

The commonest method is a wrist-tape marked with the baby's name and sex. The tape should preferably be of adhesive material to avoid it later slipping right off the wrist. For this reason some prefer to apply adhesive tape to the baby's back, but it takes a little longer to get at there. More picturesque, and gaining in popularity, is a string of lettered china beads spelling out the mother's name. This bracelet is kept round the mother's wrist until delivery, when it is transferred to the baby's wrist, the slack in the nylon thread being taken up and held by a lead seal. Another method is to employ two identical numbered metal disks; these are kept on separate strings round the mother's wrist until delivery, when one is removed to the baby's wrist.

In some hospitals in the U.S.A. and elsewhere footprints of the baby are taken as soon after birth as possible, because prints have the advantages of "individuality, continuity, and immutability," to quote the advice of the F.B.I. Footprints are preferred to fingerprints because in the newborn the ridges are more marked on the feet. The attendants have to learn how to take clean prints on suitable paper. The fingerprint expert at the local police headquarters will probably be delighted to teach the technique. He will probably use artist's oil colour "fingerprint black," rather than printer's ink, and white bank paper. The disadvantage is that in cases of possible mix-up of babies an expert has to be called to read the prints. One advantage is that the method can also be used to identify an abandoned baby—provided that its prints were taken at birth.

#### Naming the Toes

**Q.**—*What is the best way of naming the toes?*

**A.**—The generally accepted and safest method is to name the toes as the hallux, 2nd, 3rd, 4th, and 5th toes. One of the medical defence organizations has reported that, although it has been faced with claims in respect of operations performed on the wrong toe, these have usually arisen as a result of confusion of sides (i.e., right instead of left) and not as a consequence of any ambiguity in the actual designation of the toe itself.

#### Trigger Finger

**Q.**—*What is the cause and cure of a trigger finger in a healthy adult, in which the digit, when fully flexed, can be extended only after a disagreeable snap?*

**A.**—Trigger finger is a common condition, particularly in women. The cause is a swelling of the flexor tendons just as they pass through one another—at which point, of course, they also have to enter and emerge from the fibrous flexor sheath. The swelling of the tendon makes this difficult and, in fact, sometimes impossible, and the finger is held in flexion because the swollen tendon is now proximal to the entrance and cannot be drawn in. The usual cause is trauma, but there is no doubt that the condition is also common in rheumatoid arthritis. The trauma may be of a recurrent occupational nature.

The cure is simple and certain, and is by division of the proximal fibrous flexor sheath for about  $\frac{1}{2}$  in. (1.25 cm.). Spontaneous recovery is by no means uncommon and treatment by injection of hydrocortisone has been advocated. It is difficult to inject this into the sheath, and there is perhaps insufficient controlled evidence that it is curative.

#### Incidence of Acute Mastoiditis

**Q.**—*I have noticed in my practice in the past few years a considerable decrease in the incidence of acute mastoiditis. Is this so generally, and what could be the explanation for it? Could it be because many people have had antibiotics at some time in childhood, and that these have tended to destroy chronic infectious foci?*

**A.**—It is, of course, perfectly true that the incidence of acute mastoiditis has diminished enormously since the advent of antibiotics, but it is probable that the more widespread recognition and treatment of upper respiratory

infections at an early stage has also been partly responsible for this decrease. There is also a possibility that the virulence of the common pathogens has diminished.

## NOTES AND COMMENTS

**Firm Mattresses.**—Mr. W. E. HALL (Division of Hospital Facilities, King Edward's Hospital Fund for London, E.C.2) writes: I notice that in answer to a question on firm mattresses ("Any Questions?" April 8, p. 1055) you question whether plastic foam is manufactured in the form of a made-up mattress. It may be helpful to you to know that with the co-operation of hospital staff this Division was able to arrange a small trial of plastic foam mattresses, and as a result the Fund is financing a further experiment on a larger scale. The Division is arranging for a women's surgical ward of 28 beds to be fitted with these types of plastic foam mattresses purchased from the British Quilting Co. Ltd., Waterfoot, Rossendale, near Manchester, Kay Bros. Plastics, Marple, Stockport, Cheshire, and Price Bros. and Co. Ltd., Wellington, Somerset. At the same time selected types of mattress covers will be subjected to further testing under ward conditions. The plastic foam mattresses can withstand autoclaving, but we are providing another hospital with samples to see how they stand up to other forms of sterilization.

Dr. J. W. FLEMING (Tenby, Pembrokeshire) writes: In the reply to a query about firm mattresses your expert did not mention a special mattress made by Simmons, of Perivale, for orthopaedic use. This consists of a horizontal board sandwiched between springs, and is both comfortable and beneficial to lie on.

Mr. A. W. FOWLER (Bridgend, Glam.) writes: Your expert's reply to the question on how to make a "firm bed" for orthopaedic cases does not resolve the difficulty. There are two elements to a bed: (1) the mattress; (2) the base on which the mattress lies. The mattress can be soft or springy if desired, but it must rest on a firm level base. This is achieved either by placing a board beneath the mattress or by placing the mattress on the floor. There is no virtue in a "firm mattress"; in fact, for a patient with large hips this is undesirable because it will result in deformity in the spine. The soft mattress has the advantage that it absorbs the unevenness of the body contours, thus allowing the spine to remain level.

OUR EXPERT replies: I quite agree that a firm mattress without a firm basis is valueless, though I would not altogether agree that a firm base and a soft mattress are satisfactory. While undoubtedly a firm mattress is uncomfortable for some patients, there are a number of patients who prefer to sleep on the floor during attacks, so much comfort do they get from a hard surface on which to lie. However, Mr. Fowler has made a good point in stressing the importance of the base.

**Swimmer's Cramp.**—Dr. D. A. WEBB (Southmead, Bristol) writes: Regarding the question of swimmer's cramp ("Any Questions?" April 29, p. 1268), my young laboratory assistant has had her quite severe cramps prevented by quinine sulphate 5 gr. taken about two hours before the expected swim. I assumed the mechanism was similar to the cramps old people get in bed at night. The treatment is harmless.

**Correction.**—We regret a misprint in the paper on "Pneumoconiosis and Respiratory Symptoms in Miners at Eight Collieries" (May 13, p. 1337) at p. 1340, lines 46-48, which should have read: "Our findings on the prevalence of respiratory symptoms, ranging from 16% at colliery A to 43.1% at colliery F, should not be compared with . . ." In Table III (on p. 1341), in the age-group "Under 21," the figures 3.81, 3.59, and 0.22 should have related to the subjects *without* pneumoconiosis, not to those with pneumoconiosis.

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