Eighteen were not introduced to the hospital secretary and general office staff;

Twenty-four did not see the group secretary for nine months to one year;

Fourteen were not introduced to their medical colleagues;

Seven were not introduced to nursing staff;

Twelve were not told about duty rota or "on call" arrangements for one week;

Twenty-three were not taken to other departments of their hospital;

Sixteen did not know about the library, garage, laundry, maintenance, and replacement of white coats for two weeks and were not told about meals, dining room, sitting room on the same day;

Nineteen were not told about emergency arrangements regarding x-ray, E.C.G., laboratory, blood transfusions, resuscitation boxes in wards, etc.;

Twenty-five were not told about fire precaution arrangements of hospital;

Twenty were not told about arrangements for signing death certificates or the procedure of reporting cases to coroner during the first week;

One only was told medical staff standing orders;

Nineteen were not told about procedure of reporting accidents;

Eighteen did not know details of the N.H.S. organization or group and hospital organization until they found out for themselves from their colleagues.

Twenty-four did not know about the welfare facilities and social activities of the hospital for a long time.

Clearly about 75% of doctors are not properly inducted. I was told by many new house physicians that they felt strange for the first few weeks, not knowing about the investigation procedures in their particular specialty. They had to struggle hard to learn gradually from their colleagues and the nursing staff and as a consequence work and patient care suffered. Some felt really frustrated during the first week, not knowing even what they were expected to do.

Starting a new job in a strange place is a daunting experience for anyone and particularly for those who may be entering employment for the first time. Surveys have shown that the attitude which newcomers adopt towards their job is strongly influenced by the reception they meet on their first day. The needs of the registrar who has already held appointments in several hospitals are clearly different from those of the new house physicians, though both should at least be introduced by name to their future colleagues, be shown the layout of their department, know where the nearest lavatory is, and where to get lunch. Whatever form of induction is suitable, a talk, a walk round the hospital, a series of tours of departments, the important thing is that it should be the responsibility of the doctor immediately senior to the new arrival.

I should like to thank Dr. S. G. Maddock and Dr. G. E. Whittingham for their advice, encouragement and for corrections; Dr. I. Mackay, Mr. J. B. Duckworth, Mr. T. Ibison, Ladywell Hospital Secretary, and other hospital sceretaries of the group, for their help and advice; and Mrs. P. Laidler, Miss A. V. Poppleton, Mrs. B. Pimbley, and Mrs. H. Harris for secretarial assistance. —I am, etc.,

B. C. DAS

Ladywell Hospital,
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Safety-pin Swallower

SIR,—Perhaps it would be of interest in view of correspondence on the topic (27 February, p. 504; and 1 May, p. 280) if we record the latest chapter in the life of H.H., the safety-pin swallower who was the subject of a letter (12 December 1970, p. 681).

He presented to the casualty at the Royal Hampshire County Hospital, Winchester, on the 30 May 1971, and his story was exactly as described previously—that is, stating he swallowed the safety-pin accidentally while cleaning his teeth in a lorry, and strongly denying any previous episodes. His abdomen was crisscrossed with laparotomy scars, which he claimed were for duodenal ulcer. The x-rays demonstrated the half-open safety-pin in the stomach, and when we informed him we were not going to operate he was very unhappy. Incidentally, we learned that he had been in Basingstoke Hospital the previous week.

This man is currently seeking work in the south of England, and we feel that casualty officers and surgeons should be aware of his migration, especially as he appears to pass these pins with no ill effect.—We are, etc.,

A. R. L. MAY
T. G. WILLIAMS

Royal Hampshire County Hospital,
Winchester

Corneo-scleral Suture

SIR,—A prepacked corneo-scleral suture through a marked track, with a limbal-based conjunctival flap has been used in a series of cataract extractions in Manorom Christian Hospital, Thailand. It was devised as a stitch giving perfect apposition yet easier to insert than the one across a groove. The idea of marking a track for corneo-scleral suture with gentian violet is not original, and was gleaned from a colleague who had learnt it from an American ophthalmologist. But he used a fornix-based flap which did not give such a good aesthetic result as a limbal-based one, and which sometimes retracted so did not afford such good protection. So gentian violet was forgotten and continued use was made of a preplaced central mattress suture with ease and success—until one patient developed a late stretching of the whole section.

The groove method, found difficult even by some specialists, did not seem the one of choice for a general medical missionary doing relatively few extractions. So a stitch was devised through a marked track, yet possible with a limbal-based flap. The flap is turned back over the cornea and the base pushed right back to clear the limbus, revealing a greyish crescent. At "twelve o'clock," where the crescent is about 1 mm wide, a Jameson Evans needle threaded with Barraquer virgin silk (for economy, though an atraumatic needle is preferable) is passed radially from cornea to sclera, starting right up against the reflected conjunctiva and penetrating about two-thirds of the depths of the cornea. The silk is pulled through to within two inches of its end while the first assistant pulls the conjunctival flap centrally (downwards) to prevent its deep surface sticking to the silk and being drawn through the suture track. The second assistant then paints the last inch or so of silk generously with gentian violet. This part is pulled back and forth several times through the track to colour it and is finally drawn right through and out. The process is repeated just above two and ten o'clock. A keratome and scissor section is made (again easier for the non-specialist) passing between the two dots marking the ends of each track.

After doing a peripheral iridectomy, the next step is to replace a silk suture through each marked track. The ends are cut long and a loop pulled out through the section and tucked away in one or other lateral fornix. Extraction is the next step and the central suture is immediately pulled taut, tied, and cut very short. After repositioning of the iris if necessary, the other two sutures are similarly dealt with and all three are left as permanent buried sutures. So the only stitch to be removed later is a continuous running one of Kalt silk, without knots, which is put in the replaced conjunctiva before the introduction of sterile air into the anterior chamber.

Apposition with this stitch is perfect since the track is made before the section. It has been used in 63 eyes in 46 patients over a year. Late follow-up in rural parts of a developing country is impossible except in a very few patients, but results up to discharge on the tenth postoperative day have been encouraging. No residual staining was ever visible to the naked eye. In 11 cases there was some postoperative corneal haze, affecting merely the line of the incision in six of them. The impression gained was that this was seen as often in cases outside this series, but the fact was not checked.—I am, etc.,

CATHERINE MADDOX

Guernsey, C.I.

Maxillo-facial Fractures

SIR,—The danger of exposing patients to excess radiation appears to exist in the field of maxillo-facial fractures. Many casualty officers simply order "skull x-rays," thus obtaining radiographs which are of little diagnostic value. These views may lead them to believe that there are no fractures of the facial skeleton. Later the patient presents, in the specialist department, with clinical signs of fracture and must undergo further x-rays before treatment is begun. Thus he is exposed to double the necessary radiation.

These twin evils of excess radiation and faulty diagnosis could be obviated by a standard approach to radiology of the maxillo-facial area. This would entail writing the exact views required on the x-ray request card when the patient is first seen in the accident and emergency department.

In suspected mandibular fractures the following views are of most value: postero-anterior skull (with open mouth) +10° tilt, and lateral oblique mandible (right and left views). Fractures of the middle third (maxilla, orbit, zygoma, etc.) may be easily seen on occipito-mental projection (20° + 30°: O.M.).

Where multiple fractures are suspected all three views (a total of five radiographs) should be utilized. Other views may be required in certain cases (for example, reverse Towne's position for condylar fractures or occlusal films in certain suspected fractures),