intramuscular injection. On the subsequent day no further lesions had developed and from that time on she made an uninterrupted recovery.

It is well known that eczema is a contra-indication to vaccination, but it appears that vaccination of an adolescent with acne is also to be deprecated.—I am, etc.,

D. G. MAY

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Accident and Emergency Services

SIR,—We should like to support very strongly the opinions expressed by Mr. F. C. Durbin (16 January, p. 177). Those who advocate a full-time consultant working in the accident and emergency department still fail to realize that the majority of patients attend outside the 9-5 day of the consultant, so that unless three consultants are appointed the majority of patients will continue to be seen by the less experienced casualty officers.

The accident and emergency department should, we believe, be more accurately called a receiving centre. It is not a department in the accepted sense of the word. It deals with the initial diagnosis and treatment of conditions which are related only by the fact that they are emergencies or need urgent opinions. In order for a doctor to give a consultant opinion on all these conditions he would need to be fully trained as a specialist in every major field: medicine, surgery, orthopaedics, ophthalmology, and E.N.T., to name but a few. This would obviously be impractical.

The remedy, we believe, lies in recognizing that the initial care of a patient with, say an acute medical condition, is as much the responsibility of the physician as his long-term supervision, and that this applies in every specialty in medicine. The orthopaedic surgeons have for a long time recognized this and in most hospitals conduct daily trauma clinics. We believe that the same continuity of care is required in all specialties. The sorting of patients could be carried out by a registered practitioner in the receiving centre. After all, we are fully confident of the general practitioner's ability to sort out patients for referral to our outpatient clinics; why not our emergencies?

The staffing of the receiving area is one of the major problems facing every hospital throughout the country today. It arises from a gross shortage of young doctors throughout the National Health Service now that the numbers arriving from abroad have been so drastically reduced. Recent changes in the routine of general practice—namely, the introduction of the appointments system and the widely used emergency night service—has further increased the demand made upon the Hospital Service. There are just not enough doctors being trained to staff these areas in the present medical service, and this has still not yet been widely appreciated. A review of the number of established posts in accident-emergency-orthopaedic departments, carried out in September 1970, has revealed that just under 1,000 posts need to be filled every six months—that is, a total of 2,000 personnel are required each year to staff fully the accident and emergency and orthopaedic

junior posts. In 1970 a total of just over 2,000 doctors were provisionally registered with the General Medical Council in England, Scotland, and Wales. Thus, in order to staff the present posts in the accident and emergency and orthopaedic departments, every doctor qualifying in this country would have to spend six months of his clinical life in one of these posts.

With the assumption of total responsibility of patients arriving in the receiving area each department should establish a rotation of their junior staff through the receiving centre for two to three months or more. If this was practised throughout most hospitals, ten to twelve individuals would be available in rotation and the staffing problem would cease to exist.

Since 60-70% of the patients arriving in the receiving centre have suffered trauma of some sort, most hospitals have deemed it wise to put the overall administration of the area into the hands of the orthopaedic surgeons. However, the orthopaedic surgeons realize that they can only satisfactorily supervise the area if it is in close physical relationship to the orthopaedic department. Unfortunately the financial priorities in many hospitals have prevented the building of such units and the resultant unsatisfactory service has been unfairly blamed upon the orthopaedic surgeons.—We are, etc.,

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F. F. SILK

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Method of Controlling Epistaxis

SIR,—Frightening epistaxes can occur at any age, but, in particular, in adults with hypertension and arteriosclerosis. In those patients in which the bleeding point is easily accessible there is little difficulty in controlling haemorrhage, but where bleeding is high up or far back in the nasal cavity, traditional treatment, by packing and sedation, can be distressing and often ineffective.

With these facts in mind the staff of the E.N.T. department has spent some time in perfecting a nasal tampon which was made for us by Eschmann Bros. and Walsh Ltd. of Shoreham on Sea. This can be inserted

into and passed along the floor of the nose without local anaesthesia and without upsetting the patient.

When the catheter tip reaches the post-nasal wall the distal balloon is inflated. The catheter is then tightened so that the distal balloon occludes the posterior choana on that side. The proximal balloon is mobile and can be moved up and down the catheter until it is in position within the nasal vestibule. This is then inflated and the nasal cavity "closed off" on that side. In my experience this has satisfactorily controlled haemorrhage in these patients.

This epistaxis balloon has now been in use for over a year in the E.N.T. Department in Brighton and I am convinced of its efficiency and simplicity in use. Indeed, it is perfectly simple to introduce and inflate and could prove a valuable addition to the general practitioner's methods of control of intractable epistaxes.—I am, etc.,

PAUL WADSWORTH

Hove, Sussex

Treating Fibrositis

SIR,—The use of a mixture of cortisone and local anaesthetic solutions for the treatment of tennis elbow is established and widespread. It is therefore with concern that I note the absence of this method from recent papers on the treatment of myofibrositic lesions in other parts of the body.

During the past 15 years I have collected a considerable number of cases which are of interest from the point of view of diagnosis of so-called functional disease, as well as for the substitution of hope in place of resignation in certain conditions.

The following list gives an indication of the scope of this treatment especially in general practice:

- (1) Diagnostic and palliative for cases of epigastric fatty hernia.
- (2) Strains of the rectus abdominis and oblique muscles. Children are especially prone after physical exercise in gymnastics.¹
- (3) Strains of ligaments and muscle insertions round so-called arthritic joints.
- (4) Residue scar pain after operations for appendicitis, nephrectomy, gastrectomy etc.
- (5) Scar tissue round healed fractures.
- (6) Fibrositis anywhere in the back but especially at the sacroiliac joints in so-called disc lesions and industrial back injuries.²
- (7) Suboccipital pain at the muscle attachments to the skull, diagnosed as occipital headache.—I am, etc.,

I. H. J. BOURNE

Hornchurch, Essex

¹ Frommer, E. A., and Cottom, D. G., *British Medical Journal*, 1970, 4, 113.

² Jayson, M. I. V., *Practitioner*, 1970, 205, 615.

Advisory Councils on Industrial Health

SIR,—Considering the fact that the British Medical Association first sponsored the formation of "advisory councils" as far back as the end of the last war it is amazing that so few of them are active today. At a meeting of