Changes in the skin were found more often in the face than in the feet: these were mainly subtle changes—minor skin tethering, recognised only after the diagnosis had been suggested by other findings—but in a few patients the facial changes were more severe and gave rise to a characteristic reduction of mouth gape with radial furrowing. Telangiectasia was another useful diagnostic pointer; this was found in over two-thirds of the patients, the small punctate telangiectases most commonly occurring around the nails and on the lips and central face.

Investigations showed that nine of the 17 patients had evidence of oesophageal lesions, five had positive serological tests for rheumatoid factor (latex or sheep cell agglutination), and three had subcutaneous calcinosis. A single patient had pulmonary fibrosis. No other instances of systemic disease were recognised.

Systemic sclerosis in old age seems, therefore, to be quite common, but most patients have benign forms of the disease, quite often corresponding to the so-called CRST syndrome. In this mild variant calcinosis, Raynaud's phenomenon, sclerodactyly, and telangiectasia are the dominant features and the oesophagus is the only site of visceral disease. Certainly, the reported patients followed a generally favourable course and had had evidence of the disease for up to 20 years. In many patients systemic sclerosis was a more-or-less incidental finding, though some did have troublesome symptoms such as frequent Raynaud's phenomenon, pain from ulcers or whitlows, or dysphagia. There were no deaths attributable to the disease. Since the prognosis is favourable attempts to treat the disease with steroids or anti-inflammatory or antifibrotic drugs are generally contraindicated.

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The improving image of A and E

Accident and emergency services have come a long way since the Platt Report was published in 1962.[1] Nevertheless, problems remain and in many, as our special correspondent points out in the last article of the series (p 1348), the calibre of the staff and especially of the consultants in charge of the departments is crucial. It is central to the problem of "deliberately striving to cultivate a true humanity," as Rutherford *et al*[2] put it in their new textbook, in conditions often conducive to "the practice of a brand of supermarket medicine"; to the supervision and teaching that should be so important a part of the work; and to the problem of preventing abuses of the department by the hospital as well as the public. The status and authority of the consultant is also vital in competition for staff and facilities.

The creation of consultant posts in accident and emergency from 1972 has improved the status of the work and helped to upgrade many departments. Health authorities and now even hospitals themselves—despite long traditions of vested interest in casualty on the part of some specialties—have begun to ask for accident and emergency consultants. The standing of these consultants in the hospital is usually good, their right to clinical responsibility is generally accepted, and many of the former disincentives to a career in the department have disappeared, especially now that a training programme[3] has become established.

Can accident and emergency medicine, however, establish itself as an attractive enough specialty to draw in the best talents? We cannot yet expect it often to be a first career choice; but its prospects surely are at least as good as those of, say, anaesthesia and radiology in their infancy. Though accident and emergency work is intrinsically episodic its image has changed from that of a mere clearing house to a specialty in immediate management—with the bonus that its practitioners never know what to expect next.

Enthusiastic teaching should fire more medical students to specialise in accident and emergency. Knowledge of this work is important for most branches of medicine, and the range of conditions offers exceptional opportunities for teaching. Indeed, in a survey of doctors' opinions about priorities in the medical curriculum "casualty" came out fourth.[4] Students appear to value the time they spend there, but many would like it to be longer and for there to be more formal teaching. A few medical schools give sadly inadequate time to the accident and emergency department but substantial teaching depends on adequate staffing as much as on enthusiasm.

Undergraduate teaching needs, then, to be strengthened—and more money is also needed for senior registrar training posts. Another essential is that departments should not be weakened by the presence of a lot of outlying or neighbouring units. Accident and emergency work cannot be either effective as a service or attractive as a career without a case load large enough to justify plentiful staff and facilities and to provide job satisfaction. Advances in the treatment of seriously injured or acutely ill patients—and, incidentally, the increased litigation hazards of medical practice—merit the concentration of services, yet despite concentration in the past 15 years some units are still not large enough. While local pressures to keep open unnecessary casualty departments should be resisted health authorities need to be sensitive to local circumstances. Nevertheless, most areas would benefit from improved local arrangements for dealing with emergencies, by general practitioners and in other ways (this has been said repeatedly but improvement is slow to come), and where necessary immediate care schemes. Above all, the public and the profession should understand more clearly what accident and emergency departments are for.

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[4] Wright, V, Hopkins, R, and Burton, K E, *British Medical Journal*, 1979, **1**, 805.