definite agreements with their local authorities, but, so far as I am aware, they have not been consulted on whether they would agree to the provisos contained in the circular, one of which, for instance, alters the conditions of service in regard to annual leave which in most agreements is fixed at four weeks for every eleven months' service.

2. Many of the medical personnel of public health departments have consistently for years worked much more than the 52 hours a week mentioned in the circular. Of these, some, such as resident medical officers in municipal hospitals, whose rate of remuneration is, say, £300 per annum with emoluments valued at £140 per annum, will qualify for the payment of overtime at what would appear at first sight to be a very handsome figure. Other, and more senior, officers, who by reason of their greater responsibilities or longer service receive a salary of £500 or over, are particularly excluded from participation in the proposed award for working overtime, but are nevertheless included in the provision which curtails their annual leave by 50%. Why senior officers doing more responsible work should suffer from this discriminatory treatment is not clear, unless the reason lies in the large sums of overtime pay which they might earn. To take my own case, for instance, I am in charge of an important subdepartment, and, apart from my four-weeks annual leave, am on call and therefore on duty for the whole 24 hours every day of the week, Sundays included. Clause 4 of the conditions set out above, however, debars me from any participation in overtime benefits, but permits my assistants to benefit as their salaries are below the figure of £500 per annum. It seems a curious state of affairs.

Could anyone enlighten me as to the identity and powers of the South Metropolitan District Council and the National Council, of whose existence I have been up to now completely ignorant? None of my colleagues to whom I have spoken appears to know any more than I do. Have the members of the National Council, whoever they may be, the right to make such recommendations as the above in regard to the conditions of service of medical practitioners without affording such practitioners the opportunity to discuss, agree, or disagree with any or the whole of such recommendations?

The views and comments of your readers will be much appreciated, and for obvious reasons I sign myself,

A.M.O.H.

Rehabilitation Centres

SIR,—I am sure Mr. G. R. Girdlestone's letter and the memorandum from the British Orthopaedic Association on the question of rehabilitation centres (Oct. 31, p. 526) will be read with interest.

The letter assumes that rehabilitation is a water-tight method of therapy which concerns wounds and accidents, and extension of this service under the same administrative and surgical control is advised. Rehabilitation is, in truth, a method of treatment which concerns disease as importantly as injury. For instance, it is of the greatest interest and importance to the neurologist and to the general physician, more especially to those interested in the chronic rheumatic diseases. It would be a retrograde step if rehabilitation centres were placed under surgical control, for the viewpoint would be narrowed, and the best use would not be made of these centres. Recognition that rehabilitation is a matter which concerns the physician as much as, or more than, the surgeon would be a forward step with great possibilities both now and in time to come.—I am, etc.,

London, W.1. ERNEST FLETCHER.

Hyperostosis Frontalis Interna

SIR,—I read with great interest Dr. C. T. Andrews's article (Aug. 15, p. 185). It is an interesting subject, especially if one considers that practically women only are affected by it and men only by leontiasis ossea. It seems to me that its occurrence must be connected with the endocrines and conditioned by them, as it appears that the same glandular fault will lead to the one in men and at certain periods (pregnancy, menopause) to the other in women; or is hyperostosis frontalis interna in women merely an arrested form of leontiasis ossea?

The case observed by me between 1935 and 1941 was in a woman aged 47, who in 1918 after her second pregnancy developed severe right frontal headache, which never left her. Four months after the confinement she had her first epileptic fit (grand mal). Since then she has had 3 to 4 fits yearly, most of them at night with incontinence of bladder, etc., and since 1934 these fits could be controlled by phenobarbitone, 1 or 2 gr., but never the headache. There is no epilepsy in her family nor any other familial disease. Her periods were regular and normal until 1940, when she was operated on for carcinoma of the left ovary. In 1935 she underwent cholecystectomy for chronic cholecystitis without gall-stones, and appendicectomy.

When first seen in June, 1935, clinically nothing abnormal was found, but the liver was felt and there was slight venous congestion over the right forehead. B.P. 120/65. Urine: albumin, sugar, urobilinogen, and porphyrin negative; sp. gr. 1013. There was frequency by day and night. Blood count: Hb 88%; R.B.C., 2,640,000; W.B.C., 7,600—eosinophils 2%, monocytes 7%, lymphocytes 32%, polymorphs 59%; poikilocytosis; microcytes and megalocytes were found but no megaloblasts or normoblasts. Wassermann reaction negative. Radiograph: hyperostosis of both frontal bones; pineal gland calcified; fundi normal; small bilateral central scotoma. C.S.F. and ventriculogram normal. Electro-encephalogram: small right frontal delta focus involving nearly the whole of the upper and frontal region.

There was prompt reaction to liver treatment, but no remission of the pernicious anaemia has been observed. Mental condition: not dependent on her general condition; easily depressed, easily paranoic, at times very dull, almost demented, only at rare intervals fit for her own home duties, always fatigued, and sleeps on an average 16 hours. Besides those epileptic fits, narcoleptic fits come on at irregular times after due warning.

This case of hyperostosis frontalis interna is of special interest as it is complicated by pernicious anaemia. Or is the same glandular or hypothalamic disorder responsible for both? In this connexion one is certainly reminded of those still rarer diseases Cooley's and Jackson's anaemia, both of which show skull changes in radiographs. Dr. Andrews is to be congratulated on his successful treatment with benzedrine. But, more important still, as he shows, the condition must be recognized and appreciated in the differential diagnosis of headache associated with general indefinite symptoms.—I am, etc.,

LEO RAU, M.D., M.R.C.P.
Lieut., R.A.M.C.

A Supply of Trained Male Nurses

SIR,—My committee—an association run by naval medical officers to help in assisting sick-berth staff to find suitable employment on being discharged to pension—desires to draw attention to a source of supply of well-trained male nurses whose position appears to have been overlooked in the framing of the reports of the Athlone and Horder Committees.

Very shortly, it may be stated that naval sick-berth ratings are trained at the expense of the Admiralty, and efficiently carry out the sick nursing at Royal Naval hospitals, R.N. depots, and on H.M. ships. Their qualifications and Service examinations for promotion in no way fall short of the requirements for the certificate of the State-registered nurse. After at least twenty years' service they retire on pension, and those who wish to make use of their training find themselves unrecognized as possessing any nursing qualifications. A letter to this effect has been sent to the Minister of Health. Many medical men at present serving as temporary naval medical officers must have had experience and felt the advantages of having such reliable, capable, and experienced sick-berth ratings to assist them in the treatment of the sick and wounded.

My committee thinks that more consideration and recognition should be given to men who have served their country for at least twenty years at home and abroad and have been efficiently trained by giving them a definite status in any nursing Act that may come into force.—I am, etc.,

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Surg. Rear-Admiral (ret.).
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London, N.W.6.

G. L. Maltby and M. Rosenbaum (*Proc. Soc. exp. Biol.*, N.Y., 1942, **50**, 10) have made an electro-encephalographic study of 17 patients in whom a diagnosis of eclampsia was made because of convulsive seizures associated with the latter part of the puerperium, the patients being studied from one week to five years after their admission to hospital. The electro-encephalograms of 77% of these patients showed a cerebral dysrhythmia, and in 58% there was a family history of convulsive disorders. Maltby and Rosenbaum suggest that in patients with eclampsia there may be a primary cerebral dysrhythmia, and that the associated toxaemia may act as a trigger mechanism making manifest the convulsive tendency.