in fact consult their doctor, and that precisely the "respectable" ɔ is the more likely to be ignorant atters will shrink from revealing ms or fears to the familiar coun- ght it not be suggested, however, ference, that the place where she e able to find both warning and ormation is on the wall of her iting-room, where if it is suffici- ly displayed she can read it at vithout embarrassment.

, of course, that this suggestion is made than implemented, and that ould be encountered. If, however, practitioners, or a large majority, ther—displaying perhaps a stan- otice in an agreed manner, and ublished support of the profession —no doubt the censure of the over- uld be combated, and indeed some pposition might be desirable as a nsuring that all would know where s essential information in time of urally many, including some very ıld read such a notice out of mere out surely we no longer pretend oung should be "protected" from owledge which, if correctly given, ce to their safety? It might also ed that in many cases warning of d danger may save virtue as well

ation as reported by Dr. Rees does one of such increasing danger and at, in view of the patent failure of ds of information so far adopted authorities, one may perhaps be r appealing to doctors to take the ɔ their own hands and adopt the l which—especially with the aid of plicity—is sure to be successful.—

neshire. B. M. CAVANAGH.

## scharge of Maternity Patients

your excellent editorial on this July, p. 70) one sentence strikes te for an obstetrician working in nds—viz., that the number of r annum may be increased by this om 25 to 30 per lying-in-bed. I cult in practice to define a "lying- Some of my beds invariably house patients, some others always have nothers in them, but a large num- ne middle" contain one or other o need.

small units in which I have beds number of patients delivered per -in and antenatal combined, has d 35 per annum, respectively, for past. If one counts 20% of beds l (a conservative estimate in these number of patients delivered per ed rises to approximately 40 per claim no record. Several of my can top these figures, but may be ɔ write.

it most important, however, not to ate the great stress under which ity services are working, and the quote give your readers a false at least for the Birmingham area. c.,

n 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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The Welsh National School of Medicine,
Llandough Hospital,
Penarth, Glamorgan.

REFERENCES

1 Laurence, K. M., and David, P. A., *Arch. Dis. Childh.*, 1963, **38**, 98.
2 —— —— *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 permangate 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 manœuvre 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%.