

period of two months, and my observations in this and other outbreaks suggest that the incubation period is normally about 48 hours or sometimes longer, though when two cases occur with an interval of a week between one wonders whether an undiagnosed intermediate case has been overlooked.

Having disagreed on some points I would like to support Dr Wray in saying that hysteria in an epidemic can cause difficulties in differential diagnosis. If two girls in a dormitory wake up during the night and vomit profusely it is not surprising if the sight and smell of vomit induces nausea and even vomiting in some of the other girls sharing the same dormitory.

Most astute general practitioners over the years have observed diseases which were not described in the textbooks. However the cause and clinical features of some of these, such as "drop attacks," epidemic myalgia, and hand, foot and mouth disease have now become clear and well-known, and I would agree that one should hesitate before attributing any unaccountable bizarre syndrome to hysteria because the entity does not fit any disease mentioned in present medical books.—I am, etc.,

E. J. HOPKINS.

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- Hopkins, E. J., *Journal College of General Practitioners*, 1965, 9, 99.
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- Haworth, J. C., Tyrell, D. A. J., and Whitehead, J. E. M., *Lancet*, 1956, 2, 1152.

SIR,—I was very interested in the letter from Dr. N. D. Compston and others (7 February, p. 362) commenting on the article "Royal Free Epidemic 1955, a Reconsideration," by Drs. C. P. McEvedy and A. W. Beard (3 January, p. 7).

The letter recalled the similarity of my own experience of benign myalgic encephalomyelitis in Coventry in 1953 and 1956, in both clinical findings and electromyography. The statement, however, that the electromyography findings in our cases were not published is not quite correct as reference to them was made in papers published in 1954¹ and 1957² though no tracings were reproduced.

The question of mass hysteria was carefully considered in our cases, but ultimately seemed unacceptable in my view and for much the same sort of reasons as in other outbreaks. Apart from the electromyography findings, other considerations of a clinical and epidemiological nature were hard to reconcile with hysteria. Included among these were the following:

(1) In 1953 the outbreak of benign myalgic encephalitis among the nursing and physiotherapy staff at Whitley Hospital, Coventry followed upon the admission of similar patients from Coventry and a wide area of Warwickshire as cases of poliomyelitis during a season notable for the latter.

(2) These scattered cases, though clinically multifactorial, had a basic similarity.

(3) In 1956 seven more scattered cases of benign myalgic encephalitis were admitted (3 men and 4 women) after an interval of three years and against a local background much less coloured than in 1953 by poliomyelitis—and no staff cases occurred; in contrast, in 1957, which like 1953 was a year

of marked poliomyelitis incidence hereabouts, no cases of benign myalgic encephalitis were admitted or occurred amongst the staff.

(4) The ages of the 13 staff affected in 1953 ranged from 18 to 46 years, and it was especially difficult to believe that the senior element of these had become victims of a mass outbreak of florid conversion hysteria.—I am, etc.,

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Liver Scanning

SIR,—I read with particular interest the paper on the role of liver scanning in the preoperative evaluation of patients with cancer by Dr. K. P. Poulou and others (16 December, p. 585). Their results encourage the use of this investigation before undertaking surgical treatment. However, in my opinion there are two questions that need more detailed answers.

The authors state that 50% of the hepatoma patients in the scan group and 75% in the necropsy group had coexistent cirrhosis. Some scintigraphic signs seem to be more characteristic of cirrhosis, especially patchy or nonhomogeneous distribution and splenic enlargement.¹ The authors failed to correlate these signs, especially the splenic enlargement with the association of the hepatoma and liver cirrhosis. In my opinion it is more likely that the splenic enlargement is due to liver cirrhosis than to hepatoma. I have seen splenic involvement in large hepatomas only of the right lobe. Apart from the two explanations for the increase in size of the spleen (portal hypertension and splenic metastasis), I would suggest a third one: splenic reticulo-endothelial hyperactivity, which is present more often in cirrhotic than in cancerous patients, and can also be seen in the bone marrow.¹

A false positive scan picture for hepatic tumours in cirrhotics increases in incidence as the disease progresses, and reached 30% in my series.^{1,2} It is difficult to establish the moment of the association between hepatoma and cirrhosis.

In my experience, the correlation of the scan picture with the clinical course of the disease is essential. In borderline cases it is probably better to undertake laparotomy than depend on tests.—I am, etc.,

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Medical Auxiliaries

SIR,—I should be grateful if I could be granted the hospitality of your columns to remind your readers of the existence, the aims, and the objects of the Board of Registration of Medical Auxiliaries.

The board is a voluntary body, founded in 1936 on the initiative of the British Medical Association. It approves curricula and training centres, and establishes registers of fully trained members in various branches of medical auxiliary work. The board also acts as a mouthpiece for these auxiliary professions on certain occasions.

A number of bodies originally recognized by the board have now attained statutory recognition—physiotherapists, radiographers, orthoptists, dispensing opticians, chiropodists and dietitians—and registers of these are maintained and published by the Council for Professions Supplementary to Medicine and the General Optical Council. There is little doubt that registration with the board in the first instance was a valuable preparatory step towards official professional recognition.

There are other groups of persons undertaking important duties related to patient care who are not recognized by the board, who could, I am sure, benefit by advice on their training and cognate matters so as to enable them to attain professional status. The board includes ten eminent medical practitioners, representing various branches of medicine, and each professional body recognized by the board is also entitled to appoint a lay representative on the board.

The board would welcome inquiries from organizations whose members are engaged in work which is supplementary or auxiliary to the practice of medicine.—I am, etc.,

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Closure of Wounds

SIR,—It would be unfortunate if the remarks made in your leading article (17 January, p. 129) led surgeons to adopt extreme or untried practices prematurely. Especially must one express concern about the use of adhesives for closing wounds. We began our studies on this subject about twelve years ago, but did not report them in detail because the results were so uniformly disappointing. Even when natural substances which produce no antigenic or inflammatory reaction were used (such as natural collagen) the healing process was delayed. These substances needed to be absorbed or extruded before the wound reached a stable state. Substances such as the cyanoacrylates had an even more adverse effect, in that the wound was first of all held together and then frequently fell apart and healed by second intention after the foreign material had been extruded. The final wounds were obviously very unsatisfactory. Added to this, many of these substances present severe technical problems in handling, which would increase the operating time considerably.

The use of sutureless skin closures must also be adopted only with the greatest caution. In obtaining good skin healing it is important that the deep layers of the dermis are approximated rather than the surface—a point well recognized by all the older surgeons and recently well studied by workers

in China. Even when the skin is not inverted, a gap deeper down leads to a wide, thick scar and often to keloidal formation. Where the skin is thin, or its texture is such that the closure of the surface also means closure of the deeper edge, then these materials will give good results. This may often be obtained, of course, by suturing the subcutaneous tissues before closing the skin. Cross striations can be avoided by subcuticular sutures. The drawback in using these is that the ends are normally brought out through the skin at the extremes of the wound. This can be obviated by using a method we described about fifteen years ago, where fine catgut is implanted in the deepest layer of the dermis and the knots tucked in at the ends.¹

The abandonment of dressings post-operatively has been advocated from time to time by many surgeons, but one usually finds that the supporters of this are those who expect a depressingly low standard in terms of postoperative wound infection. It is very hard to justify such a procedure when interrupted sutures passing through the skin are used, as these act as a seton with a track down into the subcutaneous layer. Even when a subcuticular suture is used, however, it must be remembered that, even under ideal circumstances, it takes approximately 24 hours for epithelium to grow across the incision. The wound should therefore be protected until the natural dressing of a fine scab is formed—that is, for at least 24 hours and preferably for about three days. After this a plastic sealing dressing can be applied, and the patient can then wash the affected part in the bath safely. The use of these sprays and applications earlier than this we have shown to be most unwise, since the aerosol propellant tends to drive the sealant between the wound edges, producing all the disadvantages mentioned above in the use of adhesives. If for any reason it is essential that they be applied at the time of operation, the only safe way to do this is to apply a thin layer of gauze over the wound and then to spray the compound on to the gauze.—I am, etc.,

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REFERENCE

- ¹ Watts, G. T., *British Journal of Plastic Surgery*, 1956, 9, 83.

Air Encephalography

SIR,—It is well known that air encephalography suffered a period of disfavour because of its alleged danger in the presence of intracerebral space-occupying lesions, with or without raised intracranial pressure. One of the reasons for this disfavour was that cerebrospinal fluid was removed before the injection of air and thus herniation of the brain might occur. This was pointed out by several authors, including me.¹

It would be a pity if, because of the recent article by Dr. J. R. W. Dykes and Dr. D. L. Stevens (10 January, p. 79), removal of cerebrospinal fluid at the beginning of the examination of air encephalography again became prevalent. Furthermore, such removal very probably inhibits good air-filling of the ventricles.

Every patient undergoing air encephalo-

graphy should be treated as if he possibly had an intracranial space-occupying mass and every effort made to exclude any evidence of cerebellar or mid-brain herniation before fluid is removed. Only that way will disasters be prevented. Air encephalography is a precise investigation with a specific purpose. Estimation of the protein content of the cerebrospinal fluid is a "spin-off" benefit and should not be allowed to alter the conduct of the examination, especially if safety is reduced.—I am, etc.,

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REFERENCE

- ¹ Sheldon, P. W. E., Wickbom, I., and Pennybacker, J. B., *Journal of the Faculty of Radiologists*, 1953, 4, 275.

Disposable Feeds in Maternity Units

SIR,—Many paediatricians are anxious to use disposable feeds in their maternity units but are unable to do so because of the expense involved. For some months we have been using S.M.A. disposable feeds, the teat assembly being resterilized. After use the teat assembly is washed in salt water. After drying, each teat assembly is placed in a paper bag (M.O.H. Code A) with the collar facing the aperture. The required number is then placed in a larger bag and autoclaved at 135°C for four minutes. The resterilized teat is put on the bottle while still inside the paper bag so that the teat is not handled. This, we feel, must be the responsibility of the nursing staff. It is obvious at this stage that the nurse's hands must be clean and dry. This method has proved to be bacteriologically satisfactory. By using this method the cost per feed is 6.35d. This includes cost of labour, autoclaving, milk, and teat assembly, the latter being re-used approximately 70 times.

Most maternity units are short of nursing staff, and many units do not have terminal sterilization for feeds. With fewer mothers willing to breast feed it is inevitable that gastroenteritis will be a growing problem in maternity units. Relatively few maternity units in the country are using disposable feeds owing to lack of finance. We would like to recommend their use to regional hospital boards.—We are, etc.,

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Fees for Family Planning Services

SIR,—The action of our free and irresponsible national press in publishing the "leak" from the meeting between the Committee on Safety of Drugs and the manufacturers has produced the large number of letters in your correspondence columns that I expected. I judge that the majority were written by family doctors, so may I be permitted to offer them some consolation?

In a few years' time they are unlikely to be playing much part in family planning anyway. At the annual conference of the Family Planning Association (F.P.A.) in

June 1969 the Secretary of State for Social Services, Mr. Crossman, said, "I aim eventually to provide a comprehensive family planning service within the National Health Service." The number of doctor sessions in F.P.A. clinics has almost doubled in the last three years, and in 1969 there has been for the first time, a contribution from the Exchequer to the F.P.A. Local authorities, using public money, are providing family planning services, often using the F.P.A. as their agent. At least one London borough is providing free advice to all comers.

Hospital boards received from Mr. Crossman in December 1969 a letter which opened, "I am sure that hospitals can and should make a further contribution to family planning by providing a service of advice to their patients." It becomes clear that when Mr. Crossman says "within the National Health Service" he means "within the hospital and local authority parts of the Health Service." Far from encouraging the development of family planning in general practice, authority has decreed that the family doctor may receive no payment for contraceptive advice but only for the provision of a private prescription—to my mind the least important part of the doctor's duty when supervising the taking of oral contraceptives.

I believe that if a woman is given tablets containing active hormones, or has a device fitted into her uterus, the right person to look after her is her family doctor. I see no reason why he should have to go to work in a clinic, be it F.P.A. or hospital, in order to look after such patients. There are many family doctors, who, for religious or other reasons, play no part in giving this service. Family doctors who do should receive payment for an item of service carried out for reasons of public policy. It is quite improper to bury it in the payment for general medical services given by all. Our representatives must insist that, in addition to providing money to build up the hospital, local authority, and F.P.A. services, money must be provided to build up the family doctor services. As I have tried to show, the writing is on the wall. If family planning is to remain part of family doctoring, action is needed urgently now.

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Unheard Voices

SIR,—As a postgraduate dean I am conscious enough of the extra demands that are made on consultants' time for postgraduate lectures. I have good reason to appreciate their co-operation.

Time is indeed the essential thing; it is not extra payment that is wanted but working time and good will. This is the only real basis for postgraduate education. But when your Mr. Stubton (7 February, p. 358) says his commitments include two or three teaching sessions in the postgraduate centre *each week* (my italics), I presume he attends mostly as a willing listener. Otherwise I should call the demands on his time rapacious rather than "bland" and he scarcely deserves the sobriquet "an unheard voice."—I am, etc.,

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