merits of the advertiser's claims. We need someone unattached to any drug house who will interpret the complex formulae which disguise the true nature of many expensive and perhaps dangerous drugs now being thrust upon us from every side. We need someone to unmask the pharmacological mystery formulae, so that we can place the drug in its genuine category of usefulness. We need details of cost, which most advertisements still neglect to publish. We need someone to correlate the claims made for new and expensive drugs with the known facts. How many general practitioners or clinical consultants would benefit from the knowledge that a well-known proprietary tablet for irritating coughs consists of 10 mg. bis-[1-(carbo-β-diethylaminoethoxy)-1-phenylcyclopentane]-ethane disulphonate ?

I, personally, should always find time to welcome a representative of this colour, and I think if prescribing under the National Health Service is to be replaced on a safe and rational basis something of this sort will have to be done.—I am, etc.,

Sheffield, 8. E. C. ATKINSON.

Syringe Service for the Family Doctor

SIR,—In a recent meticulous survey for a central syringe service which would include the whole Health Service, E. Cameron Murphy[1] finds that the syringe usage of the general practitioner is 7% of the whole (hospital, public health, and G.P.). He concludes that it would be uneconomic to issue syringes to G.P.s unless they were "prepared to make considerable efforts to deliver and collect the syringes themselves."

Our experience at Westwood Hospital suggests that a large proportion would be so prepared. As an experiment, we have for some years made the hospital syringe service available to the general practitioner. It has been found that those living in the town—i.e., within one mile of the hospital—for the most part use the syringe service for all their injections and aspirations, while those from the villages—i.e., over five miles—mostly do not. The doctor or deputy calls at the "stericentre" twice weekly, where used equipment is replaced. Having dry, sterilized, oiled syringes with sharp needles always at hand is found to be a notable convenience and the time saved is appreciable. For the stericentre the work as suggested by the above survey is not great, in our case being equivalent to one more ward.

For those living at a distance we designed the flat syringe sterilizer,[2] by which six boiled but virtually dry sterile syringes are prepared and carried in a compact container.—I am, etc.,

Beverley, Yorks. H. F. BARNARD.

REFERENCES

1 Murphy, E. C., *Monthly Bull. Minist. Hlth Lab. Serv.*, 1957, **16**, 212.
2 Barnard, H. F., *Brit. med. J.*, 1956, **1**, 917.

Vision and Television

SIR,—I entirely agree with the conclusions of Dr. A. H. Griffith (*Journal*, November 30, p. 1299). I have been very interested in the effects of television on eyes since 1950, and have kept complete records since then. I find that the percentage of eyestrain in both boys and girls of 11 and 12 years is slightly higher in my patients in Bermondsey and Edmonton compared with patients elsewhere. I would very much like to have views of other ophthalmologists who have been doing this research in other parts of Great Britain.—I am, etc.,

London, W.1. R. U. HINGORANI.

"Butcher's Thigh"

SIR,—The need for prompt and efficient first-aid treatment in certain cases of this occupational injury, to which Mr. J. R. S. Paterson (*Journal*, November 30, p. 1309) has drawn attention, is illustrated by a case which came under my care at the Victoria Hospital, Blackpool.

Credit is due to Mr. M. Lange, who was then the surgical registrar, and who, receiving a terse summons from casualty, sought not to reason why but set off at high speed in that direction. Further spurred from afar by the sight of a blood-stained butcher seated in the hall, he reached the patient, the butcher's boy, who was quite unconscious and almost exsanguinated from a knife wound, 1 in. (2.5 cm.) long, situated just above the fold of the right groin. He had been brought by the butcher in his van from the scene of the accident, and, until oxygen was administered by the nursing staff, no form of treatment had been attempted. The bleeding was now minimal and it was easily controlled by pressure on the abdominal aorta through the relaxed abdominal wall. It was found that, with the fist on the umbilicus and the arm extended, an adequate pressure could be maintained for an indefinite period without fatigue. Meanwhile measures were taken to set up an intravenous plasma drip and to cross-match blood for transfusion, and shortly afterwards the whole cavalcade moved to the operating theatre. As the patient was still deeply unconscious, no anaesthetic was needed to explore the wound, and the bleeding site proved to be a V-shaped notch cut in the side of the external iliac artery. It was interesting to note how the bleeding from it could be controlled by compressing the aorta in the manner described. By the time an arterial suture was done and the operation completed the blood pressure was restored and the patient was in good condition, but he was still quite unconscious, and when later that day a spasmodic twitching developed in the limbs the outlook seemed poor. He recovered, however, and in 48 hours he was able to recognize his fiancée, a relationship he stoutly denied at first but happily accepted later. When last seen some six weeks after the accident he was back at work and complained only of an increased difficulty in counting the change.

This case illustrates very clearly the importance of the abdominal aorta as a pressure-point. The difficulty is not so much in teaching people *how* to use it as *when* to use it. It would be an intolerable manœuvre to the conscious patient and not likely to be effective, and its use should be restricted to cases of desperate bleeding from wounds of the groin or lower abdomen, where no other first-aid measure is practicable. It is of interest to note that the technique of aortic compression is taught universally to Boy Scouts but not apparently approved by all of their seniors in the ambulance brigades.—I am, etc.,

Blackpool. D. K. LENNOX.

Phenylbutazone

SIR,—I have noted of late letters in the *Journal* with reference to the dangerous side-effects of phenylbutazone in therapy. I therefore suggest tentatively a method I have found of value in warding off unpleasant sequelae of therapy, such as leucopenia, agranulocytosis, etc., or of correcting them if they have intruded.

It is to accompany the phenylbutazone with vitamin C in liberal dosage (100 mg. several times orally a day) and to catalyse the redux activity of the vitamin with small oral doses of a ferrous preparation, such as ferrous gluconate. As rheumatoid patients are initially deficient in vitamin-C storage, replenishment of stores should be a logical procedure, but the potentiation of the vitamin activity still, in my experience, is dependent on an appropriate catalyst such as the one I use.—I am, etc.,

Durban, S. Africa J. DRUMMOND.

Mongolism in a Twin

SIR,—We have been very interested in the medical memorandum by Dr. J. V. Morris (*Journal*, November 2, p. 1038) on mongolism in a twin, and the subsequent correspondence. We would like to report a case of this condition, which we have at present, a condition which does not appear to be as

rare as was once thought. We think our case is of added interest in that the parents have had two other mongol children as well as the twin.

The father is aged 35 years, and is now out of work, with a chronic anxiety state. He was on a baker's delivery round previously. The mother is also aged 35 years. She has had seven confinements, all at home and carried out by the midwife. The first child, a girl, was stillborn at full term. This birth was in 1944, the weight was 9½ lb. (4.3 kg.). This child was probably normal. The second child, a male mongol, was born in 1945, and weighed 8¾ lb. (3.9 kg.). He died at the age of 7½ months, and we do not know the cause of death. The third child, a male mongol, was born in 1946, and weighed 8½ lb. (3.8 kg.). He is alive now, quite healthy: he is clean in his habits, feeds himself, can dress and undress himself, and he is helpful around the house in small ways. He has an atrocious temper. He was graded when he was 6 years old, and given a mental age of 2 years. The fourth child, a normal girl, was born in 1949 and weighed 8½ lb. (3.8 kg.). In 1952 twins were born, two girls, one a mongol, and both were breech deliveries. The midwife states that there were two placentas. This mongol is more intelligent than the boy. She has talked at an earlier age and is already as advanced as he is. She has had no gradation tests yet. The other twin had some cerebral birth trauma resulting in a right hemiplegia, and subsequent epileptic fits. She has had only four of these, the hemiplegia has now cleared, and she is attending school, and appears to be of normal intelligence. In 1953 and 1954 normal girls were born. The one in 1953 weighed 8½ lb. (3.8 kg.), and the one in 1954 weighed 7¾ lb. (3.5 kg.).

The children all play together, but the two mongol children stick more together, play better together, and stand united against the other children in any quarrel. The mother says she always knows when she is having a mongol child, as she feels ill and vomits throughout the pregnancy. The mother's blood group is A_2 Rh-negative. So far as we can discover, there is no family history of twins or other mongols.—We are, etc.,

DAVID ANTHONY.
J. G. HUGH THOMAS.

Abercynon, Glam.

SIR,—With reference to the letter of Dr. L. L. Mistlin (*Journal*, November 16, p. 1179) concerning the aetiology of mongolism in a twin, in observations on over 500 human follicular and tubal ova, I do not see anything to prevent at times the second polar or the two polar bodies which may result from division of the first polar body from being fertilized. This may account for certain cases of twin pregnancy, and may have given rise to the mongolian twin cited in his letter.—I am, etc.,

LANDRUM B. SHETTLES.

New York.

"Nomen Proprium"

SIR,—The chairman and honorary secretary of the Association of Teaching Hospital Pharmacists oppose (*Journal*, December 7, p. 1366) the labelling of dispensed medicines on the grounds that such labelling increases the risk of ill-advised self-medication. Their hypothetical objections are heavily outweighed by other, practical, considerations. When a few years ago the local medical committee of which I am secretary sought the co-operation of the local pharmacists in labelling all dispensed medicines the committee had in mind the following points.

(1) A majority of doctors (at least in West Bromwich, and almost certainly elsewhere) practise in partnerships so that patients are sometimes of necessity seen in their homes by different doctors during the same illness. From their academic fastness your correspondents may think that "other proper systems of recording patients' treatments are available," but in the home there is no convenient practicable alternative method which does not share the objections voiced by your correspondents. (2) Rota systems result in patients being seen by different doctors who are much less closely related than are partners. A considerable proportion of rota calls is to patients already under treatment by their own doctors. These facts make even more cogent the points raised in the above paragraph. (3) A case of accidental poisoning can well arise (especially in these days of tablets) in the absence of a prescriber, yet immediate identification of the drug taken might well be vitally necessary. (4) The use of the label as a reminder to a prescriber himself is quite incidental, but is not without its value.

Your correspondents' antipathy to self-medication may be reasonable. The pharmaceutical industry and the pharmaceutical trade, however, are to a significant extent dependent on the prevalence of this habit, and they have it in their power seriously to check the habit without their refusing to help doctors with fully labelled dispensed packages. A public which is so widely informed by press, radio, and television quite properly expects to be fully informed by its doctors, and information on the pharmacist's label is rarely news. Is it the wish of your pharmacist correspondents that doctors should begin to write prescriptions illegibly?—I am, etc.,

D. SAKLATVALA.

West Bromwich.

SIR,—The opinion expressed by the Association of Teaching Hospital Pharmacists (*Journal*, December 7, p. 1366) goes against the basic principle of contemporary clinical medicine, the necessity of treating patients as rational beings. To give to patients tablets or coloured liquids without telling them what they are is not only an insult to their intellect but makes us revert to the mysterious magic of the apothecaries of the Middle Ages and is thus unworthy of a scientific physician. If we except some cases of individuals of low intellect who need magic more than medicine, patients collaborate more effectively in their treatment when knowing what they are taking. Further, when they travel or move elsewhere and need medical help, this becomes more effective when the physician who sees them for the first time knows what they have been taking. Accidents also occur—when, for example, tablets of digoxin or of antihistaminics are taken for vitamins—and this may involve responsibilities of pharmacists and physicians. There are, of course, rare cases in which the name of the medicine must not be divulged, and it is for such cases that a special sign is needed for the pharmacist, while maintaining as a general rule the careful labelling of the medicines. Until, however, such rational and scientific mode of prescribing is reached it is imperative for chemists to follow the instructions embodied in the term *nomen proprium*, as most of them ignore such instructions.

The Association of Teaching Hospital Pharmacists would have rendered a greater service to medical practice if they insisted on this point, instead of wishing to maintain this antiquated and anti-intellectual method of secrecy which is being abandoned in all other countries.—I am, etc.,

A. P. CAWADIAS.

London, W.1.

Night Hospital for Neuroses

SIR,—In January, 1958, we are opening a night hospital for the short-term treatment and resettlement of neurosis cases. Both men and women will be accepted. Patients will arrive between 6 and 8 p.m., and treatment will include individual, group, and social psychotherapy. An evening meal and breakfast will be available for patients, who will normally leave between 7 and 9 a.m.

It is hoped that these facilities will be particularly valuable for patients who are working, and special attention will be paid to the occupational aspects of each case. These facilities are being provided under the National Health Service, and cases for treatment are being considered now.—I am, etc.,

JOSHUA BIERER,
Medical Director,
Marlborough Day Hospital.

London, N.W.8.