acetabulum cannot be examined. But there can be little doubt that severe limitation of function must have been present in this hip joint, probably with advanced osteoarthritis of the socket. The absence of the innominate, together with the impossibility

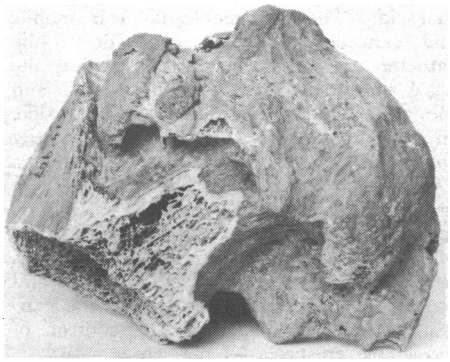


FIG. 1.—Anterior aspect of femoral head and neck. Note eburnated articular surface surrounded by craggy osteophytes masking part of the neck. The head has slipped downwards and backwards, shortening the distance between the fovea and the lateral surface of the great trochanter.

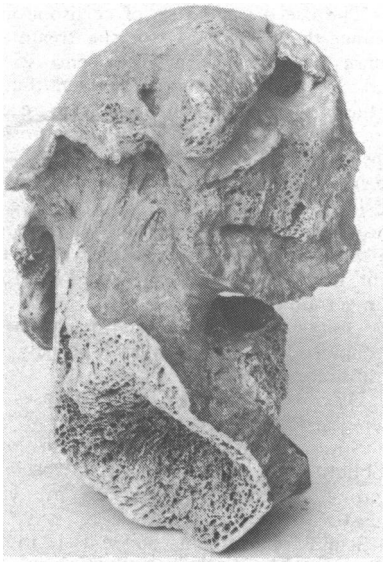


FIG. 2.—Inferomedial aspect of femoral head and neck. Note the groove made by the ligamentum teres which dips down into a deep tunnel towards the fovea. Note also the posterior displacement of the head.

of obtaining a clinical history, adds difficulty and interest to the diagnosis. The transverse diameter of the head of the bone is very close to 51·5 mm. In 12 normal mediaeval femora chosen because their femoral head diameters ranged from 50-53 mm the distance from the fovea to the most lateral part of the greater trochanter ranged from 98·3 mm to 117·6 mm. In the Carrow Abbey specimen this distance is only about 84·5 mm, which might suggest that the diminution is due to a fractured neck. There is no evidence of this, however; as far as can be seen the neck is nearly normal beneath its carapace of osteophytes.

The abnormality here seems to be primarily in the head of the bone, which has diverged posteriorly and downwards from its normal position. This is the characteristic feature of a slipped capital epiphysis spontaneously occurring in early adolescence, and there is little doubt that this accounts for the present lesion. It might possibly be a simple osteoarthritis, although this is extremely unlikely. Osteoarthritis is very common in mediaeval femora but its usual form is quite different from the specimen shown here.[1]

It is difficult to assess the age at which this person died. The epiphyses of the head and the trochanter had fused long before death and it is probable, from the severity and extent of the osteophytic reaction, that he was at least 30 years old. Be this as it may, the fragment seems to be highly typical of the late results of a juvenile slipped femoral epiphysis.

In contrast to fractures and osteoarthritis of the femur, this is an exceedingly rare condition in early burial grounds, if indeed it has ever been diagnosed. The fact that in the course of examining thousands of archaic femora I have never seen a similar specimen is, perhaps, sufficient justification for reporting this case.

My thanks are due to Mr. F. W. Cheetham, director, City of Norwich Museums, for permission to record this note.

—I am, etc.,

CALVIN WELLS

Castle Museum
Norwich

1 Wells, C., *Bones, Bodies and Disease*. London, Thames and Hudson, 1964.

Cullen's Sign in Perforated Duodenal Ulcer

SIR,—Mr. D. M. Evans (16 January, p. 154) records an example of Cullen's sign in a case of perforated duodenal ulcer. He quotes Cope[1] and Bailey[2] as stating that haemorrhagic staining at the umbilicus is pathognomonic of acute pancreatitis. In my experience it is more common in natural ectopic gestation and in spontaneous haemorrhage into the rectus sheath. The latter condition can be particularly deceptive as there is marked local tenderness and guarding.

It appears that in Mr. Evans's case there was no blood-stained abdominal free fluid. The possibility would seem to arise that in this case the blood staining at the umbilicus was due to a muscle tear.—I am, etc.,

S. C. RAW

Farnham, Surrey

1 Cope, Sir Z., *The Early Diagnosis of the Acute Abdomen*, 12th edn., p. 89. London, Oxford University Press, 1963.
2 Bailey, H., *Emergency Surgery*, ed. T. J. McNair, 8th edn., p. 536. Bristol, Wright, 1967.

Unusual Cause of Varicocele

SIR,—We report a case of abdominal aortic aneurysm presenting as a left varicocele.

A 63-year-old man presented with a two-month history of aching and enlargement of the left side of the scrotum. Examination revealed a large left varicocele and an abdominal aortic aneurysm. The aneurysm had been symptomless, though on further questioning he admitted to a throbbing sensation in the epigastrium on occasions over the last two months. At operation the aneurysm arose 3 cm below the left renal vein. It was resected and a Dacron aortailiac bifurcation graft inserted. Two months after operation the varicocele was considerably smaller and symptomless.

Renal lesions, particularly hypernephroma, are known to present with a left varicocele. In this case the aneurysm probably caused the varicocele by obstruction of the left testicular vein or by stretching the left renal vein.—We are, etc.,

A. G. JOHNSON
A. G. TYERS
A. G. TURNER

Professorial Surgical Unit,
Charing Cross Hospital Medical School,
London W.C.2

Myocardial Infarction and the G.P.

SIR,—May I comment on the letter by Dr. R. D. Martin (7 November, p. 367), in which the use of procainamide as a prophylactic agent against ventricular dysrhythmias complicating myocardial infarction is advocated in general practice. The Boston study[1] concluded procainamide afforded highly significant protection against all types of active ventricular arrhythmias, markedly reduced the need for acute therapy of arrhythmias, and prevented death from active arrhythmias. Ventricular extrasystoles have been recorded in 80% and ventricular tachycardia in 27% of closely monitored patients.[2]

However, heart block has been reported to complicate myocardial infarction in 23% of patients.[2] Since procainamide reduces both the excitability and conduction velocity of the conducting system of the heart, any tendency towards impaired A.V. conduction may be exaggerated resulting in asystole. Since it is clinically impossible to exclude first-degree heart block, we consider that prophylactic therapy with procainamide should be delayed until E.C.G. evidence is available. Heart block of any type is a definite contraindication to the use of procainamide.—I am, etc.,

L. ADAMSON
Associate Medical Director,
E. R. Squibb and Sons Ltd.
Twickenham, Middx

1 Koch-Weser, J., Klein, S. W., Foo-Canto, L. L., Kastor, J. A., and DeSanctis, R. W., *New England Journal of Medicine*, 1969, 281, 1253.
2 Lown, B., *et al.*, *American Journal of Cardiology*, 1967, 20, 494.

Vaccinia in a Patient with Acne

SIR,—Prior to proceeding on a Mediterranean cruise a 15-year-old girl requested vaccination against smallpox. This had not previously been performed. There was no family history of eczema and the girl was healthy apart from mild acne on the face and neck which at that time was not active. Primary vaccination was carried out on the right upper arm. Ten days after vaccination she developed primary lesions on the face and a temperature of 103°F (39·5°C). When first seen the original vaccination showed considerable but not excessive reaction. Four similar lesions were present on the face, two others on the trunk, and two on the other arm. All these lesions were superimposed on the old acneiform rash. Tetracycline was given to prevent secondary infection and by the next day a further four lesions had developed on the face and four more on the trunk. In view of this 2 g of antivaccinial gamma globulin were given by

intramuscular injection. On the subsequent day no further lesions had developed and from that time on she made an uninterrupted recovery.

It is well known that eczema is a contraindication to vaccination, but it appears that vaccination of an adolescent with acne is also to be deprecated.—I am, etc.,

D. G. MAY

Chessington, Surrey

Accident and Emergency Services

SIR,—We should like to support very strongly the opinions expressed by Mr. F. C. Durbin (16 January, p. 177). Those who advocate a full-time consultant working in the accident and emergency department still fail to realize that the majority of patients attend outside the 9-5 day of the consultant, so that unless three consultants are appointed the majority of patients will continue to be seen by the less experienced casualty officers.

The accident and emergency department should, we believe, be more accurately called a receiving centre. It is not a department in the accepted sense of the word. It deals with the initial diagnosis and treatment of conditions which are related only by the fact that they are emergencies or need urgent opinions. In order for a doctor to give a consultant opinion on all these conditions he would need to be fully trained as a specialist in every major field: medicine, surgery, orthopaedics, ophthalmology, and E.N.T., to name but a few. This would obviously be impractical.

The remedy, we believe, lies in recognizing that the initial care of a patient with, say an acute medical condition, is as much the responsibility of the physician as his long-term supervision, and that this applies in every specialty in medicine. The orthopaedic surgeons have for a long time recognized this and in most hospitals conduct daily trauma clinics. We believe that the same continuity of care is required in all specialities. The sorting of patients could be carried out by a registered practitioner in the receiving centre. After all, we are fully confident of the general practitioner's ability to sort out patients for referral to our outpatient clinics; why not our emergencies?

The staffing of the receiving area is one of the major problems facing every hospital throughout the country today. It arises from a gross shortage of young doctors throughout the National Health Service now that the numbers arriving from abroad have been so drastically reduced. Recent changes in the routine of general practice—namely, the introduction of the appointments system and the widely used emergency night service—has further increased the demand made upon the Hospital Service. There are just not enough doctors being trained to staff these areas in the present medical service, and this has still not yet been widely appreciated. A review of the number of established posts in accident-emergency-orthopaedic departments, carried out in September 1970, has revealed that just under 1,000 posts need to be filled every six months—that is, a total of 2,000 personnel are required each year to staff fully the accident and emergency and orthopaedic junior posts. In 1970 a total of just over 2,000 doctors were provisionally registered with the General Medical Council in England, Scotland, and Wales. Thus, in order to staff the present posts in the accident and emergency and orthopaedic departments, every doctor qualifying in this country would have to spend six months of his clinical life in one of these posts.

With the assumption of total responsibility of patients arriving in the receiving area each department should establish a rotation of their junior staff through the receiving centre for two to three months or more. If this was practised throughout most hospitals, ten to twelve individuals would be available in rotation and the staffing problem would cease to exist.

Since 60-70% of the patients arriving in the receiving centre have suffered trauma of some sort, most hospitals have deemed it wise to put the overall administration of the area into the hands of the orthopaedic surgeons. However, the orthopaedic surgeons realize that they can only satisfactorily supervise the area if it is in close physical relationship to the orthopaedic department. Unfortunately the financial priorities in many hospitals have prevented the building of such units and the resultant unsatisfactory service has been unfairly blamed upon the orthopaedic surgeons.—We are, etc.,

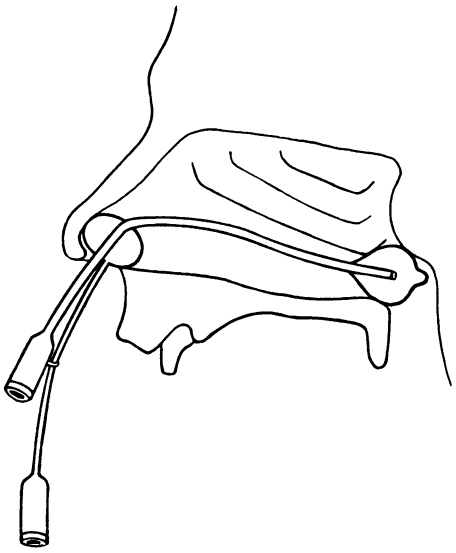
M. A. NELSON
F. F. SILK

General Infirmary,
Leeds, Yorks

Method of Controlling Epistaxis

SIR,—Frightening epistaxes can occur at any age, but, in particular, in adults with hypertension and arteriosclerosis. In those patients in which the bleeding point is easily accessible there is little difficulty in controlling haemorrhage, but where bleeding is high up or far back in the nasal cavity, traditional treatment, by packing and sedation, can be distressing and often ineffective.

With these facts in mind the staff of the E.N.T. department has spent some time in perfecting a nasal tampon which was made for us by Eschmann Bros. and Walsh Ltd. of Shoreham on Sea. This can be inserted into and passed along the floor of the nose without local anaesthesia and without upsetting the patient.



When the catheter tip reaches the postnasal wall the distal balloon is inflated. The catheter is then taughtened so that the distal balloon occludes the posterior choana on that side. The proximal balloon is mobile and can be moved up and down the catheter until it is in position within the nasal vestibule. This is then inflated and the nasal cavity "closed off" on that side. In my experience this has satisfactorily controlled haemorrhage in these patients.

This epistaxis balloon has now been in use for over a year in the E.N.T. Department in Brighton and I am convinced of its efficiency and simplicity in use. Indeed, it is perfectly simple to introduce and inflate and could prove a valuable addition to the general practitioner's methods of control of intractable epistaxes.—I am, etc.,

PAUL WADSWORTH

Hove, Sussex

Treating Fibrositis

SIR,—The use of a mixture of cortisone and local anaesthetic solutions for the treatment of tennis elbow is established and widespread. It is therefore with concern that I note the absence of this method from recent papers on the treatment of myofibrositic lesions in other parts of the body.

During the past 15 years I have collected a considerable number of cases which are of interest from the point of view of diagnosis of so-called functional disease, as well as for the substitution of hope in place of resignation in certain conditions.

The following list gives an indication of the scope of this treatment especially in general practice:

(1) Diagnostic and palliative for cases of epigastric fatty hernia.
(2) Strains of the rectus abdominis and oblique muscles. Children are especially prone after physical exercise in gymnastics.[1]
(3) Strains of ligaments and muscle insertions round so-called arthritic joints.
(4) Residue scar pain after operations for appendicitis, nephrectomy, gastrectomy etc.
(5) Scar tissue round healed fractures.
(6) Fibrositis anywhere in the back but especially at the sacroiliac joints in so-called disc lesions and industrial back injuries [2]
(7) Suboccipital pain at the muscle attachments to the skull, diagnosed as occipital headache.—I am, etc.,

I. H. J. BOURNE

Hornchurch, Essex

1 Frommer, E. A., and Cottom, D. G., *British Medical Journal*, 1970, **4**, 113.
2 Jayson, M. I. V., *Practitioner*, 1970 **205**, 615.

Advisory Councils on Industrial Health

SIR,—Considering the fact that the British Medical Association first sponsored the formation of "advisory councils" as far back as the end of the last war it is amazing that so few of them are active today. At a meeting of