

genetic predisposition is suggested by the higher incidence of a history of chronic bronchitis in relatives of patients with this disease than in relatives of unaffected individuals. The abnormality in the bronchial mucosa appears to predispose to persistence of common respiratory infections. It is possible that frequently recurrent respiratory infections may themselves be a factor in the development of the underlying bronchial mucosal abnormality. There is good evidence

that damage in the peripheral part of the bronchopulmonary tree caused by bacterial infection is at least an important factor in the gradual development of permanent disability. This matter is dealt with at length in the monograph of chronic bronchitis edited by N. C. Oswald.²

REFERENCES

- ¹ *Brit. med. J.*, 1963, 2, 1453.
² *Recent Trends in Chronic Bronchitis*, 1958, edited by N. C. Oswald. Lloyd-Luke, London.

Notes and Comments

Tetracycline in Infancy.—Dr. E. TEMPANY (The Hospital for Sick Children, London W.C.1) writes: Unlike your expert ("Any Questions?" 11 April, p. 959) I would not agree that "the only drawback . . ." in the use of tetracycline in the newborn period "is the possibility of causing staining of the teeth."

Bulging of the fontanelle as a complication of tetracycline therapy has been reported¹ in young infants and on the evidence available there is no reason why this complication may not occur in the newborn period. Also it has been shown² that the use of tetracycline in premature infants produces a depression of skeletal growth. Admittedly this growth inhibition is only temporary but nevertheless occurs.

OUR EXPERT replies: A complete catalogue of side-effects caused by tetracyclines must of course include these conditions, but the question was about contraindications to their use, and neither of these effects appears to merit this description. The bulging of the fontanelle observed in an unstated proportion of treated infants is described as "benign," and seems to be unaccompanied by any other disturbance; its mechanism remains to be explained. The reduced rate of growth of the fibula seen in premature infants given excessive doses (100 mg. per kg. daily) is immediately followed by accelerated growth when the treatment is stopped, and there is no evidence of any permanent effect.

REFERENCES

- ¹ Fields, J. P., *J. Pediat.*, 1961, 58, 74.
² Cohan, S. Q., Bevelander, G., and Tiamsic, T., *Amer. J. Dis. Child.*, 1963, 105, 453.

Weavers' Bottom.—Mr. K. F. D. SWEETMAN (Singapore 9) writes: Your expert ("Any Questions?" 7 March, p. 615) deals summarily with

the subject of weavers' bottom. In making my comments I am assuming that the patient about whom advice was sought suffers from bilateral ischial bursitis. Though called weavers' bottom, I have never seen a weaver but I have seen the condition, and from bitter and personal experience have come to call it "car-drivers' bottom." It results from the legs being too long for the driving position of the vehicle, and most of the body weight rests continuously upon the ischial tuberosities. In a person who has developed the condition, a drive of 100 miles (160.9 km.) is sufficient to bring back the effusions.

In this patient, a young girl, this is not the causation. But what about similar continuous trauma, such as sitting on the hard floor, back to the sofa, knees up under the chin, arms embracing the legs, all the while rocking gently back and forth on the ischial tuberosities while watching "the telly"? Or repeated bouncing on to the floor, landing on the point of the bottom, in physical training?

The possibility of the cause being tuberculosis is remote in a bilateral condition but can be settled efficiently by aspiration of the bursae and the routine investigation of the fluid obtained. Even in a tuberculous case, treatment with the usual antituberculous drugs should effect a cure without surgery. In the non-tuberculous condition treatment is to avoid the recurrent causative trauma by common sense, the use of an air cushion possibly being necessary. The absorption of the bursal fluid can be hastened by the intra-bursal injection of hydrocortisone or prednisolone and giving "chymoral" tablets (trypsin and chymotrypsin). In a young girl such as this surgery should not be necessary.

OUR EXPERT replies: We have, of course, no information about this girl's habits. Mr. Sweet-

man suggests that her condition must be bilateral, but we do not get this impression from the question. If it was common to get bursitis of this nature from riding in a car and from the sitting and moving about that he describes then I would have thought that we should have seen it from time to time in our hospital clinic. I have never seen this condition at any time nor have I heard of it occurring in the practice of my colleagues.

Prothrombin Index.—Dr. L. POLLER (Withington Hospital, Manchester 20) writes: In his otherwise entirely accurate answer ("Any Questions?" 28 March, p. 828) your expert uses the terms prothrombin ratio and prothrombin index as synonymous. This, in fact, is not correct. The prothrombin ratio is:

$$\frac{\text{patient's prothrombin time (sec.)}}{\text{control's prothrombin time (sec.)}}$$

The prothrombin index is:

$$\frac{\text{prothrombin time of control plasma}}{\text{prothrombin time of test plasma}} \times 100$$

Whereas the ratio of twice the control time is acceptable, the index is usually kept between 40 to 60%. The pros and cons of use of activity, ratio, and index are fully discussed by myself elsewhere.¹

OUR EXPERT replies: Dr. Poller is, of course, quite correct, and I thank him for correcting this slip of the pen. It is in fact better to avoid using the prothrombin index altogether, for the index may be determined either as the simple formula

$$\frac{\text{control's plasma clotting time}}{\text{patient's plasma clotting time}} \times 100$$

or be read from a dilution curve. In the former instance the therapeutic range is 40-65%, while in the latter it is 10-25%—a potentially very confusing situation.

REFERENCE

- ¹ Poller, L., *The Theory and Practice of Anticoagulant Treatment*, 1962. Wright, Bristol.

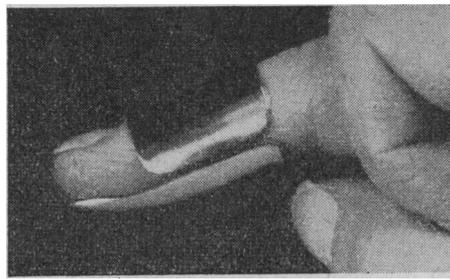
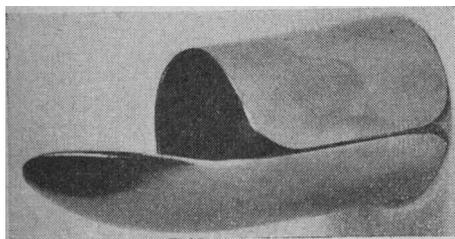
Correction.—In the leading article "Lymphatics and the Gut" (25 April, p. 1062) reference 7 should read Kinmonth, J. B., and Taylor, G. W., *Brit. med. J.*, 1964, 1, 529.

NEW APPLIANCES

Splint for Mallet Fingers

Mr. DONAL BROOKS, surgeon in charge of the hand clinic, Royal National Orthopaedic Hospital, London, writes: Maintenance of adequate splintage for mallet deformity of the finger is usually a tedious affair. Various devices have been employed, from immobilization of the finger in plaster-of-Paris to metal

splints held in position by strapping. Such methods of treatment have the disadvantages that the finger cannot be immersed in water and that they prevent a glove being worn (as they are usually bulky).



The simple splint illustrated in Figs. 1 and 2 has been devised by Mr. F. Oakley, surgical appliance officer in the workshops of the Royal National Orthopaedic Hospital. It has the merit of simplicity, and, being constructed of stainless steel, can be safely immersed in water, thus allowing the housewife to do her weekly wash, etc., without difficulty. The splint is usually made to measure, and is worn continuously for a period of six weeks. In our experience most mallet deformities of the finger are corrected by this method, whether a chip fracture is demonstrable or not.

The patient is advised to remove the splint for washing the finger at least once a day, during which time the deformity is held corrected by apposition of the terminal phalanx of the affected finger to the thumb. After drying the finger, powder is applied to avoid maceration of the skin from close contact with the metal. This splint has had a continuous trial for three years, and no snags have been encountered.