It may be that in England now (owing to the lack of domestic help, or the snoek, or some other factor) artificial feeding is easier than breast-feeding; but, Sir, the *British Medical Journal* goes all over the world. Please do not let us disseminate any authority from the medical profession for a further decline in breast-feeding.—I am, etc.,

Bristol. HUGH R. E. WALLIS.

*** This correspondence is now closed.—ED., *B.M.J.*

Rhesus-testing in Pregnancy

SIR,—Doctors engaged in the practice of midwifery are now well aware of the importance of blood replacement in the treatment of the haemorrhages of pregnancy. Increasing use is therefore being made of the emergency resuscitation services which most maternity hospitals maintain for the purpose of transfusing women too ill to be removed into hospital.

It is, however, evident that some practitioners do not realize that blood transfusion cannot be undertaken with safety unless the rhesus status of the patient is known. The blood group can be determined at the bed-side, but the rhesus grouping can be ascertained only by a somewhat elaborate laboratory technique.

As one who has had some experience in emergency transfusions I write this letter to urge on all doctors responsible for the care of pregnant women the necessity to take steps to determine early in pregnancy the rhesus grouping of the patient. Too often one is summoned to women critically ill from blood loss only to find that the rhesus status is unknown, thus increasing the hazards of blood replacement. It is the bounden duty of all doctors who make themselves responsible for the care of the pregnant woman to see that the rhesus grouping is carried out as early as possible in the pre-natal period. The doctor who neglects this precaution is most certainly failing in his duty to the mother and her child.—I am, etc.,

Sheffield. W. J. CLANCY.

Senile Deterioration of the C.N.S.

SIR,—I was very interested to read the article by Dr. Trevor H. Howell on senile deterioration of the central nervous system (Jan. 8, p. 56). I must, however, disagree with the conclusions reached. In assessing central-nervous-system physical signs in this age group, one important factor seems to have been omitted—namely the state of the vascular system. In addition the defective absorption of vitamins must be considered—achlorhydria being a not uncommon "normal" finding in this age group.

Any attempt to explain these phenomena by a central lesion seems to me erroneous. I would say that the factors operating are: (1) peripheral vascular occlusion which, although not gross clinically, has been sufficient to impair the blood flow to the vasa nervorum of peripheral nerves; and (2) vitamin B deficiency, which has again led to peripheral nerve lesions and also to mid-brain lesions with pupillary changes.

It is then on a basis of a peripheral neuropathy that I would explain the lesions found. In support of this I note that the pyramidal tracts are normal in practically all cases, and lesions in the legs are more pronounced than in the arms—a not uncommon finding in peripheral vascular disease.—I am, etc.,

Leeds. RAYMOND C. GLEDHILL.

Cotton-dust Disease

SIR,—The following quotation is from your leading article (Dec. 18, p. 1069): "It seems more likely, however, that there are only two diseases, perhaps only one: mill fever is almost certainly the early stage of byssinosis, and the remaining two conditions are very similar to other diseases caused by mouldy organic matter such as grain, flax, hemp, jute, and bagasse." This is not correct. There are three distinct conditions, distinct clinically and occupationally.

1. *Mill Fever.*—This will affect anyone unaccustomed to cotton mills, whether spinning mills or weaving sheds. It is a very mild febrile attack with anorexia after a day in the mills. After a night's sleep it is gone, giving protection, which, however, disappears if the visits to the mills are discontinued. I have often experienced it.

2. *Strippers' and Grinders' Asthma.*—This is a very chronic disease which takes many years to develop. It only concerns men in spinning mills exposed to dust arising from raw-cotton bales. It is not seen in weaving sheds or among those who tend the spinning frames and self-acting mules to which the cotton sliver proceeds from the carding engines. I was the first to describe the condition in 1908.

3. *Weavers' Cough.*—This condition is only seen among cotton weavers, and only among weavers preparing cotton cloth for the bleachers and dyers. If the cotton thread being woven for this purpose gets damp on the warp beams, under conditions described by me in 1914, offensive moulds may grown on the threads, which become dark and smell badly. When such threads are woven the operatives experience epidemics of acute illness lasting several months and clinically resembling active pulmonary tuberculosis.

What byssinosis is I have often wondered. Βύσσος is a Greek word for linen.—I am, etc.,

Lossiemouth, Morayshire. EDGAR L. COLLIS.

Mallet Finger

SIR,—Perhaps it is wise first to define the deformity "mallet finger as a lesion of the mechanism controlling extension of the terminal joint of any finger (the thumb is excluded).

From experience in the treatment of this very common industrial and domestic lesion we suspected that it was not a simple problem, and that the pathological anatomy of the tears might be as varied as the end results we observed to follow routine plaster immobilization with flexion of the proximal joint and hyperextension of the distal interphalangeal joint. Following this routine we were not unduly worried when flexion of the terminal joint persisted at the end of treatment; as Dr. W. J. Lloyd (Jan. 1, p. 30) has observed, most workmen can accommodate themselves to this deformity and are not concerned with the appearance of a useful working finger. (Precision workers, however, find the loss of complete control of the terminal joint of the index or middle finger a real working disability.) We were worried, however, by a group who after treatment complained of such pain in the distal interphalangeal joint that they could not return to work, and this pain persisted for a long period.

Therefore six years ago this hospital undertook a planned investigation of the problem, continued its close study for almost two years, allowed a period of time to elapse before assessing all the patients included in the study, and finally published[1] a detailed description of the varying surgical anatomy of these tears and a detailed account of the end results to be expected after surgical treatment.

From this study it is obvious, I think, that mallet finger cannot always be treated by a reassuring word, as Dr. Lloyd would seem to suggest. The open mallet finger caused by a grinding wheel, cutting or crushing violence—a not infrequent industrial injury—is an undisputed surgical matter.

The closed mallet finger, which may cause very troublesome and prolonged pain in the joint, is caused by the avulsion of a fragment of bone from the base of the terminal phalanx, taking with it a variable amount of articular cartilage. If the very disabling and painful traumatic arthritis of the joint is to be avoided, then early and accurate reduction of the fracture, in our view, is essential. If closed reduction fails, as it sometimes does, then early open reduction with internal fixation is essential.

The fracture type of mallet finger accounted for 25% of our series. Three-quarters of our patients had tears of the extensor tendon at varying levels, the level of the tear presenting its own problem in treatment—e.g., if any part of the tear was situated proximal to the joint, the prevention of adhesions between the tendon and the neck of the middle phalanx with the subsequent inability of the tendon to pull the joint into full extension still remains a problem.

The prognosis after surgical treatment of mallet finger seen early is not as bad as Dr. Lloyd's impressions indicate. In a close study of 61 consecutive mallet fingers treated by surgery, 20 regained full extension and a good range of flexion, the remainder had flexion deformities ranging from 10° to 30° and a good range of powerful controlled flexion. In the treatment of this condition there is undoubtedly an economic angle—we can both over-treat and under-treat: to do either may be unnecessarily expensive.

In my experience a common type of mallet finger is the partial tear in the middle-aged. The patient presents a terminal

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