

far more likely the cataclysmic crash will come quite soon, unless we can learn even at the eleventh hour the super-human task of providing a way of life at least as good as the primeval laws of nature. Mr. McKee quotes Scripture. Let him turn to the opening words of the Bible, where it is written that God made the heaven and the earth "and saw that it was good." Parsons keep reiterating "people matter" when to-day if we are to avoid messing up the whole world the emphasis should be on *things*.—I am, etc.,

Buxted, Sussex.

W. R. E. HARRISON.

Is Juvenile Drunkenness Increasing?

SIR,—Mr. L. R. N. Percey's spirited attack (*Journal*, November 13, p. 1167) is welcome. It is, however, not possible to make out from present statistics whether juvenile drunkenness is or is not increasing. In a few years' time this may be possible, since the Home Department¹ has now, for the first time, broken down the numbers of "offences of drunkenness proved"—i.e., convictions—according to age. The age groups given are: (1) under 21; (2) 21 and under 30; (3) 30 and under 60; (4) 60 and over. In 1953 there was in the whole of England (urban and rural) a total of 51,900 convictions for drunkenness in the population aged 15 years and over. Of this total, the above age groups yielded in per cent.: (1) 5.6; (2) 25.8; (3) 60.4; (4) 8.2. Naturally there are wide local variations, according to whether urban or rural, north or south, industrial or non-industrial, and a host of other circumstances. In Plymouth, for instance, the under 21's yielded 2.9%, in Portsmouth they yielded 14.2%.

	Convictions for Drunkenness, 1953		Percentage of Total Number in Age Groups			
	Total No.	No. per 10,000 Population Over 15 Years	Under 21	Under 30	Under 60	60 and Over
All cities and boroughs England (excluding Metropolitan Police District and London City)	23,400	24.9	6.8	29.5	56.8	6.9
Metropolitan Police District and London City	18,976	28.7	2.5	18.7	67.7	11.1
Bradford	680	30.1	2.8	20.3	65.0	11.9
Plymouth	174	10.0	2.9	16.7	67.8	12.6
Birmingham	4,120	48.3	4.5	29.2	60.1	5.1
Newcastle	1,517	67.6	4.7	30.1	60.1	4.1
Sheffield	503	12.6	4.8	28.8	59.7	6.7
Bristol	98	2.8	5.1	21.4	63.3	10.2
Manchester	2,203	40.8	6.3	30.4	54.5	8.8
Leeds	1,142	28.9	7.0	26.8	57.7	8.7
Liverpool	3,720	63.3	9.5	30.2	52.5	7.9
Hull	631	28.4	12.0	31.4	50.2	6.3
Portsmouth	480	24.7	14.2	39.4	37.5	9.0

In order to have a basis for future comparison I have tabulated comprehensive figures from 12 cities with a population of over 200,000. We must not overlook, however, that deductions drawn from convictions are fallible, since these figures denote not existing but *obtrusive* drunkenness; further, that it is "the man in the street" rather than the population at risk that yields the bulk of these convictions.—I am, etc.,

Isleworth, Middx.

H. PULLAR-STRECKER.

REFERENCE

¹ *Offences of Drunkenness, 1953*. H.M.S.O.

Prevention of Colds

SIR,—May we reply to some of the points raised in the correspondence which has followed the publication of our paper (*Journal*, October 23, p. 959)?

Temperature of vaporization.—Like those of Dr. I. MacKay (*Journal*, November 20, p. 1228) and Dr. C. Dickson (*Journal*, November 6, p. 1108), our vaporizers were supplied by Shepherd's Aerosols, and the thermostats were stated by them to be set at 126° C.; actual measurements showed the liquid itself to be held at about 116° C. *Concentration*.—The output of our vaporizers was, as stated in our paper, at the recommended rate. Neither Dr. MacKay, Dr. Dickson, nor Mr. A. H. Baker (*Journal*, November 13, p. 1163) has

ever reported any measurements of the concentrations actually produced in the air, and none of them has made any allowance in his calculations for loss of hexylresorcinol by adsorption on to walls, etc. *Bactericidal effect*.—None of these three workers has reported any effect of hexylresorcinol on the normal flora of the air. There is no discrepancy between our results and Dr. MacKay's experiments with sprayed cultures; in fact laboratory experiments reported by one of us in 1948¹ gave substantially similar results to those subsequently reported by him. *Morbidity*.—None of the three has made a direct estimate of the comparative number of colds suffered by persons working in treated and untreated rooms; Dr. Dickson analysed only sickness absence records, which we consider an unsatisfactory measure of morbidity, for reasons stated elsewhere.²—We are, etc.,

O. M. LIDWELL.

R. E. O. WILLIAMS.

London, N.W.9.

REFERENCES

- ¹ *Spec. Rep. Ser. med. Res. Coun. (Lond.)*, 1948, No. 262, p. 150.
² Reid, D. D., et al. (1953). *Lancet*, 2, 1303.

Death after A.C.T.H.

SIR,—With the wider use of A.C.T.H. a number of deaths immediately following the use of this drug, and presumably due to anaphylaxis, have been reported.^{1,2}

Case Record.—A housewife, aged 44, had had asthma for 12 years, exacerbated by winter bronchitis. Since 1948 she had had repeated courses of specific vaccines. She had angioneurotic oedema as a child. Mother, sister, and grandfather all had asthma. Her present attack commenced six weeks before admission, and had been continuous since. She was said to have previously reacted "badly" to penicillin, ephedrine, adrenaline, and isoprenaline sulphate. Examination on admission showed her dyspnoeic on slight exertion, wheezy, but not cyanosed. Blood pressure 170/110, pulse 90, regular. Scattered rhonchi and much bronchospasm in all lung fields. Chest x-ray, taken immediately on admission, was normal. A.C.T.H. 20 units intramuscularly was commenced on the morning of July 31. Within two minutes of receiving the first injection (into the outer side of her thigh) she complained of tingling in her fingers and toes; a minute later of a tight feeling across her chest. She very rapidly became orthopnoeic, distressed, and cyanosed, and died within five minutes, before medical aid could be summoned. Post-mortem findings were in keeping with status asthmaticus with some allergic oedema (Dr. F. E. Camps).

We feel it our duty to report this case, as it is only by the publication of similar disasters that the risks of anaphylaxis from intramuscular A.C.T.H., which is so widely given, can be assessed. Since this incident, we have treated suitable cases of status asthmaticus with cortisone by mouth in place of A.C.T.H., unless emergency and inability to take tablets demanded otherwise.—We are, etc.,

ARNOLD BLOOM.

FREDERICK WOLFF.

London, N.19.

REFERENCES

- ¹ Hill, B. H. R., and Swinburn, P. D. (1954). *Lancet*, 1, 1218.
² Howat, H. T., mentioned by Savidge, R. S., and Brockbank, W. (1954). *Ibid.*, 2, 893.

Changes in the Mental Health Services

SIR.—It is interesting to see that the L.C.C. is proposing to recommend to the Royal Commission the perpetuation of the observation unit. I spent many years in the L.C.C. mental health service and had first-hand knowledge of two of their units, and heard from many patients harrowing comments on all the others, and I have always thought that the observation unit was, and is, the weakest link in the administrative set-up for the mentally sick. The reasons for this, as I see them, are as follows: (1) Observation units form part of general hospitals, and are usually administered as a sideline by persons with little psychiatric knowledge, and not always with proper sympathy for the problems of the mentally ill. I have more than once heard the remark from these quarters, "After all, they are only lunatics." (2) Their staffing—medical and nursing—is rarely of the best for the purpose, and often a long way below it; one could hardly expect to get the fullest satisfaction from spending one's working life in a casualty clearing station.

(3) They are more often than not overcrowded, and seldom have suitable accommodation to allow of proper classification—manics, schizophrenics, acute alcoholics, confusional cases, and neurotics lying cheek by jowl.

At the onset of a psychiatric illness a high proportion of patients who have to be removed from their homes are frightened and confused; this fear and confusion tend to be aggravated by every move, and I think it should be a first principle to ensure that the patient, wherever possible, is sent from his home direct to the hospital where he will be treated. This might be effected by an extension of domiciliary services combined with an increased use of the "urgency order." The avoidance of certification would be simply brought about by suitable modification of Section 5 of the Mental Treatment Act, and omission of the phrase dealing with absence of volition. The alternative proposal of up-grading observation units, or preferably their replacement by first-class treatment centres, would, I fear, be unnecessarily prodigal in building, staffing, and maintenance costs.

Finally, what's in a name? If it be true that progress is made by a simple change, would it not be well to legislate for this by insisting on a change of name for all the hated terms every 10 or 15 years? This would doubtless prevent popular opprobrium from falling in the future on any psychiatric patients, places, or personnel.—I am, etc.,

Beaconsfield, Bucks.

J. B. S. LEWIS.

Prevention of Deformity in Poliomyelitis

SIR,—I read with interest the paper of Mr. J. M. P. Clark entitled "The Prevention of Deformity in Poliomyelitis" (*Journal*, September 18, p. 669). With your permission I would like to comment on some of the points he raises.

In my experience the all-important factor of growth makes it imperative to deal surgically with an established muscle imbalance in a child suffering from the sequelae of poliomyelitis as quickly after the onset of paralysis as is physiologically feasible, in order to prevent the inevitable development of dynamic deformities. The younger the child at the onset of paralysis, the sooner the deformities develop and the more pronounced they tend to become. This factor of growth does not exist in the paralytic adult. Hence such an urgency of surgical correction does not exist. In the poliomyelitis epidemics in Israel from 1949 onwards the overwhelming majority of victims were in their first, second, or third year of life. We have been operating on these children since 1951, before they reached the age of 5 years suggested by Mr. Clark, and we are convinced that had we waited until this age a large majority of our patients would have presented established deformities, and surgery then would have become reconstructive and not preventive. In these children we have performed 173 tendon transplantations around the ankle alone since 1951; 83 of them were done anteriorly to the ankle-joint and 90 posteriorly (into the Achilles tendon and/or calcaneus). A more detailed breakdown is presented in the following table:

Age at Operation in Years	Tendon Transplantations		Total
	Anteriorly to the Ankle	Posteriorly to the Ankle	
0-1	0	2	2
1-2	5	12	17
2-3	26	28	54
3-4	21	18	39
4-5	21	11	32
Over 5 ..	10	19	29
Total ..	83	90	173

With the exception of a few cases these children responded very quickly to re-education of the transplanted muscles. It is true to say that in many instances less difficulty was encountered in this re-education than in older children. This experience of ours prompts me to say that there is no reason to postpone tendon transplantations (at least around ankles) in children under the age of 5 years. In discussing the advisability of breaking down a "tight fascial envelope of the thighs and buttocks," Mr. Clark does not appear to differentiate between a child and an adult patient. While in an adult the existence of such a tight fascia may add considerably to the stability between pelvis and lower extremities without causing an appreciable deformity, in a growing child the persistent presence of tightness will inevitably lead to

development of deformities of pelvis, spine, and lower extremities. It therefore seems to me preferable to break down the tight fascial envelope and supply the child with a much more innocuous external splint.

With regard to "Perverted Action of Normal Tendon": this syndrome is well illustrated in Mr. Clark's first example. The tibialis posterior, flexor hallucis longus, flexor digitorum longus, peroneus longus, and peroneus brevis ("all posteriors" as we used to call them) are accessory plantar flexors at the ankle. When the prime mover—the triceps surae—becomes paralysed and the strong tibialis anterior lifts the midfoot, all posteriors by reason of their attachments to the midfoot and the bases of the metatarsals cause the forefoot to plantar flex at the midfoot joints, thus pressing the forefoot against the hindfoot. They consequently indirectly cause an increase of the vertical position of calcaneus and pes cavus. Under the changed kinesiological conditions caused by the paralysis of triceps surae, the actions of these accessory plantar flexors, the all posteriors, become "perverted."

The other example in Mr. Clark's paper of perverted action of normal tendon, "The action of the extensor digitorum longus tendons and peroneus tertius on a valgus foot resulting from a weak tibialis posterior," is a less good example, as these muscles are antagonists to each other, tibialis posterior being an invertor and plantar flexor of the foot and extensor digitorum longus being an evertor and dorsi-flexor.

The "bow-string" action of extensor digitorum longus, demonstrated by us to Mr. Clark during his recent visit (March, 1954) to my department, resulting in valgus deformity of the foot is initiated by paralysis of tibialis anterior. In the presence of additional paralysis of tibialis posterior the "bow-stringing" of extensor digitorum longus becomes more pronounced. It becomes very prominent when, in addition to paralysis of tibialis posterior and tibialis anterior, the triceps surae is weak.—I am, etc.,

Zifin, Israel.

ANATOL AXER.

Epithelioma Due to Tar Ointment

SIR,—Dr. J. O'D. Alexander and Mr. K. I. Macrosson should be commended for calling attention to the possibility of squamous-cell carcinoma being caused by tar ointment (*Journal*, November 6, p. 1089). I would suggest, however, that their report calls for some comment. Most importantly, their statement, "Cases of tar epithelium of industrial origin are almost invariably accompanied by a pronounced tar acne which has been present for years," is open to criticism. It may have been true when Professor White was writing 25 years ago, but it is not true to-day. I have seen many such epitheliomata: not one was accompanied by severe folliculitis, and most of the patients had no folliculitis at all. The statement that folliculitis is a necessary or even a usual precursor of tar cancer is not only false but dangerous, because it can lead (and to my knowledge has led) to a diagnosis of cancer being missed. Indeed, Dr. Alexander and Mr. Macrosson state that tar ointment is dangerous (only) "if it is accompanied by tar acne." The statement: "It seems that the continued insult to the skin, after the initial appearance of signs of tar irritation, is the essential factor in the production of malignant change" would not, I think, be generally accepted. Tar cancer is not caused by irritation in any ordinary sense of the word. It would be as accurate to describe the action of stilboestrol in causing male mammary enlargement as an irritation.

The authors are of opinion that the epithelioma they report was caused by tar ointment. This may be possible, but, if it was so caused, it followed the shortest exposure of which there is any reliable record: thus Henry² gives ten months as the shortest exposure in 1,335 cases. Most of his cases occurred after 20-24 years. Winternitz³ and Ross⁴ both give eighteen months as the shortest exposure in their respective series. The site of the lesion, over the head of the right fibula, would also be unusual, because it is well recognized that the unexposed skin (except that of the scrotum) is very resistant to tar cancer.⁵

The authors, however, state: "In contrast to the *superficial splashing of the skin* in industrial tar acne, in this case