raises the point that the presence of the prune-belly syndrome in an older child should be unacceptable because it represents failure to apply early preventive treatment.

In addition to the psychological and cosmetic benefit it might well be that the stronger abdominal wall would also be a positive advantage in the child's urinary dynamics.—I am, etc.,

NEIL O'DOHERTY.

West Middlesex Hospital,
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REFERENCE

- ¹ Gellis, S. S., and Feingold, M., *American Journal of Diseases of Children*, 1965, 109, 571.

Febrile Convulsions

SIR,—Dr. N. S. Alcock in his letter (13 September, p. 655) seems to me to reveal the confusion which exists in the minds of most medical as well as lay men regarding the meaning of the word epilepsy. If he would formulate a useful definition of the word he would better be able to test the validity of his implied assertion that children who have febrile convulsions are epileptics. Perhaps he would argue that everybody is an epileptic. His use of the term "epileptic threshold" seems to suggest this. However, it would be small comfort to the parent of a child who asks: "Doctor, is he an epileptic?" to be told: "Madam, we are all epileptic." Nor will this approach clarify our thoughts about the best treatment of the individual patient.

I will not presume to enter the lists in the argument for or against lumbar puncture in the investigation of all convulsions. That is another question.—I am, etc.,

G. P. McMULLIN.

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Hypotensive Reaction after Propanidid and Atropine

SIR,—We would suggest that hypotensive reactions to propanidid are not as rare as Dr. B. Kay (16 August, p. 413) and Dr. G. Johns (4 October, p. 52) would seem to suggest. In low dosage (4 mg./kg.) after atropine premedication, thiopentone and propanidid have a similar and low incidence of hypotension,¹ but with doses over 7.5 mg./kg. the incidence after propanidid is about 30% or three times that with thiopentone.² The limit regarded as significant in the above studies was a fall of 40 mm. Hg, but with large doses of propanidid several patients showed extreme hypotension to be restored by lowering the head of the table and inflation with oxygen. These studies were carried out injecting at the slow rate of 1 ml./4 seconds and faster rates undoubtedly increase the incidence of hypotension.

All such cases showed a widespread peripheral vasodilatation, though the work of Johnstone and Barron³ suggests that cardiac depression is an important factor. With a drug of such short duration as propanidid it is tempting to give more than is strictly necessary or safe as an initial dose to pro-

long anaesthesia. However, not only does this increase the dangers described but it increases the incidence of excitatory phenomena and hiccough. Podlesch and Zindler⁴ and Lear⁵ have also stressed the dangers of propanidid in the "poor-risk" patients and the necessity to reduce the dose. It seems, therefore, that the cases described by Dr. Kay represent the marked hypotensive response to a relatively large dose of propanidid in ill children.—We are, etc.,

R. S. J. CLARKE.
JOHN W. DUNDEE.

Royal Victoria Hospital,
Belfast.

REFERENCES

- ¹ Dundee, J. W., and Clarke, R. S. J., *British Journal of Anaesthesia*, 1964, 36, 100.
² Clarke, R. S. J., and Dundee, J. W., *Proceedings Fourth World Congress of Anaesthesiology*, 1969, Excerpta Medica Foundation, in press.
³ Johnstone, M., and Barron, P. T., *Anaesthesia*, 1968, 23, 180.
⁴ Lear, E., *Anesthesia and Analgesia Current Research*, 1968, 47, 154.
⁵ Podlesch, I., and Zindler, M., in *Die intravenöse Kurzarkose mit dem neuen Phenoxymessigsäurederivat Propanidid*, edited by K. Horatz, R. Frey, and M. Zindler, p. 160, 1965. Berlin, Springer-Verlag.

Equipment for Road Accidents

SIR,—I read with interest the article on equipment for use at roadside accidents (25 October, p. 214). In this a list of equipment is suggested for general practitioners to carry. I feel that one could make a strong case for the supply by the Ministry of Health of a small basic kit to all medical practitioners in whatever branch of medicine they are employed—for example, in my own specialty, psychiatry.

The article points out that the accident services are tending to be more and more centralized all the time, and the time which elapses between the accident and the patient being admitted to an accident unit is therefore likely to be longer. Having quite recently been first on the scene at two road accidents, while able to use makeshift splints and so on, I was unable to give the patients what they probably needed most—a pain-relieving injection—because I was not carrying at the time the syringes and a supply of morphine or pethidine. The Ministry of Health could surely devise a small standard kit which all doctors could keep in their car for use in such circumstances.—I am, etc.,

W. J. STANLEY.

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Respirators in Respiratory Failure

SIR,—I am grateful to Professor J. S. Robinson for clarifying the misconception arising out of the reporting of comments made by him at the Annual Scientific Meeting of the B.M.A. at Aberdeen (19 July, p. 165). I am pleased to note his remark (27 September, p. 780) that there is indeed still a place in medicine for the cabinet respirator. However, I cannot accept as valid his assumption that because the Cape Engineering Co. have neither sold nor manufactured these machines in recent years it is proof that they are obsolete or useless. The fact that the demand for them has so drama-

tically vanished does not mean that it is accepted that they are valueless. It merely indicates that the disease for which they were devised had virtually disappeared shortly after the machine was produced. The manufacturers are not subsidized to keep stock of expensive apparatus for potential sales in such circumstances.

In the same issue (p. 781) Dr. G. T. Spencer has most ably demonstrated the class of case in which the cabinet is so valuable. Moreover, the final sentence of his letter adds weight to the point I have made above concerning the commercial aspects of demand and supply. I would, however, like to add that not only those patients with chronic respiratory defect will continue to require that machine, but also those who are in the acute stage of respiratory paralysis and in the category mentioned by Dr. Spencer. From a very wide experience of the cabinet in such cases—and indeed in those with total respiratory paralysis—I should be sorry to see a void left in the availability of this machine and in the expertise needed in its application. It would be unwise to assume that acute poliomyelitis leading to such a class of respiratory defect will never again occur, either sporadically or in epidemic form.—I am, etc.,

W. HOWLETT KELLEHER.

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Know Your Nematodes

SIR,—Last week I watched an episode of a programme called "Know Your Onions" on B.B.C. 2 in which the participants talked about the preparation and cooking of a set meal. Eventually the question of sausages was discussed. You can imagine my concern when I saw one of the "experts" cut into what appeared to be the raw article, extract a morsel, and eat it.

If the sausages were pork, as I imagine they were, the technique demonstrated was ideal for acquiring trichinellosis. Anyone who had the misfortune to see the patients infected during the outbreak in Liverpool in 1953 will share my concern at this deplorable failure to respect the simple elements of hygiene.

If the particular individual in the programme likes his sausage meat that way that is his own business, but since it can be presumed that this programme has some following the B.B.C. should surely pay reasonable attention to health details in it.

I have written to you rather than to the *Listener*, which I suppose would be the more obvious thing to do, because my last letter to that journal was not published. In it I pointed out that the television doctor had given a programme on the medical aspects of holidays abroad without mentioning the dangers of imported disease in the returned traveller. In view of the extensive literature on the subject—for example, the recent report of 2,000 cases of falciparum malaria with 58 fatalities over the last 15 years in this country¹—I regarded this as quite a performance.—I am, etc.,

BRIAN MAEGRAITH.

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REFERENCE

- ¹ Shute, P. G., and Maryon, M., *British Medical Journal*, 1969, 2, 781.