cleared relapsed and required dapsone again, and of the three patients whose dapsone requirements had fallen two needed an increased dose in order to control the skin lesion. The changes that occurred in the macroscopic appearances of the small intestine, in the heights of the intestinal villi and of the surface epithelial cells, in faecal fat excretion, and in serum and red cell folate levels as a result of the diet, and their reversal on reintroducing gluten, were all compatible with gluten sensitivity.

These recent findings will be reported in full elsewhere, but to our mind they demonstrate that in a number of patients the skin disorder is influenced by a gluten-free diet, and that there is a direct relationship between the gut and the skin in dermatitis herpetiformis. The fact that in some patients the skin lesions do not improve with a gluten-free diet, pre

sumably, therefore, by analogy, the skin lesions cannot be expected to respond in all patients with dermatitis herpetiformis.

Since idiopathic steatorrhea is known to have a genetic basis it is likely that the gluten sensitive enteropathy in dermatitis herpetiformis will also have a genetic basis; nevertheless this does not exclude the possibility that a similar or related acquired defect is responsible for both lesions.—We are, etc.,

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REFERENCES

1. Marks, J., Shuster, S., and Watson, A. J.

2. Fry, L., Keir, P., McMinn, R. M. H., Cowan,
J. D., and Hoffbrand, A. V.

3. Fry, L., McMinn, R. M. H., Cowan, J. D., and

4. Shuster, S., Watson, A. J., and Marks, J.
Lancet, 1968, 1, 552.

5. Van Tongeren, H. M., Van der Steak,
W. J. B. M., and Schilling, P. H. M.
Lancet, 1969, 1, 452.

6. Marks, R., Whittle, M. W., Beard, R. J.,
Robertson, V., and Cowan, J. D.

7. Macdonald, W. C., Dobbs, W. O., and Rubin,

Mountain Accidents

Sir,—Details of mountain accidents for 1967 are given in the Tables. The figures are based on accident report forms returned from official mountain rescue posts to the Mountain Rescue Committee. There are now 65 official mountain rescue posts; they are situated in all the mountainous areas of Great Britain. In all cases the victim sustained physical injury, but in addition to the accidents recorded many searches and rescues were undertaken for persons lost, cleft, or trapped in caves; also 200 cases of injury to skiers were reported for the year, chiefly in Scotland.

There has been a slight increase in the total number of mountain accidents in 1967, compared with 1966 and 1965. However, there were slightly more accidents in 1966 than 1967. This pause in the steady increase in the number of accidents each year was probably due to the widespread epidemic of foot-and-mouth disease in the last quarter of 1967. During this time the number of walkers and climbers was greatly reduced by voluntary co-operation of walkers, ramblers, and climbers with the farmers and agricultural authorities.

Table I shows that roughly one quarter of accidents have occurred in each of the three main climbing areas—Wales, the Lake District, and Scotland—with the Pennines and sea cliffs making up the remaining quarter. The accident incidence in the various hill districts remains practically constant. Table II also shows that again the proportion of accidents between climbers, walkers, and cavers remains constant when compared with previous figures. It will be seen that there are a few more walkers than climbers involved in accidents.

**TABLE II.**—Nature of Injury

<table>
<thead>
<tr>
<th>Injury</th>
<th>Head and back including fractures</th>
<th>54</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fractured limbs</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Heart attack</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>Exposure and frostbite</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Found dead</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Drowned</td>
<td>13</td>
</tr>
</tbody>
</table>

Injuries to the lower limb and head are the most common type of injury encountered. The wearing of a firm protective helmet (similar to the industrial helmet) by climbers is increasing, but the fashion is not yet sufficiently established to reduce the number of head injuries. Inflatable "jet" splints have been used with satisfaction in the first-aid management of fractures of the lower limb. Inflatable splints have also been issued to selected and experienced mountain rescue teams. Instructions have been given to users to keep the pressure in the splint at a minimum consistent with the immobilization of the fractured limb, to reduce the pressure in the splint every one or two hours according to the state of the patient. No report of any untoward effect has been received following the use of these splints.

Daytime accidents have increased proportionally with the increase in cliff-climbing, chiefly on the South Coast and Cornwall.

**TABLE III.**—Causes of Accidents (Where Known)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Slips</th>
<th>109</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Broken fall per se</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Climbing alone</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Loose rock</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Abseiling</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Glissading</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sled weather</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>In caves</td>
<td>11</td>
</tr>
</tbody>
</table>

Swept into or falls into the sea | 6 |

As previously reported,1 almost half of all accidents in mountainous areas happen to young people aged 21 or less. This high incidence of youth in mountain accidents has been stressed by the Central Council for Physical Recreation, the Scottish Council for Physical Recreation, and the Mountain Rescue Committee. A mountain leadership training board has been set up by the official bodies under the aegis of the Central Council for Physical Recreation. A certificate of mountain leadership is being instituted. It is hoped that leaders of youth groups will be encouraged to take this certificate and thereby obtain a reasonable knowledge of mountaineering and suitable first aid for the hills. Cases of exposure show an increase. This may be partly due to the better recognition of the need of rescue teams owing to wider publicity in mountaineering and medical journals.2—We are, etc.,

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M. K. HARTLEY.
Honorary Secretary, Mountain Rescue Committee.
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REFERENCES

7. Campbell, R., Aide Memoire Sec 1, Les Acci-
des dus aux accidents de montagne, Club Alpine Suisse, 1965.

Chloroquine-resistant Malaria in West Malaysia

Sir,—We wish to report the occurrence of chloroquine-resistant *Plasmodium falciparum* malaria in the south of West Malaysia, an area in which this has not previously been recorded.

Chloroquine-resistant *falciparum* malaria was first noted in Malaia in September 1962, among Commonwealth military personnel operating in Perak along the Malaysia-Thailand border.1 Sundosham2 recorded a further instance in which infection appeared to have been contracted at Tanjung Rambutan, near Ipoh in Perak. He stated that this was the furthest south in Malaia where chloroquine-resistant *falciparum* malaria has been recorded.3

The Ministry of Defence (Army) set up an investigation to ascertain the incidence of

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1. References...

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2. References...

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3. References...