myself would challenge his concluding paragraph:

"... But once it is there [place of safety] the best interests of the baby and the rehabilitation of the parents are not contradictory aims: they are joint ones, and the apparatus for dealing with both is available."

I do not question the soundness of this statement in the majority of such cases. My comment is, and was, concerned with the tragic minority where the best interests of the child do conflict with those of the parents, and indeed where the best interests of the child may involve the infliction of further suffering on the parents if we are to hope for a planned future for the child. If anyone doubts the existence of this tragic minority, where attempts to consider the joint interests of the parents and child have failed, the simplest research at a hospital such as this would demonstrate the price in injury and death of this failure to the children concerned.

I have enjoyed Dr. Yudkin's comment about the police, but am troubled by the advice given in the memorandum that referral to them should wait until after investigation by the children's officer. We are all aware, if only through "who-done-its," of their unfauling request, "Please do not touch anything"—but we assume in this context that the children's officer should investigate, question, discuss, and interview various bodies and then, where he may find it necessary, call in the police, apparently without regard to the acute difficulties inherent in such a delayed investigation to the police.—I am, etc.,

E. E. Sumpter
Paddington Green Children's Hospital
London W.2.

Modern Situations

Sir,—The Medical Officer of Health for Manchester, Dr. Metcalfe Brown, is to be congratulated for his grasp of modern situations in providing his midwives with two-way wireless telephone instruments to be used on domiciliary visits if required. No one can possibly deny the advantages of such an instrument for the busy general practitioner, particularly when traffic conditions very often make returning in one's tracks a major tragedy, when this could have been avoided by a suitable message. Dare one suggest that some of the disputed "merit money" be made available for such modern equipment?—I am, etc.,

J. A. Frayns
Shipley, Yorkshire.

Glucose-6-phosphate Dehydrogenase Deficiency in Marfan’s Syndrome

Sir,—I was very interested to read Dr. P. Cannon’s report (30 April, p. 1112) of a case of glucose-6-phosphate dehydrogenase deficiency occurring in a Jewess with Marfan’s syndrome. The acute haemolytic episode was apparently precipitated by drugs which included two of the newer penicillins.

It is fascinating to speculate on the significance of the association of the enzyme deficiency in that case with Marfan’s syndrome. As Dr. Cannon has pointed out, it may be the first recorded example of such an association. In 1959 my colleague and I described a case of a Jewess in Singapore who suffered an acute haemolytic episode after treatment with sulphamethoxypyridazine, pyrimidin, and penicillin injections. She had glucose-6-dehydrogenase deficiency. This enzyme deficiency is common among Sephardic Jews from oriental and Mediterranean countries. It has been thought to be rare among the Jews of Ashkenazic stock, who comprise the majority of the Jews living in Europe.

The Jewish lady described by Dr. Cannon seems to be of Ashkenazic origin. However, since the condition has also been described in association with Marfan’s syndrome, it is still debatable whether we could dismiss her racial origin as being of no significance.—I am, etc.,

W. O. Phoon,
Medical Officer,
Shell Eastern Limited.
Singapore.

References

Allergic Dermatitis from Sellotape

Sir,—The following case may be of interest, in view of the allergens which were established as responsible for the patient’s eczema.

The patient, a female of 54, was admitted for treatment for leg ulcers and associated varicose eczema involving the legs, with secondary spread to the trunk and arms. She had suffered with varicose veins for approximately 30 years, and considered that she had begun following her pregnancies. She had had ulceration of the legs before, and had had her veins stripped seven years previously. The present ulceration and eczema dated from three months prior to her admission.

Following biopsy of an eczematous lesion on her arms, she developed a pronounced eczematous reaction beneath the strips of Sellotape used for fixing the dressing. This had been used in place of Elastoplast, to which the patient claimed she was sensitive. When her widespread rash had settled down she was patch-tested to a wide range of possible allergens to confirm the reaction to Sellotape and Elastoplast, and possible sensitivity to local applications previously used. The following significant results were obtained:

<table>
<thead>
<tr>
<th>Time</th>
<th>WOol alohol 5% in P.M.F.</th>
<th>Elastoplast</th>
<th>Sellotape plain side</th>
<th>Sellotape adhesive side</th>
<th>Release-coated cellophane film</th>
<th>Polyvinyl behenate powder</th>
<th>Polyethylene glycol 10% in acetone</th>
</tr>
</thead>
<tbody>
<tr>
<td>48 Hours</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>96 Hours</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

Patch testing with pure polyethylene glycol in normal patients gave no reaction.

Sellotape consists of cellophane, which is cellulose and polyethylene glycol, plus an adhesive on one side. There is approximately 20% of polyethylene glycol present. In some instances the plain side may be coated with a releasing compound, polyvinyl behenate. The results of tests in this patient were considered interesting in view of the times at which the reactions developed to test materials. For example, the adhesive of the Sellotape appeared to delay the reaction, and the release-coated cellophane film gave negative results. Absence of reaction to the polyvinyl behenate confirmed that this was acting as a protective layer on the cellophane film.

We concluded that this patient must have a true allergy to the polyethylene glycol component of Sellotape. Such an occurrence would appear to be exceptionally rare.

We wish to thank the manufacturers for helping us investigate this case.

—We are, etc.,

Midlex Hospital,
R. H. Meara.
London W.1.

Prevention of Tetanus

Sir,—We refer to the contribution of Drs. A. O. Lucas and A. J. P. Willis1 on the prevention of tetanus, which is likely, as was that of Bruce,2 to be quoted as evidence for use of tetanus antitoxic serum (A.T.S.) in tetanus prophylaxis. The authors have shown that 13 tetanus cases which occurred during the "non-serum era" exceeded the expected numbers of cases during this period by about nine. More detailed statistical considerations of the various data presented, however, do not show any significant difference in the numbers of cases of tetanus under various regimens—namely, A.T.S., antibiotic, or "none" in a presumably non-immune population. For instance, computing from mean numbers of doses from Table II,3 we find that 9,498 injured were likely to have received A.T.S. during the four years. The one case of tetanus among these compared with the 19 cases out of 36,633 without A.T.S. is not statistically significant (t = 1.73; t at 5% level being 1.96 from Table). Based on Table IV,4 theoretically the numbers of persons receiving different prophylaxis out of 11,603 injured during 1960 and the tetanus cases in each group would be as follows:

<table>
<thead>
<tr>
<th>Nos. Injured</th>
<th>Prophylaxis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A.T.S. (Gr. 1)</td>
</tr>
<tr>
<td>Totals recorded</td>
<td>5</td>
</tr>
<tr>
<td>Cases of tetanus</td>
<td>15</td>
</tr>
</tbody>
</table>

2. Bruce, E., ibid., 1961, 1, 112.