## Postoperative Leg Vein Thrombosis

SIR,—Mr. L. R. J. de Jode and others (3 October, p. 56) are surprised that the results of their investigations of the effect of stimulating the muscles of one leg of each patient, while using the other leg as a control, in a study of the incidence of postoperative thrombosis (by the $^{125}$I-fibrinogen method) revealed a higher incidence of thrombosis in the stimulated leg, in contrast to Mr. N. L. Browse and Mr. D. Negus (12 September, p. 615) who using a similar technique found, like Doran and White,[1] a reduced incidence in the stimulated leg.

We are surprised at the use of the method of comparing one leg with the other in an anaesthetized, paralysed patient undergoing positive pressure respiration when we have no knowledge of the effect on the blood flow in the unstimulated leg in such circumstances. Though a knowledge of the behaviour of veins with the help of $^{125}$I-fibrinogen is important, we prefer to assess the clinical findings, which are, after all, clinically significant. We have stimulated both lower limbs in a group of patients submitted to major surgery compared with a similar group unstimulated, and found that there was no significant difference ($\chi^2$ test) in the incidence of clinically diagnosed venous thrombosis between the two groups, thrombosis being diagnosed in 22 of 113 stimulated, and 43 of 172 unstimulated, patients. There would appear to be some more surprises on the way.—We are, etc.,

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REFERENCE
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## Children in Hospital

SIR,—Professor R. S. Illingworth in his review of *Hospitals, Children and Their Families* (10 October, p. 101) says "Those of us who are fortunate enough to work in children's hospitals, as distinct from general hospitals, do not have to face these problems because the nursing staff and doctors are constantly dealing with children—and have taken up children's work because they like children."

Paediatricians working in general hospitals have had experience of working in children's hospitals in an era when the total severance of child from parent was thought to be both essential and beneficial. The doctors and nurses responsible for this brutality liked children—but they were blind. Their eyes did not open spontaneously—eyes never do. They were forced open by a tiny minority of people, many of whom were neither paediatricians nor children's nurses.

The central pathway of child hospital care in the future belongs to the district general hospital because it is nearest to the child's home, family doctor, school, and church; because its presence is needed by the district hospital's maternity department; and because only on this local basis can inpatient, day attendance, and outpatient care for all the disabilities of childhood—acute and chronic, physical, intellectual, and emotional—be combined logically. The message of that book is that E.N.T. children should belong in with the others.—I am, etc.,

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## Frenzel's Spectacles for Recognition and Evaluation of Nystagmus

SIR,—It has been known since the time of Barany that spontaneous nystagmus owing to a peripheral vestibular lesion is inhibited by visual fixation. When by contrast the nystagmus is due to a central lesion this inhibition does not occur. The numerous neuro-otological and electronystagmographic studies carried out with D.C. amplification by Hallpike and his colleagues[1-3] have done much to clarify a complex field.

Despite manifest advantages of this kind of equipment for the differential diagnosis of these two main types of spontaneous nystagmus something must unfortunately be added about the practical difficulties which attend its use. It is expensive and requires for its proper maintenance and operation a laboratory of substantial size, well equipped, and with an expert technical staff. In a few of the larger centres this is, of course, a possibility, and here there can be no doubt that electronystagmography with its valuable provision of permanent records has come to stay. There can be no doubt too that with continued technical improvements we may expect the equipment to become progressively cheaper and easier to use. Until this occurs, however, its use in small clinics is not a practical possibility a situation which in view of the clinical importance of the matters concerned must be counted a matter for serious regret.

With this in mind we have been led to consider the extent to which a much simpler and less expensive device—Frenzel's glasses—could with certain modifications be used to fulfil at any rate in large part the diagnostic functions of a modern electronystagmograph. Frenzel first described his *leuchtbrille* in 1928. Visual fixation on surrounding objects is inhibited by means of strong +ve lenses (15-20D) and the light from small electric bulbs mounted between the lenses and the eyes. This light also illuminates the eyes for inspection under the magnification provided by the lenses. With normal room illumination some degree of visual fixation on surrounding objects is still possible, but this can be substantially reduced if the examination is carried out with the room in darkness. Used in this way the glasses have been systematically applied to the evaluation of the characteristics of nystagmus in a number of typical cases, and some data obtained have been compared with those derived from electronystagmographic recordings.

Frenzel's glasses have been found of particular value in patients in whom ocular fixation is so developed that the nystagmus cannot be demonstrated in light during tests for caloric or positional nystagmus. When, however, such tests are repeated with ocular fixation prevented by Frenzel's glasses it is possible to observe typical nystagmus. The value of Frenzel's glasses in this situation is particularly worthy of note in testing for positional nystagmus which is typically rotational or oblique in character, and cannot on this account be fully revealed electronystagmographically. The condition is a notoriously distressing one and its diagnosis is therefore a matter of much importance.[4] The occurrence of the nystagmus needs to be observed and for this Frenzel's glasses may be of unique value.—I am, etc.,

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## Nicotine and Smoking

SIR,—Recently I attended a symposium on addiction to tobacco smoking held under the auspices of the local regional unit for alcoholism and addiction (Adfer) at Cardiff. There I was persuaded that the great cost of the damage to health brought about by inhaling tobacco smoke outweighs the gain in revenue from taxation, apart from the burden of suffering entailed. I also learned that attempts to "cure" the smoking habit by persuasion, abreaction, or whatever have a high initial success rate but that the majority of patients relapse. The addiction is to nicotine; most of the harm comes from the smoke.

Just as the act of love has been separated from the act of reproduction by the Pill it should not be beyond the wit of man to separate nicotine addiction from carcinogenesis. Let us devise a model cigarette of an acceptable shape, size, and consistency which contains an aerosol device in place of the lethal weed. With such a toy the addict may still enjoy the Freudian satisfactions, he will still have 12 or 15 inhalations, he will still get intermittent shots of 100 $\mu$g. of a stable solution of nicotine, but he will not inhale carcinogenic smoke. He will however have to learn to accept the "plastic cap removing fumble" as a substitute for the "lighter search—strike fumble."

The tobacco companies need not fear loss of revenue because they should be allowed a free market and uninhibited promotion in return for shouldering development costs. The Government will have the satisfaction of fulfilling a duty to promote the nation's health and could balance revenue by allowing the new product a negotiable period duty-free while increasing the tax on cigarettes. If the experiment succeeded tax could be applied if necessary and an agreeable export market developed.—I am, etc.,

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