister for failing to tell the patient's wife of his improved condition. The reprimand was not well taken. However, exactly the same thing occurred two weeks later. I was by now fully convinced that most doctors and nurses regarded patients as interesting cases and their relatives as nuisances. The patient was eventually discharged after three months' stormy recovery. His wife and family knew well that he would probably not have long to live, but at least they did know and had been able to discuss the future with someone. No doubt the family doctor could have done this, and far better than an untrained first-year student, but surely there should be someone in the hospital who actively helps relatives with their questions and problems?

Dr. Kyle's article aroused again the anger I had at the time about the doctor's attitude to his patient and relatives. Surely sensitivity is a most important quality for any doctor, not just the general practitioner?—I am, etc.,

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PATRICK TRUST.

### Asthma from Aspirin

SIR,—Professor C. A. Clarke (25 January, p. 256) suggests aspirin for asthmatics. The most dangerous drug for an asthmatic may be an aspirin. Unfortunately this fact does not appear to be generally recognized.

Several years ago an asthmatic patient who had mild lower backache was given one tablet Equaprin (meprobromate and acetyl salicylic acid), which shortly afterwards resulted in the most severe attack of asthma which she has ever had, before or since.

It is well known that aspirin can cause acute allergic reactions such as giant urticaria or angioneurotic oedema. I also must mention that sedatives should never be given to asthmatics, although a small dose combined with ephedrine may not be harmful.

All my asthmatic patients are instructed never to take any aspirin or tablets containing aspirin, and I never prescribe sedatives.—I am, etc.,

Gillingham,  
Kent.

EDWARD L. MOLL.

### Cardiac Monitoring in a Regional Hospital

SIR,—We were most interested to read the excellent account by Dr. C. P. Aber and others (25 January, p. 209) of their cardiac monitoring unit at the Kingston General Hospital, Hull, for we have for the past year been running a similar unit at this hospital. Our practice and techniques have been very much the same, and our results have been comparable. We have however differed in one respect that may be important.

Our unit consists of several rooms of varying size. There is an "acute" ward of three beds, each fully equipped as at Hull, and centrally monitored. Next door is a "post-acute" ward of four beds to which patients are usually transferred after two or three days. Mobile oscilloscope monitors are available for use here as necessary. There are two other wards, one female (three beds) and one male (ten beds), for convalescents. Thus we are able to keep our coronary thrombosis patients in the same unit and under the care of the same medical and nursing staff until they are sent home. We think this is important, for a small but significant number of dangerous arrhythmias do occur in the second, and even in the third, week after initial infarction; and treatment of these late crises is easier and more effective if carried out within the unit instead of in a general ward. This has been our experience, and Dr. Aber and colleagues' figures for successful resuscitation in their unit and in their medical wards seem to bear us out.

We think, therefore, that to retain patients in the cardiac monitoring unit throughout their illness is a distinct advantage. We also think, incidentally, that our "acute" ward is rather small, but we are limited by space. We hope that these comments may be of help to others who may be thinking of establishing similar units in regional hospitals.—We are, etc.,

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### Hyperbaric Oxygen in Carbon Monoxide Poisoning

SIR,—Drs. H. J. S. Matthew and A. T. Proudfoot (18 January, p. 187) meet my advocacy of hyperbaric oxygen in carbon monoxide poisoning with unbridled enthusiasm of their own in favour of treatment with intravenous mannitol. Their results in the treatment of 100 patients with carbon monoxide poisoning are impressive, but effectiveness of one form of therapy does not preclude the effectiveness of another. They mention mortality as a yardstick of success. Dr. I. Ledingham in his chapter on hyperbaric oxygen in *Modern Trends in Pharmacology and Therapeutics*<sup>1</sup> points out that it is not the mortality that is affected by this form of therapy but the morbidity. This is because "unquestionably, patients with coal gas poisoning recover more quickly with hyperbaric oxygen than with conventional therapy, and this presumably will decrease the number of associated complications and sequelae." The mortality "appears to depend on the high survival rate of patients arriving at hospital alive rather than a failure of the therapy itself." This might explain the success reported by Drs. Matthew and Proudfoot.

An annotation in the *Lancet*<sup>2</sup> stated "when available, treatment with hyperbaric oxygen may be vital." Your own leading article<sup>3</sup> expressed the view "... where this is available, exposure to hyperbaric oxygen at 2-2½ atmospheres pressure is the treatment of choice. . . ." Smith<sup>4</sup> records 70 patients with carbon monoxide poisoning treated with hyperbaric oxygen with two deaths. A personal series of 15 patients with