Unabsorbable Sutures

SIR,—There have been two recent accounts (*Journal*, September 16, p. 659, and October 21, p. 949) of unabsorbable sutures being found in the uterus some years following caesarean section. It was suggested in the first that the ligatures, being silk, were therefore unabsorbable and responsible for accompanying sepsis. The use of such sutures was therefore condemned. A very similar case is described below, and again the suture material was apparently thread and was still present in the uterus when removed 13½ years later.

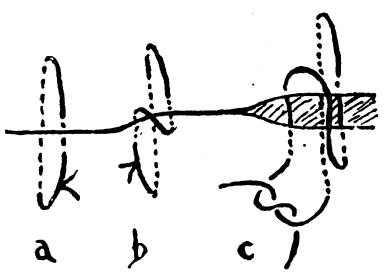
A woman aged 39 complained of vaginal discharge and pain in the left groin. The discharge was sometimes bloodstained and offensive and had been present for 13 years. She had had an upper-segment caesarean section 13½ years before, the operation being performed because of toxaemia. She was sterilized seven years ago and had had a dilatation and curettage performed four years ago. On August 3, 1949, a dilatation and curettage was performed by Mr. Mortimer Reddington, when about 4 in. (10 cm.) of thread was pulled out. The bleeding persisted and so a hysterectomy was performed and the uterus found to contain a very neat layer of sutures, except for one with a knot at the end running into the uterine cavity. There was also a small fibroid in the fundus, and the left ovary was removed at the same time.

Mr. Reddington has recalled another case which kept coming back and back with an infected wound and from which was removed finally a piece of thread about 2 ft. (61 cm.) long.—I am, etc.,

Dartford, Kent. M. NEAL RANKIN.

A Modified Skin Stitch

SIR,—The vertical mattress suture is widely used to obtain accurate coaptation of skin edges, but where thin skin overlies an excessive amount of fat, as sometimes happens, for example, in the axilla and groin, gaping of the edges tends to occur and small lobules of fat bulge through the gaps in the incision. The modification of this suture, illustrated herewith, in which the superficial portion of the stitch is reduplicated, has been found of value in holding the edges together. A small "S-bend" is produced by each stitch, but this straightens out when the silk is removed.—I am, etc.,

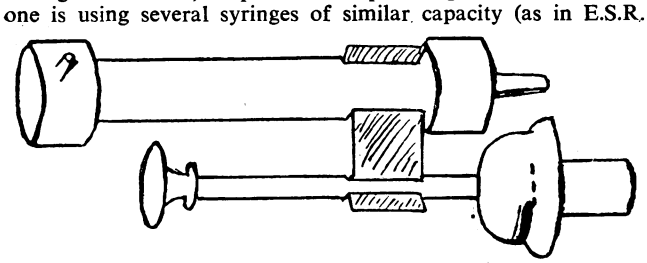


A.—Ordinary mattress suture. B.—Modified mattress suture. C.—Modified suture placed.

Birmingham. J. W. RIDDOCH.

A Clip for Syringes

SIR,—It is generally admitted that syringes and their pistons are not interchangeable. A badly fitting piston renders the syringe useless when required for aspirating fluids. To obviate this nuisance I have devised a simple double metal clip which, during sterilization, keeps the three parts together so that when one is using several syringes of similar capacity (as in E.S.R. estimations) it is impossible for them to become detached and subsequently fitted to their wrong units. The clip is so small that it does not need to be detached while the syringe is in use. Messrs. C. F. Thackray, Park Street, Leeds, can supply these clips.—I am, etc.,



Leeds. DAVID A. HERD.

Orf in Man

SIR,—I was most interested to see the letter from Drs. A. Lyell and J. A. R. Miles (November 11, p. 1119). My attention was first drawn to the condition by Dr. Ian Macquarrie when I came here as his assistant over 25 years ago. He recognized it as being an infection due to contact with sheep. A specimen of the lesion was sent for pathological examination, but its exact nature was not established. I must have seen upwards of 30 cases since then, the last a month ago.

The lesion is invariably single, and seems to confer immunity, as the condition has not occurred twice in the same person. With the exception of two cases all my patients have been males, and the lesions have been on the hand or forearm. The two exceptions were small girls who had pet lambs. In one case the lesion was on the upper lip, and in the other on the leg. At first sight the condition looks alarming, but, as mentioned in the letter, one is struck by the comparatively little pain and the absence of any general reaction. The temperature has been normal in all cases in which it was taken. The glands connected with the area of the lesion are often enlarged, but do not go on to abscess formation. Rarely has a definite history of trauma been obtained, but, as one patient said, "We are always getting pricks and scratches at farm work."

Treatment by slicing off the top of the blister, applying hot foments, and cauterizing the lesion daily with copper sulphate shortens the duration of incapacity. The condition, in my experience, is not so very rare, and, now that Drs. Lyell and Miles have proved it definitely to be orf, I think it should be added to the list of scheduled diseases.—I am, etc.,

Aspatria, Cumberland. A. K. RANKIN.

Mass Radiography

SIR,—Critics, mainly in London and Birmingham, have been scathing, almost vicious, in their denigration of mass radiography. Fortunately their efforts have not been crowned with success and the work advances. I do not wish here to defend mass radiography; it does not need it. Those who have been engaged in the work during recent years have no doubt concerning its value or of the high position that it holds in the armament against pulmonary tuberculosis.

The critics often say that the receipt of a satisfactory report on a miniature film is apt to engender a false sense of security. It is argued that as a result warning symptoms will tend to be overlooked during subsequent months. There is considerable weight in this argument and it applies equally to the satisfactory report on either a miniature or a full-size film. It depends for its validity on two factors. First, it is insufficiently realized that pulmonary tuberculosis may develop with great rapidity, cavitation, perhaps in both lungs, appearing within a few months. Secondly, that rapidly developing cases are frequently unaccompanied by any disturbance in general health. In many cases the symptoms of pulmonary tuberculosis are conspicuous by their virtual absence. In this country there is at present one at least out of every 500 adults who is suffering from active tuberculosis and in need of treatment, a potential menace to his Mantoux-negative contacts, whose general health and sense of well-being is so good that medical advice has not been sought. Some form of routine radiography of large numbers, whether on large films, miniature films, or fluorescent screen, offers the only hope of an early diagnosis.

But there is a large group of patients in whom the disease is usually more advanced, who are already attending their doctors, and, because of the triviality of their symptoms and absence of physical signs, are being treated as cases of upper respiratory tract infection. It is with these cases that there is room for improvement in the management of pulmonary tuberculosis, for failure to refer them for radiography condemns many such patients to the consequences of pulmonary cavitation which early diagnosis, adequate bed rest, chemotherapy, etc., would avert. Experience with mass miniature radiography, in spite of what they say about it, leads one to support most strongly those of your subscribers and correspondents who have been advocating that much greater attention should be paid to the symptomatology of tuberculosis and that greater use should be

made of the chest clinic *x*-ray apparatus. Any doctor who fails to send for a chest film a patient suffering from the symptoms of a respiratory tract infection of longer than three weeks' duration runs the grave risk of missing a case of tuberculosis. Your correspondents have on several occasions given lists of suspicious symptoms. It is not necessary to mention them again here. I have mentioned only those which are in my experience the commonest. Large film and screening sessions should be part of the weekly routine of a chest clinic, and doctors should feel free to send to it any case that arouses the slightest suspicion. I do not think it is far from the truth to say that one adult per 1,000 of city populations is being treated for respiratory tract infections when all the time pulmonary tuberculosis, perhaps remarkably far advanced, is the cause of the trouble.

If in the next five years we are to progress with the early diagnosis of pulmonary tuberculosis, then it is imperative that existing radiographic facilities be greatly improved and used more than they are to-day. At present emphasis is on treatment. In the near future, by the widespread use of routine radiography and B.C.G. we should shift the emphasis to where it rightly belongs—prevention.

In spite of the declining case mortality during the past 50 years pulmonary tuberculosis still remains supremely the major medical problem of the day. As a result of the appalling havoc it causes in the lives of so many tens of thousands of young adults, it should receive the respect that it deserves and which I feel it is still not receiving.—I am, etc.,

Buckhurst Hill, Essex. THOMAS PAXON.

Child Welfare—Past, Present, and Future

SIR,—Professor A. Moncrieff (October 7, p. 795) criticizes the pattern of child-welfare work under local authorities as being geared to vital statistics of thirty or forty years ago, while he himself uses the decline in breast-feeding as a stick to beat the service, which he summarizes as being "largely continued as part of a campaign to reduce deaths in infancy from digestive disorders."

About fifty years ago the prevalence of artificial feeding was considered to have contributed to the rise in deaths from diarrhoeal diseases (Tatham, 1904). In 1906 Newman stated that epidemic diarrhoea was the most destructive of all diseases attacking children under 5 years of age, and it was being shown (Matthew Hay, 1907–8) that the excessive mortality in bottle-fed babies was proportionately greater in the one-roomed houses. It was then easy to point the moral. During the next twenty years numerous investigations were undertaken to discover the cause, although we are still in doubt, but by the mid-1920's the proportion of infant deaths due to digestive disorders had fallen to 10% in the larger Scottish towns, although it remained a serious problem longer in the English towns. This has fallen steadily ever since, apart from a slight rise during the last war when, with exceptions (Glasgow, 1944), the outbreaks have been in hospitals and other places where children are congregated together. The improvement in general education, the increase in personal cleanliness, and the rise in the standard of living are probably the main reasons why deaths from digestive disorders are no longer a menace to the baby in its own home. The educational influences of the public health services are usually given some of the credit, although the child-welfare services as such were only in their infancy in the 1920's.

The decline in breast-feeding had a good twenty years' start on the child-welfare services, and although I am not convinced that child-welfare officers do not encourage breast-feeding whole-heartedly there is no justification for going all righteous about it. After all, the child-welfare medical officers and health visitors come on the scene after the hospitals, midwives, and general practitioners. The bigoted medical officer who is "whole-hearted," instead of helping the anxious mother who is having feeding difficulties, will make her feel a criminal if she is not breast-feeding, and will now be able to quote Professor Moncrieff that she is fulfilling her proper task in the community. America is held up as an example of a country which has reduced its infant mortality more rapidly than Great Britain. What is its record in breast-feeding?

Professor Moncrieff raises so many hares it is impossible to chase them all. He does not seem to have made up his mind whether he would rather have the medical part of the service run by general practitioners, assisted in the nursing of sick children by the health visitor, who is apparently to displace the present specially trained home nurse, or by specialist paediatricians as envisaged in circular 118/47; but, if the latter, is the paediatrician (who does not realize the value of routine medical inspections in getting to know the child and its mother, noting the progress made over a period and using the opportunity to assess the mother's care and standard of nutrition) going to interest himself in sanitation of schools, the present school curriculum, or even school meals and hygiene? The present school medical officers do these things, but then they are specialists in school medical work, not specialists in diseases of children.

The main idea is that the present maternity and child-welfare officers and school medical officers should disappear. This, as Professor Moncrieff says, is implicit in circular 118/47, which has a good deal to answer for in producing frustration in the service. Before it was suggested by obstetricians and paediatricians that maternity and child-welfare and school medical work was a boring routine and soul-destroying, and how much more interesting it would be if the participants did either (*a*) obstetrics or (*b*) paediatrics, the majority of medical officers did not find their work boring: they had chosen to do preventive work, and after several years' experience of it they found it absorbing. It is uncertain what proportion of doctors is equally interested in preventive and in curative work, but in my opinion it is only a minority, and if the present trend continues the amount of preventive work done will decrease.

After the issue of circular 118/47, and action which is being taken as a result of this circular, medical officers in the public health service find their status is falling. Having trained themselves to do one job they are now being told to go and do something else. No longer are they to have the opportunity of acquiring an insight into the whole field of maternity and child-welfare and school medical work, studying the family as a whole. They must specialize and keep themselves abreast of the times. It will be so much more interesting for them. At the same time they must not refer a child direct to a specialist, that is the privilege of the general practitioner; and, although the preventive services never dealt much in drugs, should the medical officer consider that a mother or child should benefit by medicine, the mother must now be sent on a second journey to the general practitioner. Is it surprising that there is frustration and that those already in the service are advising their younger colleagues to choose another branch of medicine?

Professor Moncrieff tells us that forward-looking authorities and progressive medical officers have already adopted the suggested changes. As far as maternity and child-welfare and assistant school medical officers are concerned they will presumably progress presently out of the public health service altogether into the ranks of the obstetricians and paediatricians.—I am, etc.,

Chelmsford. HILDA MENZIES.

REFERENCES

Hay, M. (1907–8). *Special Enquiries on Infant Mortality.* Appendices to Annual Reports, Medical Officer of Health, Aberdeen.

Newman, G. (1906). *Infant Mortality.* London.

Tatham, J. F. W. (1904). *Report of Inter-Departmental Committee on Physical Deterioration.* London.

Factory Doctors in the Health Team

SIR,—Various correspondents have stressed the value of school medical examinations and the need for closer teamwork between public health medical officers, general practitioners, and other health workers. No one so far has mentioned the appointed factory doctor. Since nearly a quarter of a million children enter industry each year, the importance of close liaison between the school medical service and the appointed factory doctor is clear. It must be rare for a general practitioner to know the work or conditions of employment of more than a handful of the youngsters for whose health he is responsible. They come for cure when ill, but otherwise may remain for long in subnormal health. Close team-work of the school medical officer, appointed factory doctor, and general practitioner would appear to offer great opportunities for health promotion and prevention of disease. Employers as well as parents and youngsters are often in need of advice and grateful for assistance.—I am, etc.,

Farnham Royal, Bucks. M. E. M. HERFORD.