object of teaching students the art of satisfying the needs of sick people. This art is based on a personal relationship of doctor and patient, and both the American and British studies of the subject lead to the conclusion that careful attention must be given to cultivating it. In the American experiment this is emphasized by a course in the first year called the "Introduction to Clinical Medicine," which is given by an internist long interested in "individualizing" the patient, a physical anthropologist interested in constitutional differences, a psychiatrist, and a social worker. In the British report the same aim is pursued throughout the course by teaching that the patient must be treated as an individual and as a whole.

It appears to me that sufficient facts and views have been collected in the British report for medical schools in this country to settle on their individual aim and to decide how much change they require to make. In Edinburgh very useful integration of lectures has been arranged by the departments of surgery, medicine, pathology, and therapeutics, and weekly demonstrations on diseases set out by these departments in combination.

I hope that you will be able to report interesting progress in the American experiment, and the commencement and development of similar enterprises in this country. The question is whether doctors are anxious to continue to direct the technical efforts of themselves and others towards the greatest possible benefit of the patient, or whether they are willing to become more absorbed in detailed medical technique. It is in hospitals that there is most risk of this narrower outlook, and if it becomes general doctors will lose some of the direction in medical affairs which they now have.—I am, etc.,

London, W.1. J. M. Alston.

Girls with Moustaches

Sir,—In "Any Questions?" (March 24, p. 652) there is a query about the best way of removing a small moustache from an otherwise normal girl of 15. The answer deals solely with methods of removal, and does not give suggestions about treatment, which in my opinion is most important. Brunettes, especially when there is a familial or racial darkness of hair, frequently show an exaggeration of hair growth on the upper lip at adolescence. These hairs may tend to coarsen in the next five to ten years or they may gradually become less noticeable. The only treatment needed in the early stages is tactful handling, combined with artificial bleaching in suitable cases. Ten volumes hydrogen peroxide made faintly alkaline with ammonia and applied as a compress for a few minutes daily and then carefully rinsed off is usually sufficient to camouflage the condition. If coarser hairs develop, electrolysis or diathermy will be the method of choice, and fairly coarse hairs are easier to treat than downy hairs.

Neuroses and feelings of inferiority and shame commonly start in adolescence when the hirsuties is first noticed, and sympathetic, though practical, handling of the problem is most necessary. The increased tendency since the war to the development of acne, together with earlier applications of face-creams and cosmetics and the greater popularity of sun-bathing, may contribute to some thickening of down hair into frank hirsuties. Endocrine factors as such probably play little part in the appearance of hirsuties in a girl of 15. Wax depilatories should be condemned for use by young girls, as both fine and coarse hair is pulled out when the cold-set wax is finally dragged off the face.

Rubbing with pumice and the use of chemical depilatories (barium sulphide) are both temporizing measures. Although the free growing ends of the hair appear again in due course, they are not sharp and "stubbly." This treatment has to be applied regularly, and the hairs will gradually coarsen and the area affected will tend to enlarge at the periphery. Manual depilation by plucking out coarse hairs has to be repeated every few weeks. The roots tend to coarsen, to elongate, and to become distorted. Later, if electrical treatment is started, difficulty will be experienced in killing the root with a safe current—that is, a current that will not also damage the skin.

There is need for a much better understanding of the problem of hirsuties, and how it affects the mental and emotional make-up of women. A careful consideration of the treatment to be suggested is most necessary.—I am, etc.,

Kew. Clara M. Warren.

POINTS FROM LETTERS

Artificial Lighting

Dr. G. Lawson (London, E.2) writes: I have found, in common with other practitioners, that the bane of an evening surgery in winter time is a difficult rash almost impossible to diagnose in artificial light. Having considered the possibility of fluorescent lighting and finding this to be too expensive, I have discovered that an almost perfect colour reproduction is given by a daylight bulb. These 100-watt lamps can, with advantage, be used in conjunction with an ordinary 60-watt lamp, which softens the somewhat cold light derived from the daylight bulb alone, but can be switched off when a difficult problem arises.

Retrolental Fibroplasia

Mr. Eugene Wolff (London, W.1) writes: . . . In a paper (*Proc. R. Soc. Med.*, 1950, **43**, 235; *Amer. J. Ophthal.*, 1950, **33**, 1768) I pointed out that the most striking feature of the pathological picture of this interesting condition was the anterior end of the retinal detachment which usually accompanies the disease. This consists of the clear cells of the ciliary body, which normally unite very firmly with the underlying pigmented layer at about the third or fourth month of intrauterine life. . . . I also showed that the membrane behind the lens was in fact inflammatory and not the remains of embryonic tissue as generally supposed. Without going into further details, I would only like to repeat here the suggestions I made for the order of events. A noxious stimulus reaches the embryo very early, probably in the first few months of intrauterine life. Its effect on the eye is primarily on the retina, which remains non-attached in part or as a whole. (The noxious stimulus may affect other parts of the organism, especially the brain, as pointed out by Krause, hence his name for the disease, encephalo-ophthalmic dysplasia.) Fluid collects under the retina and a real detachment is produced which gradually becomes total. This may give rise to a mild uveitis, which is responsible for the retrolental membrane and the posterior synechiae, when these are present. It is therefore extremely unlikely that any post-natal treatment can be of much avail.

Absorption of Iron

Dr. E. Lozinski (Montreal, Canada) writes: Your leading article (February 3, p. 231) . . . recalled to me an almost forgotten study (S. J. Usher, P. N. MacDermot, and E. Lozinski, *Amer. J. Dis. Child.*, 1935, **49**, 642) in which it was shown that the administration of a soluble iron phosphate preparation was quite effective in improving the simple anaemia of infants. It would seem . . . that whatever may be the situation in experimental animals the amount of phosphate and calcium supplied by the dietary regime of these children was not a factor of consequence with respect to the assimilation of iron even from an iron phosphate compound.

A Vaccination Dressing

Dr. R. D. Dewar (Deptford, S.E.14) writes: One of the difficulties encountered in vaccination against smallpox, especially when dealing with large numbers, is the delay occasioned by allowing the lymph to dry before a dressing is applied. The delay can be avoided by using as a dressing one half of a cachet, such as is in normal use for the internal administration of powders. This "cap" can be applied immediately after vaccination and secured in place with a small piece of adhesive plaster. It is sufficiently deep to prevent contact with the vaccination area, it is both cheaper and more convenient than other forms of dressing, and in addition it prevents those unsuccessful cases which are due to the application of a dressing before the lymph has dried. The dressing can be discarded within a few hours, after which no dressing is necessary, in my opinion, for at least the first few days. Normal-sized cachets (No. 2) cost about 10s. a thousand. I am indebted to Dr. W. W. King-Brown, of Peckham, for introducing this dressing to me. I understand that it is not a new idea, but I have not previously seen it reported and I believe it is not widely known.

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