feature has greatly facilitated venepuncture in patients in whom the extremities were habitually cold, the veins contracted and impalpable, even in warm surroundings.

Since the exhibition of chlorpromazine considerably reduces the amount of thiopentone required to abolish consciousness, recovery time is not significantly retarded; this would suggest that, in suitably selected cases, the drug could be used safely in this way for ambulant patients.—We are, etc.,

J. D. W. PEARCE.
H. L. THORNTON.

London, W.2.

Measles

SIR,—In your leading article (*Journal*, April 23, p. 1018) I was interested that the occasional difficulty in distinguishing between measles and the early stages of scarlet fever should have been mentioned at a time when I was about to report the following rather unusual case.

A boy, aged 2½ years, had scarlet fever in January, 1955. On April 1 he had a running nose, a hard, dry cough, and Koplik's spots so typical that they were demonstrated to his mother. By April 7 he had the typical rash of measles, and his sister, aged 6¾, who slept in the same bed, was found by the mother to have Koplik's spots, and when seen by me the same evening looked miserable, with a temperature of 102° F. (38.9° C.), a hard cough, running eyes and nose, and photophobia. The following day a colleague saw the sister and confirmed the diagnosis of measles from the typical rash, which was becoming confluent when seen by me the next day. By April 10 the boy was much better, but the girl had striking circumoral pallor with the beginning of desquamation on the cheeks: her temperature was still raised to 102° F. (38.9° C.); she had a strawberry tongue, injected fauces, and enlarged cervical glands. On April 11 her measles rash was still present, but the fingers, palms, soles, and cheeks were now peeling, and superimposed on the measles rash was a typical scarlatiniform eruption. Granny, who had raised 16 children through every infectious fever without the help of a doctor, confidently diagnosed a combination of measles and scarlet fever—a diagnosis with which I concurred. On April 13 the boy was completely better, but the girl still had a temperature of 102° F. (38.9° C.) despite having started sulphonamides two days before. On April 15 she was much better and both rashes were fading.—I am, etc.,

London, W.6. DAVID JACKSON.

Roseola Infantum

SIR,—Dr. E. L. McQuitty's article on roseola infantum (*Journal*, April 23, p. 1005) wisely draws attention to the most commonly occurring member of the exanthemata in infants under the age of 2. I have been noticing sporadic cases in my practice ever since the annotation in the *Journal* in 1950.[1] Dr. McQuitty mentions the paucity of references to the condition in the literature, but his most recent reference is 1950. Almost a page is given to it in my book[2] in the chapter on "Common Disorders Recently Recognized." In my opinion the importance of the recognition of this, and of other mild disorders encountered mainly in general practice, lies in the fact that exact diagnosis increases a general practitioner's confidence in himself and thus his patients' confidence in him.—I am, etc.,

Plymstock, Devon. DENIS CRADDOCK.

REFERENCES
[1] *British Medical Journal*, 1950, 2, 876.
[2] Craddock, D., *An Introduction to General Practice*, 1953, p. 480. H. K. Lewis, London.

SIR,—In his paper on "Roseola Infantum" (*Journal*, April 23, p. 1005) Dr. E. L. McQuitty states: "In Britain, only Schlesinger (1937) refers to a few cases seen in London." That is not accurate. An outbreak in a maternity hospital was described in this country in 1949,[1] and was subsequently referred to in an annotation in your *Journal*.[2]—I am, etc.,

London, E.3. S. FREIER.

REFERENCES
[1] James, U., and Freier, A., *Arch. Dis. Childh.*, 1949, 24, 54.
[2] *British Medical Journal*, 1950, 2, 876.

Cross-infection in Hospital

SIR,—I have read with interest the articles by Dr. E. J. L. Lowbury (*Journal*, April 23, p. 985) and Dr. P. N. Edmunds and his colleagues (p. 990).

The reservoirs of antibiotic-resistant pathogenic staphylococci are: (1) Blankets on ward beds and waiting-room or casualty couches, or on theatre trolleys: these blankets should be washed every month in a solution of "lissapol" and then soaked in "fixanol" solution, and dried without further rinsing. (2) Pillows and mattresses: these should be treated with hot, moist, gaseous formalin in the hospital sterilizer every 10 days or every time the bed has a new occupant, whichever time is the shorter. (3) Floors, ledges, shelves, locker tops, table tops, etc., should be treated every day with the M.R.C. urea ninol mixture. (4) Hands: nurses' hands should be protected by thin rubber gloves when the napkins of infants are being changed, bedpans carried about or cleaned, dressings changed, etc. The "washing" of a nurse's hands is a farce. Gloved hands, however, can be "washed" effectively in water containing a substance like "milton." A nurse should wash up, dry her hands on a sterile towel, and then apply sterile powder to her hands and don dry thin sterile rubber gloves. Whilst wearing her gloves she can wash her hands dozens of times, with effect each time. (5) Nurses should wear an efficient mask and a sterile overall when at work. (6) All plates, cups, saucers, and other crockery, including drinking-glasses, knives, forks, and spoons, and any other cutlery should be boiled after every meal, in addition to ordinary cleansing procedures. (7) In addition to the above measures, the M.R.C. technique for dressing wounds should be adopted and strictly enforced. Septic plasters, septic burn wounds, and septic surgical cases should be segregated from clean cases; and these septic cases should not have their dressings changed or removed in an open ward or theatre used also for clean cases. A special theatre and ward should be kept for septic cases, and attendants working there should have their noses and throats swabbed at frequent intervals. If the attendants are found to be infected, the organism should be examined bacteriologically to find an antibiotic to which it is sensitive; the attendants should then be treated with this particular antibiotic until nose and throat swabs are clear. Emergency admissions and infectious cases should not be admitted to an open ward but placed in cubicles for 48 hours: the disposal of the case should then be reviewed.

Many of the measures recommended are described in an article in the *Lancet*, 1954,[1] and can be seen in action in a hospital in greater London.—I am, etc.,

Epping, Essex. FRANK MARSH.

REFERENCE
[1] Marsh, F., and Rodway, H. E., *Lancet*, 1954, 1, 125.

The Changing Face of Medicine

SIR,—Mr. Clifford Kennedy's stimulating address (*Journal*, April 30, p. 1045) contains ideas of great importance, as well as a few crusty notions belonging to an age now departed and never likely to return. When, however, he says that the surgeon finds he is loath to undertake the risky case, I feel a challenge to be essential. If this is true the state of the profession is indeed inglorious. I don't believe it. Nor do I believe Mr. Clifford Kennedy when he says, "I have done it myself."

The responsibility of the doctor, physician or surgeon, is to make up his mind on the ascertainable facts and to take the action best suited to the patient under his care. No fear of possible legal consequences can alter that. The alternative is to resign and take up a job in a less responsible occupation. It is the hallmark of the doctor that he must decide. On his decision his own actions and those of many other persons—medical auxiliaries of all varieties—depend. The idea that the younger generation lacks courage and a spirit of adventure is common to all ages of history, and it is almost always untrue. The fact is that adventure

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