

a fact that it is almost impossible to obtain the services of a general practitioner to give anaesthetics in the chair, at least in this area.

The week-end course referred to is for intravenous anaesthesia, using ultra-fast-acting drugs (barbiturates) to obtain a very light anaesthesia. The death-rate reported so far is nil, and the "accident" rate almost infinitesimal. During the 12 months ending April 1966 it was calculated that two million such anaesthetics were administered with no ill effects. Surely a record many regional boards would wish to emulate.

Surely it is time that the medical profession ceased to regard the dental profession as their inferiors in intelligence, and only fit to be patronized by them. We are a profession well able to think for ourselves, capable of avoiding danger to our patients, and in this particular field often have far more experience of anaesthetics than our medical-practitioner colleagues.

In conclusion, I might add that of all anaesthetic deaths in the dental chair on record over 90% were administered by medical practitioners. I agree that the number recorded is small, and few enough anaesthetics are given by general practitioners, but the record is significant.—I am, etc.,

Wembley,
Middlesex.

L. I. SMITHSON.

Hand-grip Measurements in Carpal Tunnel Syndrome

SIR,—Kendall¹ found that 96% of his patients with carpal tunnel syndrome were ordinary housewives doing a normal degree of hard work. He mentions the symptoms of this condition as paraesthesia and pain, mainly referred to the fingers and hand in the distribution of the median nerve, numbness of the fingers with occasionally muscular weakness, and wasting in the small muscles of the hand. All the chores he described involved gripping a utensil, and it is of interest that prolonged use of the hands without gripping—for instance, in piano playing—is not recorded as being provocative.

My own patients with this condition, far from having muscular weakness, always appeared to have a strong grip, and some remarked that they gripped too hard. One patient had difficulty in relaxing her grip from the handle of the push-chair, and another said that she had the same experience after holding a pen to write a letter.

It was decided to measure the grip of 14 patients while asking them to hold the recording instrument as if it were (1) a flat-iron, (2) a sweeping-brush, (3) a cloth to be wrung out, and 30 grip measurements were made.

Eleven controls of a comparable age, sex, and married status, but with no symptoms of the carpal tunnel syndrome, were selected at random for comparison, and 31 grip measurements made.

The dominant hand was always used in the test, unless symptoms were confined to the other hand. Grip was measured by means of a Baumanometer cuff. This was rolled up and inflated to 30 mm. Hg, producing a conveniently sized roll about the same width as a thick broom handle. Patients were then instructed to grip this in the manner described.

Comparison of Average Grip in Patients and Controls in mm. of Hg.

	Patients	Controls
Ironing	144.4	74.4
Sweeping	115	76.8
Wringing cloths ...	206.2	153.3

Although the numbers are small, these results do suggest that patients with carpal tunnel syndrome have a harder and more sustained grip than normal for simple household tasks. It was encouraging to note the effectiveness of simple explanation and instruction in relaxation, particularly if combined with a sedative, in relieving their symptoms. Kendall considers the cause of the condition to be an ischaemia of the median nerve, although the exact mechanism is not clear. There certainly appears to be swelling of the flexor tendon sheaths as they pass under the retinaculum in company with the median nerve. Continual overgripping would make even a slight manual task, such as knitting, a source of considerable strain, though whether this would cause swelling and oedema of the tendon sheaths is not known. Neither does it explain the tendency to nocturnal pain and tingling. However, it would account for the common observation that these patients have difficulty in straightening their fingers after manual work. If symptoms are related to overgripping, then it is surely illogical to use night splints in treating this condition, as has been suggested.²—I am, etc.,

Crewkerne,
Somerset.

L. E. WEAR.

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- ² Campbell, E. D. R., *Physiotherapy*, 1963, 49, 74.

Appointment System in General Practice

SIR.—Dr. J. S. K. Stevenson (27 August, p. 515) shows how the number of requests for home visits can be reduced by running an appointments system throughout the day. He says that this reduction "requires that the patient must regard himself as being medically supervised by the group as a whole and not by a particular member of it." In other words, abandonment of personal doctoring. It requires no such thing. Indeed, the contrary may be true. My partners and I have run an appointments system in this group practice of five doctors for over six years. We have retained personal doctoring (actually strengthened it) and at the same time cut down home visiting.

Patients ask for home visits because this is the traditional pattern of general practice in this country. They do it because they have always done so, not because it is any longer always necessary. It made sense in the last century when patients sent for their doctors only when they were seriously ill, but nonsense today when most people aren't very ill and can easily come to the doctor in their cars. (Doctors are just as hide-bound about re-visits, as Dr. Stevenson showed in a previous article¹ when he cut down his re-visits by 15% by asking himself if they were all necessary. I have done the same since reading that article.) Most patients are considerate and know that their doctors are overworked. They read it constantly in the newspapers, they see it with their own eyes,

and if tactful and humane receptionists remind them of it and suggest that a surgery consultation by appointment might be more appropriate than a home visit many of them accept the suggestion. Not only does it save the doctor's time but saves theirs also; better to know you will be seen in the surgery at 4.30 p.m. than to sit around waiting for the doctor to call from 1 p.m. to 7.30 p.m. Better (and this is where personal doctoring works in our favour) to make an appointment with your own doctor than to accept any one of the group who might come out to a late call. Routine calls, as opposed to late calls, are always done in this practice by the patient's own doctor. But if we wanted to reduce home visits still more we could arrange to have all home visits done by a member of the group and keep personal doctoring only for surgery consultations.—I am, etc.,

Newcastle upon Tyne. ANDREW SMITH.

REFERENCE

- ¹ Stevenson, J. S. K., *Brit. med. J.*, 1963, 1, 1370.

SIR,—I was most interested to read Dr. J. S. K. Stevenson's excellent article on "Appointment Systems in General Practice" (27 August, p. 515).

I am at present writing a paper on "A Critical Assessment of Appointment Systems in General Practice." My experience and conclusions are based on a system that was introduced last year, and has since been abandoned because of the increased work load. It was with interest, therefore, that I read of the "two-year" period of teething troubles before reduction of his work load was obtained.

I note that Dr. Stevenson has measured work load by "total doctor-patient contacts." After the introduction of "all-day consulting" and the acquisition of a fourth partner there was an observed reduction in work load as measured in this way. However, earlier in the article I note that the consulting time in the surgery was raised by 25% to give "all-day consultation." If one has reduced the total "doctor-patient contacts" by increasing the consulting time can this really represent an actual reduction in work load? I feel that to obtain a real reduction in work load one must reduce the total number of doctor-patient contacts whilst keeping the time factor constant.

It would be interesting to inquire whether, in addition to the reduction in "total doctor-patient contacts," there was a reduction in the "total doctor-patient contact time."—I am, etc.,

Bury, Lancs. SIMON A. P. JENKINS.

Schools for Haemophiliacs

SIR.—I was greatly interested in the article "The Haemophilic Boy in School" (23 July, p. 224), and endorse much of what the authors say about the need for a special boarding school for haemophiliacs. At the special school (founded in 1901 and the oldest school for the physically handicapped attached to any institution) associated with the Children's Convalescent Home, West Kirby, Cheshire, we look after a number of severe haemophiliacs not exceeding 12 in

number at any one time, and at present varying in age from 5 years to 14 years.

The school, which takes 145 children, draws them mainly from the north of England and the Midlands. It is large enough to have a fairly close age range in the classes, and practically all the children are able to attend school, a few in wheelchairs. A ward teacher is available for bedside teaching.

The following notes were made by the headmistress, Miss H. G. Thom, at my request:

"The school is mixed, with an age range of 5 to 16 years, and is non-selective with I.Q.s ranging from 70 to 120. The curriculum is varied, with specialist teachers of woodwork, art, pottery, domestic science, and commercial subjects. Haemophiliacs vary like any other children, but are often much retarded by reason of poor school attendance. Segregation of haemophiliacs has been tried here in school, but they become very aggressive among themselves and squabble much less in a class of mixed handicaps. Their standard of work is also very much better when in a mixed community. Most tend to be indolent, possibly due to their type of handicap, and need competition to spur them on."

This aggressiveness is also noticed out of school and often starts with words such as, "You can't hit me [that is, in retaliation]. I'm a haemophiliac." Pairs of haemophiliac brothers are often just as bad. However, at about 12 years old they do begin to get a little insight into their affliction and learn to keep out of trouble.

While from the medical side there is a strong case to be made for segregation of haemophiliacs into their own special schools, the teachers might find that it is difficult to get the best out of the average and below-average child.—I am, etc.,

West Kirby,
Cheshire.

LEWIS A. MCAFEE.

Education of Handicapped Children

SIR,—We should like to endorse the remarks made by Dr. K. S. Holt (3 September, p. 587) for the broad medical and educational approach to handicapped children. It is our belief that one of the major functions of the school health service in relation to handicapped children is to meet with the teachers and endeavour to decide in exactly what ways physical defects interplay with educational attainment. We further consider that this approach of "educational medicine" should cover children attending ordinary schools with such defects as vision, hearing, or minor incoordination of movement. An essential feature of the broad approach is for doctors and educationists to be able to meet and understand each other. Cooperation in this respect is of more importance for the subject and the children than attempting to define individual spheres and influences.—We are, etc.,

F. E. JAMES,
Principal School Medical Officer.

W. G. JACKSON,
Director of Education.

Nottingham.

Fungi in Nails

SIR,—Like Drs. P. D. Samman and D. I. Williams (20 August, p. 466) I also noted the inaccuracy of the leading article regarding

the efficacy of griseofulvin in the treatment of fungus skin infections (6 August, p. 316), but, realizing the comprehensive nature of your journal, was prepared to hold my fire.

Both Dr. Samman, who has expert knowledge of all nail conditions, and Dr. Williams, who was a pioneer on griseofulvin therapy, in general terms suggest that the treatment of fungus infections of the toe-nails is usually unsuccessful. This is certainly not my own experience, and although I admit avulsion alone, or griseofulvin alone, is inadequate, the combination of both using the proper surgical technique and avoiding reinfection from footwear is usually successful.

My routine technique is to prescribe griseofulvin tablets q.i.d. for two months to clear up the skin infection, and the nails are then avulsed by a dermatologist under a ring block anaesthetic. Care must be taken to curette the nail bed and nail folds, which are then cauterized with trichloroacetic acid, which also controls bleeding, and a non-adherent fungicidal dressing is then applied. The patients are not immobilized and are instructed to destroy or sterilize their footwear, and usually within two weeks no dressings are required. Griseofulvin therapy is continued throughout and for eight weeks after the operation.

I feel it is unfortunate that two authoritative dermatologists should on this subject throw in the towel, as, apart from creating dependency, they are indirectly promoting the spread of "athlete's foot" amongst the community.—I am, etc.,

London W.1.

I. MARTIN-SCOTT.

Iatrogenic Bacteriuria after Vaginal Surgery

SIR,—Bacteriuria following intermittent catheterization or continuous bladder drainage is a well-recognized consequence of gynaecological surgery¹⁻⁴ and yet catheterization is an unavoidable sequel in a large group of such operations. Various complicated techniques have been introduced in an attempt to avoid infection, and one doubts if these techniques are worth while or even necessary since iatrogenic bacteriuria has not been proved to have any chronic deleterious effects. Beeson⁵ has shown that pyelonephritis does not develop in rabbits following the introduction of coliform organisms either into the bladder or into the blood stream unless the kidney has been injured beforehand either by diathermy coagulation or by circulating staphylococci. De Navasquez⁶ found the same and postulated that probably chronic pyelonephritis in man in the absence of any obstructive lesion develops only following prior damage to the kidney, and that the importance of an ascending mechanism of infection has only been assumed, not demonstrated with certainty. Clarke⁷ has suggested that catheter bacteriuria persists only in the presence of factors favouring infection such as a stone, tumour, or obstruction, and Cox and Hinman^{8,9} have shown how catheter bacteriuria and induced bacteriuria clears spontaneously owing to the intrinsic strong defence mechanism of the normal bladder.

A retrospective study was made in this hospital on 100 patients who had had a vaginal

repair from six to 18 months previously. One half had been treated by an indwelling catheter drained intermittently and given the indicated antibacterial agents. The other half, a comparable group, had been catheterized only when necessary. 49% of the first group and 65% of the second group had, in hospital, urine which was considered infected. Laboratory examination of the urine included microscopy of centrifuged deposit, qualitative assessment of the presence of protein, and culture of a 5 mm. loopful of centrifuged deposit. The observation of more than 5 pus cells per high power field or the presence on microscopy or culture of a + or more of bacteria was held to support a diagnosis of urinary-tract infection.

Cattell and Lefford¹⁰ noted that their conventional method (similar to that in use here) did not fail to detect significant bacteriuria though these authors preferred a simple quantitative method as giving fewer equivocal results. Evans and Rippey¹¹ made a comparison between a method similar to that used here and quantitative cell counts and quantitative bacterial cultures. They preferred the latter methods as giving fewer equivocal results, while the more conventional method tended to give a slightly higher proportion of false positives or dubious findings. We feel that the simpler and less time-consuming conventional method not only demonstrates unequivocal infection but allows other evidence to be considered which cell counts, or bacterial counts, alone or together, fail to allow.

Using these criteria only three patients might be said to have urinary-tract infection at follow up examination. None of these three had been treated by indwelling catheter, but it is doubtful if this small number demonstrates a significant difference between the two methods. What is unexpected is that catheterization, whether intermittent or indwelling, is followed by chronic urinary-tract infection in such an apparently small proportion. It suggests that the case against post-operative catheterization should be re-examined since it may well have been overstated.—We are, etc.,

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Inadequate Personalities

SIR,—I read with interest Dr. William Sargent's Watson Smith Lecture (30 July, p. 257). He and his colleagues are evidently obtaining good therapeutic results in the management of their emotionally ill patients by the use of a variety of medications which, by and large, are still used empirically and often enough on a trial and error basis. Dr.