1/10-1/1,000. Such reactions are abolished if the serum is preheated for 11 hours at 56°C prior to injection.

These findings are in contrast to those of Dr. Bryant and his colleagues in that these workers were unable to show attachment of IgE at two and four hours after sensitization. However, they do agree with the findings of other workers who have been able to sensitize chimpanzee and monkey lung and human skin passively in vitro by exposure to IgE antibody for a short time.

Our results indicate that human IgE attaches rapidly to macaque monkey skin and elicits a P.A. reaction at two, four, and 24 hours; these reactions being abolished if the serum is heated for 11 hours at 56°C. Most importantly, they emphasize the importance of using "clean" experimental monkeys with a known history.—We are, etc.,

T. S. C. ORR

Fisons Ltd: Pharmaceutical Division, Research and Development Laboratories, Loughborough, Leics

M. C. POLLARD
Pharmacology Control Laboratory, Beecham Pharmaceuticals, Worthing, Sussex

+ Consultant Posts in Baghdad

Str.—Several advertisements have appeared in the B.M.J. inviting applications from consultants in certain specialties to serve for periods of three months to one year in a special unit attached to the Medical City Teaching Hospital, Baghdad. As one who has been working for over two years as a visiting professor to the medical college and in the teaching hospital I can assure any consultants who may be interested that I have found work in Baghdad a most rewarding experience. The clinical conditions encountered are many and reasonable facilities for their investigation and management exist. Educational standards are good; a high general standard of education and knowledge of English is demanded of all entrants to the medical college, all teaching being in English; the students are keenly interested and lively; and a teacher is often bombarded with questions.

Apart from medicine Iraq is a wholly fascinating country to anyone interested in history and archaeology—the centre of an ancient and sophisticated civilization, of which substantial remains is going back 5,000 years still exist, and also there is much to see of the early Muslim world. Finally, may I say that ancient Arab courtesy and welcome have to be experienced to be understood. Without them I doubt if I, who had originally intended to serve here for only one year, would now be entering my third year of service.—I am, etc.,

H. H. LANGSTON

Medical College, Baghdad

Diet and Colonic Cancer

Str.—In your leading article, "Diet and Colonic Cancer" (2 March, p. 356), you credit Dr. C. D. P. Burkitt for the thesis "that diet and faecal constituents are important in the aetiology of cancer of the large bowel," which he attributes to "the low-residue diet of the West high in refined carbohydrates and low in fibre." This has obviously happened because Burkitt in his article did not even refer to my work, published much earlier than his, let alone give me due credit for this thesis. Allow me, therefore, to quote from my article: "not only establish priority but, even more important, to draw attention to the explanation why diets rich in cellulose and vegetable fibres are protective. Perhaps this may lead to additional information which could be set up to prevent colonic cancer.

In my article I stated that cancer of the colon was far less common in North Indians as compared with South Indians, and that one likely explanation might be that while milk from the latter has large quantities of acetic acid which may act in a protective manner, in the intracellular mucus of the mucous membrane of the colon by virtue of its acid milieu in North Indians while giving no such protection to the South Indians.

An acid milieu precipitates the mucus and prevents it from escaping from the mucus cells, thus protecting the mucus cells from the adverse inflammatory and proliferative changes referred to above. In an alkaline milieu, on the other hand, the intracellular mucus of the mucous membranes is rendered fluid and escapes from the cell, thus producing inflammatory and proliferative changes in the mucus with a marked increase in mictotic activity. Such hypomastatic growth duration is often a prelude to neoplasia.13

—I am, etc.,

S. L. MALHOTRA

Calcutta, India


Geriatric Policies

Str.—May I take sides in the dialogue between Professor G. F. Adams (28 September, p. 789) and Dr. H. H. Hodkinson (2 November, p. 290) and state that the easiest solution of the geriatric problem is permanent hospital admission. This is the line of least resistance, and by taking it everybody is left alone in peace. A time comes, of course, when all the geriatric beds are taken, but this again is a perfectly calm and peaceful stage of the long waiting list. As a geriatrician with a high turnover and no long-stay problem I must admit that I am a "spiv." Someday the "spiv" must carry the "can" for me. They are my own long-suffering consultant colleagues in other specialties who just have to learn to deal with their own geriatric problem instead of getting their "chronic cases" transferred to the geriatric unit. Some of them do it in good humour, some of them with grinning teeth. But they all do it. There is just no alternative.—I am, etc.,

STEPHEN SZANTO
Geriatric Departments, Royal and Plaistow Hospitals, London

Disco Deafness

Str.—Early deafness in young people as a result of exposure to excessive noise in "discos" must now be assumed epidemic proportions. The importance of this problem has been brought especially to my mind because an 18-year-old medical secretary, who has worked for me, has now been found to be suffering from this condition. If every general practitioner in the country had one such new case a year there would be 20,000 new cases in the country annually.

We can only guess at the degree of disability in later years when the normal hard-ears of 80 and 90 would be replaced by disabling deafness in many people. This is a preventable cause of deafness and the medical profession should press for controls to regulate sound at "discos." No doubt controls will eventually be applied, but in view of the enormity of the problem, the sooner the better.—I am, etc.,

M. S. SWANT
Birmingham

Variation in Intravenous Infusion Rates

Str.—We share the views of Drs. F. C. Flack and T. D. Whyte (17 August, p. 439) that most hospital staff are probably unaware of the variability of intravenous infusion rates under normal ward conditions. In a recent study at this hospital we measured the time over which 1,898 infusions were administered to 141 medical and surgical inpatients. The times at which the infusions were begun and discontinued were recorded by the nursing staff and later compared with the rate of administration prescribed by the physician or surgeon.

The results, which are shown in tables I and II, illustrate the fact that less than half the infusions were administered over the

<table>
<thead>
<tr>
<th>Deviation (%)</th>
<th>Percentage of Bottles</th>
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<tbody>
<tr>
<td>Fast</td>
<td>Slow</td>
</tr>
<tr>
<td>&lt;20</td>
<td>8-58</td>
</tr>
<tr>
<td>20-40</td>
<td>6-64</td>
</tr>
<tr>
<td>40-60</td>
<td>2-00</td>
</tr>
<tr>
<td>60-80</td>
<td>0-53</td>
</tr>
<tr>
<td>80-100</td>
<td>0-05</td>
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No deviation in 48.42%.

<table>
<thead>
<tr>
<th>Infusion Rate</th>
<th>Bottles with Additives</th>
<th>Bottles without Additives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too fast</td>
<td>18-0%</td>
<td>18-9%</td>
</tr>
<tr>
<td>Too slow</td>
<td>27-0%</td>
<td>37-7%</td>
</tr>
<tr>
<td>Correct</td>
<td>54-1%</td>
<td>43-4%</td>
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</tbody>
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