subsequent child will be affected is between 1 in 10 and 1 in 8. This gives much too gloomy an outlook. Of 117 mothers at a London maternity hospital who gave a history of a previous pregnancy resulting in a malformed child, only three had a malformed child.[3] However, any estimate of the risk based on malformations in general is of little value, since it appears at the moment that it is only the same or similar malformations that tend to recur with undue frequency in later children and that the risk varies in different types of malformation. None of the common malformations recur with a frequency as high as 1 in 10. Your annotation quotes Record and McKeown's findings of about 1 in 35 for central nervous system malformations, but does not make clear that it is only the risk of the same and other central nervous system malformations that is raised and not the risk of deformities of other parts of the body. For talipes equino-varus the risk is of about the same order, while that for congenital heart disease is very much less. The only deformities with a high rate of recurrence are those determined entirely by single dominant or recessive factors, and these are rare.

Third, Murphy is quoted as stating, "The hazard of malformation increases with the age of the mother, rising progressively year by year after the mother has passed 30." Murphy arrived at this conclusion by an unsound statistical method[3 4] and there is evidence that maternal age has little effect on the incidence of deformities except in the case of mongolism.

Finally, the animal experiments, such as those of Warkany mentioned in your annotation, though of great theoretical interest, must not be taken as indicating that similar agencies necessarily play any part in causing human deformities. For example, there is no good evidence that malnutrition causes deformity in man.—We are, etc.,

C. O. CARTER.
J. P. M. TIZARD.

The Eugenics Society, London, S.W.1.

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[1] *Congenital Malformations*, 1947. Philadelphia.
[2] *Brit. J. soc. Med.*, 1950, **4**, in the press.
[3] Carter, C. O., *J. Obstet. Gynaec. Brit. Emp.*, 1950, in the press.
[4] Stevenson, S. S., Worcester, J., and Rice, R. G., *Pediatrics*, 1950, **6**, 37, 208.

New Scholarships in Public Health

SIR,—In recognition of the services of Sir George Elliston, who has just demitted office as its chairman after eleven years' tenure, the board of management of the London School of Hygiene and Tropical Medicine has decided to offer two scholarships of £150 each, with free tuition, for students taking its course for the Diploma in Public Health commencing in October, 1951. Official intimation will be found in the advertisement columns. These are additional to the Bygott Scholarships, awarded by the University of London, also tenable at this school, about which official notification will appear later.

The Board hopes that the Elliston scholars will eventually join the preventive services in the United Kingdom, the number of recruits to which has been seriously reduced by the discrepancy existing between the emoluments offered and those obtainable now in other branches of the medical profession. We hope that many more of the medical officers of health of the future will become the pivotal points of the medical services of their areas. All thinking people deplore the increasing tendency for each section—domiciliary, hospital, and preventive—to develop and function as separate entities. The medical officer of health with the proper outlook and background should, we think, be the co-ordinator: this implies a very adequate clinical training, and we hope that men of good quality will give careful consideration to adopting community health as their career.

The modern course for the D.P.H. is much more a cultural discipline than a technical training, and there are few young medicals who would not derive great benefit from it whatever their ultimate aim.—I am, etc.,

ANDREW TOPPING,
Dean.

London School of Hygiene, W.C.1.

POINTS FROM LETTERS

Psychology in the D.P.M.

Dr. J. B. G. SMITH (Sutton, Surrey) writes: . . . I feel psychology does need some standardization, especially from the textbook point of view . . . no two examiners or tutors will recommend the same books. . . . D.P.M. psychology, too, is complicated by the varying emphasis shown by examiners. How is the unfortunate candidate to know who are the ardent devotees of Freud, Jung, or Adler and so will exhibit a bias towards their respective doctrines ?

Dr. A. K. GRAF (Brentwood, Essex) writes: . . . I cannot agree with the views expressed by Dr. A. Folkson (January 20, p. 140). . . pure psychology (is) a most stimulating and sound basis for the understanding of preclinical and clinical aspects. . . . Much does not seem relevant to clinical work at first, but as time and experience progress and the psychiatrist learns to deal with all the manifold aspects of his specialty he will find in time opportunity of using most of the academic knowledge he has gained in studying psychology for the D.P.M. When he reaches consultant status and has to work with non-medical psychologists he will sorely realize how deficient his knowledge in their specialty is, and, humiliated by the clinical relevance of such knowledge, he will at a late age hurry to make up his shortcomings in pure psychology by renewed reading and study of academic psychology.

Athlete's Foot

Dr. T. B. RANKINE (Liverpool) writes: I have had some personal experience of this affliction while resident in the West Indies, in which climate athlete's foot tends to be a considerably more severe disease than is the average case met with in Britain. While the treatment outlined in the article by F. R. Bettley (January 6, p. 28) may be adequate for these cases I feel that it may well be found to be disappointing in the more severe case—and it would certainly fail to arrest the progress of any but the most trivial case in a more tropical climate. The basis of treatment is in keeping the affected skin as dry as possible. If Whitfield's ointment be merely spread on the socks the fungus will soon thrive on the sodden skin bathed in the sweat accumulating under the layer of ointment. I have found that the most effective regime was as follows: (1) The feet are kept as cool as possible, preferably only open sandals being worn over thin woollen socks. (2) At night—or in the evening if no more walking is to be done—the feet are bathed in a basin of hot water, carefully cleaned, and the loose scales removed. Then follows thorough drying, paying particular attention to the interdigital clefts. The feet are now swabbed with spirit—this may prove a trifle painful but it is by no means unbearable—and then allowed to air for a period. The ointment is now applied and thin socks worn. (3) In the morning the feet are swabbed with spirit till all moisture (and this includes the ointment) is removed. The feet are now liberally dusted with an absorbent powder—the pulv. acid. salicyl. co. of the *B.P.* is a good preparation for the purpose—using the sock as a powder-puff. Plenty of powder must be used, and in severe cases it may be wise to shake a further quantity into the shoes themselves. Obviously this process may be repeated in the course of the day, a fresh pair of socks and shoes employed, etc., according to circumstances. . . . Another important point is that cure is never permanent, for the fungus seems to get into the footwear and there lodge until the next occasion that hot damp feet are offered to it. It is therefore a wise plan for the patient to repeat the morning dusting (the spirit is not now needed) for the rest of the summer and to resume the powdering at the first sign of itching and redness between the toes. The sheet anchor of the treatment is the absorbent powder. Whitfield's ointment need be employed only when a rapid response is not obtained with spirit and powder.

Corrections

Dr. R. BOWERS writes: In my article on haemangiomatous naevi (January 20, p. 121), Case 41, in the moderately improved group, was treated for nearly two years, not one year as stated. Thirty paintings in one year would have been excessive, especially for a child aged 5 months.

In Dr. W. N. Leak's letter (February 3, p. 246) on "Foetal Asphyxia" the last sentence of paragraph 2 should read ". . . the cerebral (*not* central) blood of the foetus . . ." and the first sentence of paragraph 4 ". . . suffering from pure nervous shock, while surgical (*not* nervous) shock is mainly . . ."

In "Diagnosis of Aortic Stenosis," by Dr. D. Lewes (February 3, p. 211), in Table IV, under "pulse volume" in Cases 14 and 16, for "dicrotic" read "anacrotic."