course disfiguring and leaves her with a permanent vaccination scar on her face. Ballet dancers who have to be lifted by male partners do not like to be vaccinated on the shoulder because of the visibility of the scar and the dressing, but also complain bitterly of burst vaccination blisters on the thigh. Where indeed can such ballet dancers be vaccinated?—I am, etc.,

Slough, Bucks. N. C. HYPHER.

Meniscectomy and Degenerative Change

SIR,—Mr. J. P. Jackson (1 June, p. 525) suggests that the damage to the articular cartilage in a knee joint occurs as a result of removing a meniscus, and appears to ignore the fact that the articular cartilage is damaged by the trauma which produced the tear in the meniscus.

The quasi-scientific citing of the opposite knee as "a control" is to be deprecated. The opposite knee could be used as a control only if it had sustained trauma sufficient to damage a meniscus. Is it Mr. Jackson's contention that this knee would be better and show less degenerative change than the one from which a meniscus had been removed?—I am, etc.,

Hull, Yorks. C. R. BERKIN.

Monoamine Oxidase Inhibitors

SIR,—In his letter (18 May, p. 433) Mr. A. G. Johnson stresses the importance of patients who are taking monoamine oxidase inhibitors being made aware of the need to make this fact known to other practitioners. Mr. Johnson urges that patients should be given a card indicating that such products have been prescribed.

At the request of the Committee on Safety of Drugs the A.B.P.I. prepared, in consultation with interested member companies, a standard warning card for issue to patients who are prescribed these products. The text of the card has been approved by the Dunlop Committee. In addition to a caution about foods such as cheese, and the need to avoid taking other medicines, patients are instructed to show the card to other doctors or their dentist.

Supplies of this card or similar cards issued by individual companies may be obtained on request to the manufacturers concerned.—I am, etc.,

A. G. SHAW,
Secretary,
Association of the British Pharmaceutical Industry.

London W.1.

Aphthous Ulceration

SIR,—I am prompted to reply to the letter from Dr. A. J. Moore (25 May, p. 494) in which he claims that trauma is the usual cause, despite his quotation from Sircus, Church, and Kelleher: "local trauma *seemed* (italics mine) to play a part in some cases, but nothing definite of this nature had been observed by the majority of patients."[1] He then proceeds to give his list of three types of trauma which produce ulcers, which to an experienced dental surgeon carry no weight at all, as they are all self-explanatory causes—so easily diagnosed and treated.

I have been interested in these ulcers—so truly called idiopathic—for nearly half a century, and it is my experience that they are invariably due to psychological stress. I could quote very many cases to support my statement. The local treatment I have found most useful was to "touch" the centre of the ulcer with pure phenol, which promptly eased the pain and promoted rapid healing. I found that treatment with hydrocortisone hemisuccinate sodium (Corlan) tablets was very disappointing, but I am happy to report that I am getting very good results from a new preparation called Bonjela composed of choline salicylate and cetyldimethyl benzyl ammonium chloride in the form of a clear jelly which can be easily applied by the patient. The use of a bristle toothbrush (soft) can be useful when the mouth is already sore and painful, or if too sore for that then a badger hair toothbrush.

I still recall with awe the fate of the wife of a surgical colleague who suffered from severe attacks of idiopathic ulceration of the mouth and one of his colleagues advised her to have all her own teeth extracted, and this was done, without, of course, any benefit. When I met her she was wearing dentures and sucking Corlan tablets.

Finally, a wartime experience. An officer in the A.T.S./W.R.A.C. reported sick with severe idiopathic ulceration in the mouth and genitals. She was admitted to the camp reception station and put on sedatives, as she was in a state of intense emotional stress. She refused to give a history or to be examined. I sent for the command medical specialist, who persuaded her to be transferred to a base hospital for general psychiatric treatment. This is the only case in my personal experience of these ulcers on both sites mentioned at the same time.—I am, etc.,

E. DAVIES-THOMAS.

Aberystwyth, Cardigan.

REFERENCE

1 Sircus, W., Church, R., and Kelleher, J., *Quart. J. Med.*, 1957, 26, 235.

Recurrent Tetanus

SIR,—May I add a third case of recurrent tetanus from my own records in Jamaica to those reported by Mr. S. Y. D. C. Wickramasinghe and Dr. Malinie Fernando (2 December, p. 530) and Major M. G. Sahadevan (25 May, p. 492)?

A 65-year-old female had a mild but typical attack with marked trismus and generalized hypertonus lasting for about three weeks with uneventful recovery. She had a second more severe attack five months later in which opisthotonos persisted for three weeks and mild generalized spasms occurred during the second and third weeks. She again recovered after about five weeks. She was treated with antiserum in the first attack and toxoid in the second. No source of infection was found.

It is of interest that in all three cases recurrence occurred within six months, and recovery resulted. Major Sahadevan suggests that tetanus is an unusual complication of haemolytic anaemia, but this is not so rare in West Africa or the West Indies, where chronic ulceration is often a feature of haemoglobinopathy. Three such cases with sickle-cell disease were reported in 1957.[1] In this condition the muscle contracture of tetanus with accompanying hypoxia may lead to bone crises and collapsed vertebrae.—I am, etc.,

R. D. MONTGOMERY.

East Birmingham Hospital, Birmingham.

REFERENCE

1 Montgomery, R. D., *Trans. roy. Soc. trop. Med. Hyg.*, 1960, 54, 385.

Records System for General Practice

SIR,—Undoubtedly one of the most important tools in general practice is the record system; but unfortunately this is the most neglected, probably because it lacks the excitement and glamour of other medical aids. It was heartening to read about the "K-Wallet" (18 May, p. 420), and this is certainly an improvement on our present post-first-world-war model, but it still contains its worst feature—namely, the odd size which is not related to any normal size. The "K-Wallet" could serve well as an interim idea, but we must look further ahead, and this is where Dr. J. K. Hawkey and others (15 June, p. 699) have the right long-term approach.

I have been studying medical records for 18 months with the help of an Upjohn travelling fellowship, and it becomes more and more clear to me that we must make a complete break with our old outdated traditional medical-record envelopes. The new international sizes are here to stay, and it is from this base that we should build. Any changeover will mean time and money, and it is only sensible that the greatest care should be taken before embarking on this. It is up to the general practitioners to devise a suitable report system, bearing in mind not only the present demands but, if possible, those that may arise in the foreseeable future.—I am, etc.,

Worcester. A. J. LAIDLAW.

Claims of Latin

SIR,—Mr. D. L. J. Freed (15 June, p. 703) makes a good point when he advocates the retention of dog Latin in medical terminology. I recently completed a tour of duty as chief medical officer to the United Nations force in Cyprus, where our "official" language was English. All my medical colleagues spoke adequate or good conversational English, but we occasionally had difficulties in medical terms when discussing patients. Latin usually solved the problem, and I would agree that it is not necessary to have the fourth declension to make use of it.—I am, etc.,

P. L. G. COLE.

Headquarters Scotland (Army), P.O. Box No. 85, G.P.O., Edinburgh 1.

Ministry-supported Research

SIR,—The British Medical Association's Planning Unit publication *Research Funds Guide*[1] will I am sure prove very useful to those seeking financial support for medical research in Britain. Unfortunately the almost complete omission of any reference to Ministry-supported research and development is bound to mislead readers as to the extent and nature of our activities in these fields.

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