Haemophilus Infection in Bronchiectasis

SIR,—I was interested to read the article on haemophilus infection in bronchiectasis by Dr. E. C. Allibone, Mr. P. R. Allison, and Dr. K. Zinnemann (*Journal*, June 23, p. 1457). I drew attention to the prevalence of haemophilus in chronic non-tuberculous lung conditions in childhood in 1927.[1] I cannot, however, endorse their confidence in the effects of treatment with antibiotics, which seem to me to be ineffective in eliminating the organism in such cases. Whereas in 1927 I regarded it as rather probable that the haemophilus was the actual cause of the persistent illness in these children, I would now rather take the view that the disease is bacteriologically non-specific and the result of bronchial obstruction with partial collapse and secondary infection in the collapsed areas. In fact, I would now rather regard the haemophilus as a secondary invader. It is a very common organism to find in the respiratory tract. The authors describe "relapse" as occurring in their cases. I am not clear what meaning they attach to this word. I think it can hardly be supposed that reinfection occurs. The odds against this happening would be enormous; besides, they describe relapse as occurring on the average every six weeks. Their observations would therefore indicate that the haemophilus is not eradicated but only temporarily suppressed.

I am also not very happy about the use of the term "purulent bronchiectasis" in children. We rarely see the disease which used to go by this name—that is, a persisting bronchial dilatation with fetid sputum. No doubt workers in the northern cities see more cases of the type described in my M.D. thesis of 1927, but the number of cases in this area requiring bronchoscopy and bronchography has steadily diminished. We see very few cases of primary tuberculosis with collapse, and in most of our cases of whooping-cough or non-specific respiratory infection collapse is very transient and bronchiectasis distinctly rare.—I am, etc.,

Farnborough, Kent. DUNCAN LEYS.

REFERENCE

1 Leys, D. G. *Chronic Pulmonary Catarrh*, 1927, chapters 3 and 4. London.

Apartheid in Blood Transfusions

SIR,—Might not Dr. David J. Adderley (*Journal*, June 30, p. 1546) be mistaken, and himself the victim of an emotionally charged concept? To assert that there is no essential difference between blood from different sources involves a large assumption, and, so far as I am aware, not sufficient work has been done to substantiate it.

It is known that there is a gradient of increasing proportion of group O blood from east to west across Europe. Thus, at a time when the ABO groups were unknown, it would have been safer to transfuse, say, an Irish person with blood from an Irish source rather than with blood from, say, Poland. No one will imagine that the last work has been done on the constituents of blood or its various groupings. With such a difference as between populations within Europe, there is at least a prima facie case for postulating differences between bloods from different continents. Before Dr. Adderley suggests offering gratuitous advice to the profession in South Africa, let him reflect that its ideas may not be altogether wrong. Let us not confuse scientific integrity with support for a political theory of racial equality.—I am, etc.,

Wednesbury. J. TORLEY.

Post-menopausal Oestrogen Production

SIR,—Might we make a plea for the use of a standard method of estimating oestrogenic activity from vaginal smears? Dr. R. A. Struthers in a recent interesting article on post-menopausal oestrogen production (*Journal*, June 9, p. 1331) employs a method of grading which makes it difficult to compare his findings with those of many other workers in this field. Authorities such as Shorr,[1] De Allende and Orias,[2] and Horwith[3] all use a cornification index which is calculated as the percentage of cornified squames in several unselected fields of superficial, intermediate, and basal cells. On the other hand, Dr. Wachtel,[4] in her recent article entitled "Suggestion for a Cytological Test of Cancer Cure," calculates the cornification index "by counting the percentage of cells with pyknotic nuclei among 200 unselected superficial and intermediate squames. The basal cells are omitted from this count."

It seems logical to assume that a cornification index provides a better yardstick and is less liable to personal interpretation than any other forms of grading, but it would be of greater value if it was always calculated in the same way. Working at Dr. P. M. F. Bishop's endocrine clinic, we have found that a count of all the vaginal epithelial cells—that is, including the basal cells—gives a more accurate clinical picture.

We would also like to know if Dr. Struthers had any particular reason for obtaining smears by scraping the anterior wall of the upper vagina as opposed to aspiration from the pool of secretion in the posterior fornix. We find the latter method gives a much more representative slide and avoids contamination from the lower third of the vagina.—We are, etc.,

MOIRA MURRAY.
London, S.W.3. FREDA OSMOND-CLARKE.

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1 Shorr E., *Bull. N.Y. Acad. Med.*, 1940, **16**, 453.
2 De Allende, I. L. C., and Orias, O., *Cytology of the Human Vagina*, 1950, translated by G. W. Corner. New York.
3 Horwith, M., New York Hospital, personal communication.
4 Wachtel, E., *J. Obstet. Gynaec.*, 1956, **58**, 176.

Maladjusted Children

SIR,—Dr. M. Park (*Journal*, June 23, p. 1487) is disappointed at the poor response to his appeal for action based on the report of the Committee on Maladjusted Children,[1] set up with commendable initiative by the Ministry of Education. This lack of response, I fear, reflects the disappointment of many in the medical field at the nature of the main recommendations of this informative report. There is a marked difference of emphasis from the evidence submitted to the committee by the British Medical Association[2] and from the recent memorandum of the Royal Medico-Psychological Association.

An adequate service must meet the needs of the school child, the pre-school child, the post-school child, the child at the non-maintained school, and the emotionally handicapped parent. The most important categories, the pre-school child and the emotionally handicapped parent, can be least effectively dealt with on these recommendations. To deal with the child from the non-maintained school a call is made for new legislation. The proposed administrative structure is a complex of three local authority departments (education, school health, public health), grafted on to which is the regional board concerned. To the perils and difficulties of divided authority is added a contortion of the educational system to supply a community family mental health service. This proposed service would needlessly duplicate the service already supplied freely to all categories of patients by the regional hospital boards under the terms of the National Health Service Act, 1946; this family-orientated service has grown apace in the last five years and is based on the collaboration of the general practitioner and the school medical officer, one responsible for initiating referral direct from the home and the other from the school.

Much attention has properly been given by the Ministry of Health to the mental health problems presented by the psychotic patient; the obviousness of the problem and the number of occupied hospital beds have compelled attention. Affecting as it does approximately 0.5% of the population, psychosis is, relatively, a minor problem in mental health when due regard is given to the problem of emotionally handicapped individuals, who amount to an unquestioned 6%, perhaps 30%, and possibly a higher percentage of the population. The Ministry of Health has certainly not ignored this greater problem, but we are still awaiting a