ill defined right hypochondrial and epigastric discomfort was felt. However, these symptoms were sufficiently severe to demand cessation of therapy. They improved and subsequently disappeared soon after therapy with these drugs was suspended. So it appeared to us that abnormality of alanine transaminase was a good indication of hepatotoxicity in these patients.

These tests have now been adopted as routine in this clinic in all patients receiving therapy with rifampicin and isoniazid in any combination. It will be interesting to see whether patients showing abnormality of SGPT are also slow acetylators. This may be a good screening test for those who will be treated with this very effective combination and is to be investigated.—I am, etc.,

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Depressive Illness and Aggression in Belfast

SIR,—I was most interested to read the paper by Dr. H. A. Lyons (5 February, p. 342) concerning depression and aggression in Ulster. However, I wonder what account has been taken of the effect of the disruption of general practitioner care on the referral of patients to hospital outpatients during the present troubles. It would seem to me that this might well have had an effect on the figures for the referral of depressive patients per se, but would be less likely to have affected the figures for suicide attempts.

I am, etc.,

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Bacteroides Infections

SIR,—We read with interest the paper by Dr. Onagh Tracy and her colleagues (29 January, p. 280) on “Lincomycin in the Treatment of Bacteroides Infections.”

In their article they mention that they were unaware of any published clinical account of the use of this group of antibiotics in bacteroides infections. At the Fifth International Congress of Chemotherapy held in Vienna in 1967 we described the case of a 55-year-old woman suffering from diverticulitis associated with bacteroides septicemia, which responded satisfactorily to lincomycin.1 The minimum inhibitory concentration of the organism for lincomycin was 0.25 μg/ml. We are, etc.,

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Torsion of Testicle

SIR.—Your timely leader and the article by Dr. R. H. Chapman and Mr. A. J. Walton (13 January, p. 164) emphasize the problems of diagnosis of torsion of the testicle. My own approach to any patient referred with a diagnosis of epididymitis is to ask myself first if this could be either torsion or tumour. Torsion is common, is commonly overlooked, and is often misdiagnosed as epididymitis. The latter is the most frequent diagnosis in general practice, and in a small “epidemic” of torsions which I dealt with some years ago—some 36 cases in 2 months—the correct diagnosis was made only once by the general practitioner.

Having seen two patients referred as having appendicitis, who in fact had torsions, I was reminded of Mr. Thomas Moore’s letter (5 February, p. 374). At first sight, the pain may be similar, but I find that it is often rather lower and more medial than is usual in appendicitis, and the signs of peritonitis are less marked than one would expect for the severity of the pain if it were caused by appendicitis.

As the congenital anatomical anomaly which makes torsion possible is in my experience always bilateral, I find it of value to examine the unaffected testicle. If the anomaly is present, the testicle can be turned easily through 180° or more so that the lower pole is uppermost. The normal testicle tends to flip back at about 160°. This test, incidentally, is also of great value in cases of chronic or recurrent torsion or in those occasional individuals with longstanding testicular pain for which no cause is immediately apparent.

There is really only one disaster in exploration—namely, to explore a testicular tumour through a scrotal incision in mistake for a torsion. This, however, is another problem.—I am, etc.,

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1 Burkitt, R. British Medical Journal, 1956, 2, 345.