

past few years. There was no radiological evidence of malformation and all but one were boys. Relapse occurred after one month (two cases), three months, and 11 months. The last of these had unilateral ureteric reflux up to the kidney. This was absent when the cystogram was repeated two years later.

These findings may reflect the stringency of our follow-up arrangements. We plan to see children with neonatal urinary tract infection every month until such time as the urines have been free of leucocytes for a period of 12 months. Our screening test is microscopy for leucocytes, done by the clinician; if there is leucocyturia diagnostic urine is obtained by bladder puncture. A considerable proportion of these children have been followed for longer periods, but we have not seen any instances of recurrent leucocyturia after the children have been cleared according to the above criteria.—I am, etc.,

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Hepatitis Contracted in the Course of Employment

SIR,—The article by your Legal Correspondent (4 December, p. 632) is to be welcomed for underlining the far from generous compensation offered to the widows of doctors who die from disease contracted in the course of their duties.

We would point out that the impression is given in the article that a discretionary injury award up to two-thirds of the officer's average remuneration can be made. While this is true if he does not die but is totally disabled (an unlikely event with serum hepatitis), in the event of his death his wife can only receive one-third of this—that is, two-ninths of his average remuneration.

These facts again underline the very poor cover offered to N.H.S. employees by the superannuation scheme. We believe that many doctors, especially the more junior ones, are quite unaware of how little their widows will receive if they die, and these facts should be more widely known by all N.H.S. medical staff.

We agree that there is a strong case for the acceptance of serum hepatitis as a prescribed disease under the Industrial Injuries Acts and for an immediate increase in the injury allowance paid to widows and dependants.—We are, etc.,

PHILLIP HARRIS
Chairman,

D. B. SCOTT
Secretary,

Medical and Dental Staff Committee
Royal Infirmary,
Edinburgh

Consultant Grades and Continuity of Care

SIR,—Once more I read (*Supplement*, 11 December, p. 73) of a conference which overwhelmingly threw out a proposal for a subconsultant grade.

I wonder how many psychiatrists attended the meeting. Whatever may be true of patients in other specialties, psychiatric patients need continuity of care and do better with therapists who are available in terms of time and place rather than in terms

of status. Rotating registrars cannot satisfy this need. Maybe this is why psychiatric nurses, who get to know their patients well, are so important. It is not brilliant diagnostic skill most of our clients require; it is an informed, concerned relationship that continues long enough to produce change.

Moreover, the medical assistant grade (foolishly named as it is) provides the relative permanency and level of salary which a number of doctors are happy to accept. Married women who have acquired skill and experience, but do not seek the responsibilities and burdens of consultancy, are an important case in point.

Can I make a plea for rational re-appraisal of these needs and suggest that we retrieve the baby from the bath water?—I am, etc.,

Ross Clinic,
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J. K. W. MORRICE

Humidifiers in Anaesthesia

SIR,—Dr. J. N. Lunn and his colleagues (11 December, p. 653) describe as "inherently safe" a gas humidification procedure during anaesthesia in which the water reservoir is maintained at 40°C. Though the apparatus they describe may indeed prove satisfactory in preventing heat loss, it will create ideal conditions for the proliferation of *Pseudomonas* and other opportunistic pathogens.

The importance of anaesthetic apparatus as a reservoir of infection, especially with Gram-negative bacilli, has now been fully established,^{1,2} yet Dr. Lunn and his colleagues do not even mention the problem. As an interim measure, all humidifiers should be equipped with small immersion heaters, so that the water can at least reach boiling point at frequent intervals. Medical microbiologists who have to cope with the consequences of infection from ventilators and other anaesthetic equipment however look forward to the millenium when all such equipment will at last be built completely out of heat-sterilizable materials, and when no patient has to breathe through apparatus which has been used and contaminated by others.—I am, etc.,

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¹ Phillips, I., and Spencer, G., *Lancet*, 1965, 2, 1325.

² Bassett, D. J. C., *Proceedings of the Royal Society of Medicine*, 1971, 64, 980.

Obesity and Smoking Habits

SIR,—I read with interest Dr. T. Khosla and Professor C. R. Lowe's communication on "Obesity and Smoking Habits" (2 October, p. 10) and the ensuing correspondence (30 October, p. 298; 4 December, p. 625).

In a recent M.R.C. project (undertaken jointly with the Hebrew University, Jerusalem, under the auspices of the International Biological Programme) anthropometric and physiological studies were carried out in Israel on immigrants from the Yemen and from Kurdistan. The subjects were aged 20-30, and the proportion of cigarette smokers was similar to that in the U.K. or America. Among both Yemenite and Kurdish men smokers (all levels of consumption) were taller than non-smokers, but

there was little difference in weight. The non-smokers did, however, have a higher value for upper arm skinfold thickness (mean of readings over biceps and triceps). The numbers here were small, and it would be interesting to know if any quantitative assessment of leanness-fatness has been made in a larger series of smokers and non-smokers compared for "obesity." Such measurements might be of greater relevance than "overweight" based on standard tables or a weight-height ratio in assessing the risk of "obesity" associated with smoking status.

Incidentally, might I be permitted gently to challenge Dr. G. Pincherle's description (30 October, p. 298) of smokers of 1-19 cigarettes per day as "those who exhibit moderation in non-smoking." Surely no-one in that category is a non-smoker, and 19 a day is hardly moderation.—I am, etc.,

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Respiratory Syncytial Virus in Hospital Cross-infection

SIR,—Dr. R. K. Ditchburn and others (18 September, p. 671) writing about the spread of respiratory syncytial (R.S.) virus in a hospital for children open a debate on a very serious problem—namely, how to reduce the risk of cross-infection of children hospitalized because of any infectious disease, and especially one caused by viruses.

We have reported an outbreak of acute respiratory illnesses caused by R.S. virus in a home for infants consisting of three ward rooms.¹ All the infants (15 aged 1-13 months) as well as the 12 staff members were healthy during the week before the outbreak.

The first infant who became ill (4 April, 1964) was a 13-month-old boy from a room where there were six other infants between 5 and 8 months old. He had been away from the home for five weeks, and the day after his return he fell ill with fever, nasal discharge, and a cough. Chest x-ray showed bronchopneumonia. Paired sera from this child showed a significant rise in complement fixing (C.F.) antibody titre against R.S. virus.

From 6 to 10 April all the infants in this ward developed acute respiratory illnesses. Between 11 and 16 April a further three infants (aged 1-1½ months) in one room on the second floor showed clinical signs of acute respiratory illness, and between 18 and 30 April all the five infants (aged 1½-5 months) in the other room on the second floor also became ill in succession. When this outbreak of acute respiratory illness had passed, all of the 15 children had been ill with fever, nasal discharge, and coughs. One-third had had signs of lower respiratory tract disease, such as bronchitis, bronchiolitis, and bronchopneumonia. These last mentioned infants were all seriously ill but survived. The incubation period for R.S. virus infection was estimated at 3-5 days. R.S. virus was recovered from nasopharyngeal and/or throat swabs from 13 out of 15 infants. Complement fixation tests against R.S. antigen showed at least four-fold rises of antibody in seven out of 15 paired sera, including sera from two children from whom virus was not isolated. R.S. virus was recovered two days before the onset of illness as well as nine days after onset. There was no rise