Congenital hydrocoele—giving rise to a translucent swelling surrounding the testicle—is a frequent finding and over 90% of them disappear spontaneously in the first three months.

It is perhaps hardly necessary to mention the fact that the foreskin is normally "tight" in the newborn infant and not retractable. Provided a good stream of urine flows, all is well.

Urine is secreted and passed in utero during the latter half of pregnancy, and sometimes the baby passes urine during delivery, when it may go unnoticed. After birth it is unusual for a baby not to urinate in the first 24 hours and exceptional for urine to be withheld past 48 hours. But serious causes for delayed passage of urine are extremely uncommon and are nearly always accompanied by other grossly abnormal physical signs—as in the case of renal agenesis. Continuous dribbling of urine, however, should lead to the suspicion of ectopic ureters (again an extreme rarity).

Brownish-pink coloured urine may stain the napkin and cause alarm about possible bleeding, but in the first week this is almost certain to be due to a heavy deposit of urates, which is of no serious significance.

This is not, of course, anything like a comprehensive account of all the minor disorders of the first month. But it may serve as a reminder that, though usually not upsetting to the baby, they may sometimes be of considerable gravity in the maternal imagination—and even occasionally in that of her medical attendant.

Colleagues in Health Care

The Home Nurse

FROM A SPECIAL CORRESPONDENT

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Fifty years ago, the editor of the *British Journal of Nursing* wondered whether nurses on the newly-established State Register could be induced to accept posts in rural districts because of the isolation, the poor remuneration, and the element of patronage involved in lay control. Today, communications have removed isolation, salaries have risen steadily, and since 1965 the Queen's Institute of District Nursing has discontinued the training which it had supervised from 1925, and all home nurses are now employed by the local authorities, many of which now offer training courses.

The Queen's Institute gave district nursing a tradition and a name of which its trainees were proud. "Queen's" nurses have always believed that they could keep chronically ill patients free from bedsores far more successfully than their hospital colleagues, and no figure has inspired more affection and esteem than the district nurse. Practice-attachment of home nurses has increased rapidly and with satisfaction to all concerned; general practitioners recognize and appreciate the role of the home nurse more readily than that of other workers in the community health field.

Training

No educational qualification is needed by the State-registered nurse who wants to gain her national certificate. The local authorities which provide training courses may pay nurses while they undertake a programme of supervised practical training and a theoretical part in a technical college or similar institution. The course lasts for 16 weeks and there is a written and practical examination. The syllabus is laid down and standards supervised by a panel of assessors. The home nurse with a national certificate earns £1,203-£1,635; the State-registered nurse who has not gained her certificate gets £45 less. A national training scheme has been introduced for enrolled nurses, who have a 10-week in-service training course. On gaining the certificate the enrolled nurse gets no extra money; this is a disincentive to recruitment since in hospital the enrolled nurse can earn more by promotion to senior State-enrolled nurse, by weekend overtime, or by working in the geriatric field. There are many areas in home nursing where the State-enrolled nurse can work with satisfaction both to herself and to her patient. In most areas bathing attendants are needed to help the slightly infirm with their personal toilet, but these are often employed by cleansing departments, and are therefore paid more than a State-enrolled nurse or even a recently qualified State-registered nurse; such anomalies do not encourage team spirit.

Changing Functions

The work of the home nurse has changed considerably over the years. Dressings are now usually prepacked sterile ones, though in some areas patients still bake their own dressings in tins (incidentally, many years ago "Queen's" nurses used to encourage their patients to buy cheap paper towels to wrap individual dressing packs long before centrally sterilized supplies were thought of). Mersalyl injections are not given very often since the advent of oral diuretics, and though the nurse has more time for the rehabilitation of stroke patients, there are more postoperative dressings than there used to be and practice nurses wonder if sepsis in hospitals is increasing. Gravitational ulcers are common but there is a strong tradition of success in healing them. "Disposables" have modified the nurse's work, and have also raised severe problems about getting rid of them, which have not received adequate thought.

Work loads in urban areas are heavy, and if a nurse has to make 20 visits in a morning some of these must be very short, and it is easy to become a mere caller with incontinence pads. As recently as 1966 an important study of the work of the district nurse,[1] undertaken when practice attachment was still in its infancy, found that district nurses spent a high proportion of their time on record keeping and travelling, and that few general practitioners were aware of the professional qualifications of nurses who looked after their patients, and had very little contact with them. This has now changed completely, but there still exists a lack of communication between hospital and other services. One home nursing super-

visor instances a chronic bronchitic, virtually totally dependent on oxygen, who had been in hospital for two years. A big effort had been made by the medical social workers to re-establish him, and he had been found a small flat in sheltered accommodation with a warden. Unfortunately, the home nursing service was not informed until he arrived in their area on a Friday night, with no oxygen available, some miles from his former doctor. Many similar stories are recounted in a recent study of patients discharged from hospital.[2]

Uneasiness among Supervisors

Many supervisors seem anxious about the changing situation in the social and community work and doubtful about new proposals for training. There is evidently a need for clarification of the role of home nurses and health visitors, since it appears that in some circumstances "practice nurses" without the qualifications of either may be undertaking the work of both.[3] On the other hand, the morale of home nurses in the field seems very high. Perhaps this is because their work is a good example of the sociologist's concept of front-line organization.[4] In other words, the initiative is held by the field workers, each unit tends to work independently of others, and there are barriers to direct control of these activities from above. It is just possible that unease among supervisors arises from the same cause as the job-satisfaction of the home nurse.

This story may indicate the part that the practice-attached nurse plays.

Miss A.B. is 32 and has had muscular dystrophy since she was 3 years old. Both her parents, two sisters, and a brother died within four years, her siblings all from muscular dystrophy. She moved into a country area when she was no longer able to take care of herself to live with her twin brother. She had an electric chair, and a respirator for night use. The nurse called to assess her nursing needs and ordered a ripple mattress, and a full length sheepskin for use in the electric chair; thus the skin of her pressure areas has been kept intact. She has a pair of "lazy-tongs" to help her reach small articles, and a Polystyrene mould (light and neat) to support her in her wheelchair. The brother has been taught how to cope with the respirator in an emergency and Miss A.B. was introduced by telephone to another patient in the practice who has paralytic poliomyelitis and was able to offer practical hints.

She feels that her present period represents her retirement, a time when her work is finished and she is resting. Her weekly bedbath is given by two nurses and is an opportunity to talk over problems.

This care by this patient's doctor, nurse, physiotherapist, welfare officer, and brother is a good example of team effort to provide support for the handicapped in the community. The same team will later have to undertake the care of her brother, who is now beginning to show signs of the same disease.

References

1 Hockey, L. *Feeling the Pulse: A Survey of District Nursing in Six Areas.* London, Queen's Institute of District Nursing, 1966.
2 Skeet, Muriel, *Home from Hospital: A Study of the Home Care Needs of Recently Discharged Hospital Patients.* Dan Mason Research Committee, London, 1970.
3 Department of Health and Social Security, *The Nurse working with General Practitioners: an Evaluation of Research and a Review of the Literature.* London, H.M.S.O., 1971.
4 *Nursing Times*, 1971, **67**, 129.

Any Questions?

We publish below a selection of questions and answers of general interest

Seasickness Immunity in Old Age

Compton Mackenzie said in Octave Eight: "One of the blessings of old age is that it brings immunity from seasickness." Is this generally true, and, if so, why?

Seasickness is rare in the aged in part because of progressive deterioration of labyrinthine sensitivity. This is also associated with deafness, and many other causes of deafness give an immunity to seasickness. A further factor is the maturity and experience of age which lessens the impact of psychological factors involved.

Long-term Steroid Therapy

The life of a professional man of 48 with atopic eczema and associated asthma has been transformed by the use of steroids (methylprednisolone 4 mg b.d.). He has been receiving this drug for the past 15 years with no apparent side effects, apart from slight mooning of the face. Is it reasonable to continue with this therapy indefinitely?

The safest dose of a corticosteroid is the lowest required for control of the disease. Assuming that this patient has not responded to other therapy for his eczema-asthma syndrome (including disodium cromoglycate, Intal) it would certainly seem reasonable to continue steroid therapy. There is, however, no evidence that methylprednisolone has any advantage over the more conventional prednisolone. By using 1 mg tablets of prednisolone it is often possible to wean patients to a lower dose of steroid than can be achieved using 5 mg tablets since a decrease of 2·5 mg (half a tablet) may result in an exacerbation of the disease where a drop of 1 mg will not. For conversion purposes 5 mg prednisolone is equivalent to 4 mg methylprednisolone.

Inheritance of Peroneal Muscular Atrophy

A woman's grandfather and one of his sisters have peroneal muscular atrophy (Charcot-Marie-Tooth disease). What is the likelihood of the woman's children being affected?

Peroneal muscular atrophy may occur in autosomal and X-linked dominant and recessive forms.[1] In order to advise this patient it would therefore be desirable to have the full pedigree, including for example the sex of the parent through whom the patient is descended from the affected grandparent and the number of the patient's aunts and uncles on this side of the family. It would also be desirable for the parent to be given a neurological examination. However, if no other members of the family are affected and both the parent and patient show no signs of the disorder the risk of transmission is not high.

1 Pratt, R. T. C., *The Genetics of Neurological Disorders.* London, Oxford University Press. 1967.