

women do in fact consult their doctor, and points out that precisely the "respectable" woman who is the more likely to be ignorant of these matters will shrink from revealing her symptoms or fears to the familiar counsellor. Might it not be suggested, however, with all deference, that the place where she ought to be able to find both warning and factual information is on the wall of her doctor's waiting-room, where if it is sufficiently clearly displayed she can read it at any time without embarrassment.

I realize, of course, that this suggestion is more easily made than implemented, and that criticism would be encountered. If, however, all general practitioners, or a large majority, acted together—displaying perhaps a standardized notice in an agreed manner, and with the published support of the profession as a whole—no doubt the censure of the oversensitive could be combated, and indeed some degree of opposition might be desirable as a means of ensuring that all would know where to find this essential information in time of need. Naturally many, including some very young, would read such a notice out of mere curiosity, but surely we no longer pretend that the young should be "protected" from factual knowledge which, if correctly given, will conduce to their safety? It might also be suggested that in many cases warning of unsuspected danger may save virtue as well as health.

The situation as reported by Dr. Rees does seem to be one of such increasing danger and urgency that, in view of the patent failure of the methods of information so far adopted by public authorities, one may perhaps be excused for appealing to doctors to take the matter into their own hands and adopt the one method which—especially with the aid of a little publicity—is sure to be successful.—I am, etc.,

Marple, Cheshire.

B. M. CAVANAGH.

Early Discharge of Maternity Patients

SIR,—In your excellent editorial on this subject (11 July, p. 70) one sentence strikes a false note for an obstetrician working in the Midlands—viz., that the number of patients per annum may be increased by this measure from 25 to 30 per lying-in-bed. I find it difficult in practice to define a "lying-in-bed." Some of my beds invariably house antenatal patients, some others always have delivered mothers in them, but a large number "in the middle" contain one or other according to need.

In two small units in which I have beds the total number of patients delivered per bed, lying-in and antenatal combined, has been 33 and 35 per annum, respectively, for some time past. If one counts 20% of beds as antenatal (a conservative estimate in these units), the number of patients delivered per lying-in bed rises to approximately 40 per annum. I claim no record. Several of my colleagues can top these figures, but may be too busy to write.

I think it most important, however, not to underestimate the great stress under which the maternity services are working, and the figures you quote give your readers a false impression, at least for the Birmingham area.—I am, etc.,

Birmingham 16.

R. B. PARKER.

Growing Up with Spina Bifida

SIR,—It is very pleasing that attention has at last been drawn to the increasing problem that will have to be faced by the community of the treatment and care of children born with spina bifida cystica.

It was pointed out in a recent leading article that the problems of the thalidomide embryopathies, the poliomyelitis, and the cerebral palsies have been publicized but that the numerical and socially far greater problems of spina bifida cystica received little mention. One reason for this may be that the major central nervous system malformations, of which spina bifida cystica is but one, tend to affect social class III, IV, and V with very much greater frequency than the social class I and II, who tend to be the more active and vociferous members of the community. Another possible factor may be that in the past the majority of the babies affected with major central-nervous-system malformations were either stillborn or failed to survive more than a month or two.

Perhaps with the increasing public awareness of this problem not only will more facilities for the early and adequate treatment and their education, in many instances in special schools, be demanded but perhaps more funds for research into all aspects of these abnormalities will be made available.

Spina bifida cystica is, however, not a uniform problem throughout the British Isles. The incidence of the major central-nervous-system malformations ranges from around 3 per 1,000 births in the Home Counties to 13 per 1,000 total births in parts of South Wales.^{1,2} It is therefore necessary to provide adequate centres for the treatment and eventual education at least in those areas where the incidence is highest and therefore the need greatest.—I am, etc.,

K. M. LAURENCE.

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REFERENCES

- Laurence, K. M., and David, P. A., *Arch. Dis. Childh.*, 1963, 38, 98.
- , *J. Coll. gen. Practit.*, 1964, in press.

. The formation of a Parents' Association called the Hydrocephalus Association with the aim of uniting parents of children with hydrocephalus or spina bifida was announced by Dr. John Lorber in the *B.M.J.* of 25 July (p. 250).—ED., *B.M.J.*

Jane Austen's Last Illness

SIR,—Sir Zachary Cope (18 July, p. 182), in his analysis of the symptoms, as described by laymen, of Jane Austen's last illness, has made a reasonable diagnosis of the cause of her death, but I wonder if he has considered sufficiently the feverish side of the illness. Fever is unusual in Addison's disease, and I suggest that Hodgkin's disease is the probable diagnosis—particularly the generalized form without much involvement of the superficial lymph nodes. This could account for all the symptoms mentioned including the skin pigmentation and the initial pain in the back.

I considered Hodgkin's disease as a possible diagnosis in Jane Austen's case several years ago, after I had attended a young man with lymphadenoma (proved by biopsy of a

small superficial lymph node) which started with pain in the back. His disease, which was without marked enlargement of superficial lymph nodes, ran a similar acute course to Jane Austen's disease.—I am, etc.,

Woodstock, Oxon.

F. A. BEVAN.

Infection and the Water-closet

SIR,—Mr. W. R. Sloan (18 July, p. 189) reports a method of avoiding splashed buttocks. The degree of splashing is likely to depend on the height above the water.

To test this, a number of sheets of newspaper were prepared with a central hole of 2 cm. radius. A fingerstall was filled with water and a little sand to the appropriate size and shape. The sheets were held at various heights above the surface of a bucketful of potassium permanganate solution. The fingerstall was held in the central hole, then released. All splashes within 10 cm. of the hole were counted.

The results were:

Height (cm.)	Discrete splashes	Confluent blobs
10	2	2
20	84	4
30	127	15
40	36	1
50	6	0

Clearly this is only a simplified model of the actual situation, but the findings suggest that there is likely to be a fairly well defined height of maximum splashing, and that quite a moderate increase in height above this will probably reduce the incidence of splashed buttocks almost to zero, as Mr. Sloan has found.—I am, etc.,

Ilford, Essex.

A. M. C. JENNINGS.

Colorimetric Estimation of Glucose

SIR,—One of the first workers to use a buffered mixture of glucose oxidase, peroxidase, and a chromogenic oxygen acceptor for the estimation of glucose recognized the interference of uric acid in these methods.¹ Charcoal or an ion-exchange resin, therefore, usually has to be used to remove it from such biological fluids as urine, which contain a high concentration, before the glucose can be measured accurately.

Even a lower concentration of 5 mg. uric acid per 100 ml. in normal human plasma would lead to an underestimation of its glucose content by about 7%, when using a manual enzyme method with o-tolidine,² if it were not for the fact that zinc-hydroxide protein precipitation removes all but 0.05 mg. per 100 ml.—a level which is no longer inhibitory.³ A similar manoeuvre has been applied to the estimation of glucose enzymatically using the automatic analyser.⁴ Most such methods, however, employ simple dialysis of the blood sample, when normal uric-acid levels still interfere and lead to glucose underestimation by about 6%.⁵

Modification of a glucose-oxidase method for use with the automatic analyser,³ based on an original manual method,² has recently become necessary to accommodate the increased sensitivity of the new tubular-flow cell. This has been performed by extra dilution of the plasma sample, and it has been found in consequence that glucose underestimation by a plasma-uric-acid level of 4 mg. per 100 ml. is reduced from 6% to 3%.