the child in a hostel, family group home, or hospital? In these, or any alternative form of care, is he able to provide a standard comparable to the standards of a good home —which is presumably a reasonable description of the child's own home? If Hull has such provision, its inhabitants are fortunate indeed.

(2) Are the parents expected to resume their parental functions? The complex emotional problems that parents of a handicapped child face are well documented and make their task of making an optimum environment in which their child can develop its maximum potential difficult enough. The parents in question must inevitably be at further disadvantage in this respect as a result of the action taken.

(3) Arising out of (2), are there facilities to counsel and support these parents as they need, as opposed to the scant service that is usually available to the parents of handicapped children? Having decided on the course of action undertaken, did the consultants consider whether they had the ability or the time to undertake this part of the family management themselves, or arrange for it to be undertaken by other colleagues?

(4) Is further surgery necessary? If so, will the same disregard of the parents' views obtain?

I would consider these to be relevant questions that should have been considered in coming to a decision whether to operate or not. With the information available to me I believe that the decision was a mistake. The question is, can we learn from it?—I am, etc.,

JOHN LOWTHER

Llanfrechfa Grange Hospital,
Cwmbran, Mon.

Oil Myelography

SIR,—Dr. James Bull's concise description of oil myelography (3 February, p. 280) is timely in drawing attention to the larger-dose technique which is of particular value in myelography for disc lesions. When withdrawal of contrast is contemplated, the use of a fairly large-bore needle is indeed necessary—I use a gauge 18 Yale spinal needle. Furthermore, withdrawal can be more complete if the needle is advanced by about 5 mm after entering the spinal canal, as the tip will then be in oil in the prone position even in a spacious theca. It is safer to do this with cerebral spinal fluid flow as a guide before the oil is injected, as the oil is more viscous and flow difficult to assess. In lumbar disc myelography the use of television screening for special films and for location at withdrawal is essential, but my own personal preference, in that situation, is to take standard posteroanterior, oblique, and horizontal beam laterals which can be assessed at later reviews and are not dependent (like barium meals) on the judgement of one radiologist as to optimum projection and angle for demonstration. Television screening for the performance of lumbar puncture seems an unnecessary refinement, not only from the point of view of location of the needle tip but also in the interest of reduced radiation to the operator (who probably, like myself, will have many other screening and arteriographic commitments). Furthermore, an aseptic technique is easier to maintain if screening is not used until the contrast is injected.

To avoid subdural or extradural injection or leak into the tissues in myelography for disc lesions, which is not usually urgent, I recommend that the examination be postponed for at least seven days if the needle does not seem to be properly sited by first intention, if there is blood staining, or if diagnostic puncture has been performed in the preceeding six days.—I am, etc.,

DAVID J. MITCHELL

Wrightington Hospital,
Near Wigan

Efficacy of Whooping-cough Vaccines

SIR,—The paper from the Public Health Laboratory Service entitled "Efficacy of Whooping-cough Vaccines . . ." (3 February, p. 259) does not seem quite to justify that heading. We are informed of attack rates in inoculated and uninoculated children, with no indication at all of the severity of attacks in the two categories.

Those of us who undertook pertussis immunization from the earliest days did not necessarily expect to prevent all whooping cough. What we did hope to show was that when the disease attacked an inoculated child it tended to be mild in character and that immunization provided lasting immunity. A high percentage of mild cases in an inoculated group of children compared with more serious disease in a control group must surely be evidence of efficacy.

A paper published in 1954[1] described carefully compiled observations obtained 3·5 to 4 years after pertussis immunization, the subjects then being of school-entry age. Of 586 children studied, 100 (17·1%) had contracted whooping cough, but only 27 had had moderate or severe attacks; the remaining 73 had had mild attacks. Of a control series of 242 children inoculated with diphtheria toxin only, 123 (50·8%) contracted the disease; 68·3% suffered from moderate or severe whooping cough and only 31·7% from mild attacks. Admittedly, the vaccine which I used in 1949-50 (Wright-Fleming) must have been very suitable during the period in which my inoculations were made. Pertussis typing was yet to come.

If anyone is interested in a logical approach to assessing effectiveness of pertussis immunization, may I suggest perusal of tables VI, VII, and VIII of the paper cited. —I am, etc.,

GUY BOUSFIELD

Horsham, Sussex

1 Bousfield, G., and Holt, L. B., *Medical Officer*, 1954, **92**, 289.

Immunization against Influenza

SIR,—I would disagree strongly with the first sentence of your leading article "Novel Attack on Influenza" (17 February, p. 373) in which it is said that "we are all acutely aware that influenza vaccination has not prevented yet another epidemic of influenza." It is really quite illogical to expect prevention of an epidemic when less than 5% of the population have been vaccinated. Influenza vaccination has, in fact, not yet been tried in Britain. So far, it has only been played with.

In the case of vaccination against any other major disease, campaigns have been mounted for the protection of a great proportion of the population. Pressures are rightly put on mothers to vaccinate children against diphtheria, whooping cough, and tetanus and teenagers against rubella and tuberculosis. The protection rates obtained with most of these vaccines do not differ greatly from those obtained in adults with modern influenza vaccines. Yet in our population of 50 million people the total number of persons vaccinated in any one year against influenza remains probably below the two million mark.

Until influenza vaccination is taken seriously and tried on a proper scale, statements about its failure to prevent epidemics are without any foundation whatsoever.—I am, etc.,

T. C. G. SMITH
Medical Adviser,
Duphar Laboratories Ltd.

Southampton

Short-term Service Abroad

SIR,—Dr. T. D. Lusty (9 December, p. 611) is interested in recruiting more doctors for short-term service in developing countries and mentions in particular work among the Bantu and Zulus in South Africa.

I volunteered to work among the Zulus in South Africa three years ago. A mission hospital was prepared to take me as a consultant, but the immigration authorities in South Africa flatly refused to grant me a visa for travel. This obviously was due to the colour of my skin. May I ask Dr. Lusty, "Are the opportunities to practice medicine in South Africa open to all races?"—I am, etc.,

P. RABINDRAN

Central Hospital,
Koforidua, Ghana

Role of Pacing after Myocardial Infarction

SIR,—Dr. M. E. Benaim (10 February, p. 355) infers that our article (6 January, p. 10) provided some statistical evidence that pacing for heart block after acute myocardial infarction may not be necessary. We did not claim that our results had any statistical significance with regard to pacing, although we do think that our figures compare moderately well with those of other series in which pacing has been practised. We would dispute that pacing is definitely superior to isoprenaline infusion for complete heart block after myocardial infarction, since pacing itself does have a risk. We agree that the only way to solve the problem would be with a controlled trial.

Dr. Benaim quotes two patients in whom pacing was advantageous and we have little doubt that this was the right treatment for these men. A rather similar situation was reported by one of us some years ago.[1]

Dr. Benaim asks why we decided to adopt a non-pacing policy. At the time when our study began we believed that the evidence to date was not conclusively in favour of pacing. It was our impression that the majority of patients with inferior myocardial infarction and heart block improved spon-

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