benefit from this type of arrangement. Certainly there is present need to initiate controlled trials to measure the hospital effect on coronary patients. The only other data available,¹ on an in-hospital but non-randomized trial, indicate that the early reduction of mortality in the coronary care unit is not sustained over time.

It is for these reasons that we have sought professional criticism directed at the specifics of Dr. Mather's trial and with particular reference to any evidence of bias and selection beyond that clearly stated in the preliminary report. We have been unable to find any grounds for invalidation of the technique of this study.—I am, etc.,

BENEDICT J. DUFFY

Tufts University School of Medicine,
Boston, Mass., U.S.A.

¹ Hofvendahl, S., *Acta Medica Scandinavica*, 1971, Suppl. 519.

Availability of Cadaveric Kidneys

SIR,—Mr. J. S. Garfield's letter 4 December, p. 622) on this subject is to be applauded. However, we feel that poor facilities and over-worked staff cannot fully explain the present lack of kidneys for transplantation. In our experience, the busier peripheral hospitals produce more kidneys than more generously staffed and better equipped teaching hospitals.

We feel that the biggest single obstruction to the utilization of potential usable kidneys is lack of awareness by the staff of the extreme shortage of organs and of the type of patient who may prove to be a suitable donor. When the staff caring for hospital patients become aware of the need for, and the success of kidney transplants, their co-operation is more likely to be obtained, in spite of the admitted difficulties and extra work involved.

With these principles in mind, a concerted effort has been made to elicit maximum co-operation from six large Liverpool regional hospitals, using the following scheme.

(1) The Coroner wrote a document outlining a series of recommendations which would prevent the rights of the prospective donor (and coroner's evidence) from being interfered with by the removal of organs after death.

(2) This document, together with a personal letter explaining the need for cadaver kidneys, was circulated to every consultant in the hospitals via the hospital secretaries, with a request that the principle of kidney removal should be debated at a medical board or staff committee meeting.

(3) When unanimous approval had been obtained at this level, one of us met the consultants, junior staff, and sisters to present the logistical sequence of events preceding cadaver nephrectomy, and to receive their comments.

(4) The hospital pharmacists, central sterile supply department, and theatre directors were approached personally, and the correct perfusion fluids and instruments were purchased. Reprints of relevant articles concerning techniques were obtained when requested.

(5) All those assisting in the procurement of organs are informed of the destination and result of the transplant. Also, staff in participating hospitals are kept informed of the

number and success of transplants procured in the region.

(6) New house staff are addressed on this subject early in their appointment.

We do not claim priority in the use of these methods, but feel that a summary of them will be of interest to those clinicians like Mr. Garfield who are prepared to make the necessary effort to save the lives of patients in terminal renal failure.

Revision of the Human Tissue Act (1961) may well lead to more successful retrieval of cadaver kidneys. But in the meantime continual efforts should be made to remind clinicians and nurses at all levels that they have the ability to save lives of others by identifying suitable donors in their wards. It is up to the surgeons in the regional transplant centres to forge the links of communication and to provide the necessary reminders and feedback, if the best results are to be obtained.—We are, etc.,

R. A. SELLS
M. R. HEAL

Department of Surgery,
University of Liverpool

Natural History of Ventricular Septal Defect

SIR,—In your leading article on the natural history of ventricular septal defect (4 December, p. 571) you state that "improvement may also occur naturally in several different ways: by the development of obstruction to flow in the blood vessels of the lung; by a tendency for some defects in infancy to get smaller or even close entirely; or by the development of a muscular obstruction to the outflow tract at infundibular level, which is sometimes even severe enough to cause reversal of the shunt and the development of cyanosis."

The first and third of these propositions can hardly be described as improvement, but rather as manifestations of the relentless progress of disease. The development of pulmonary hypertension in these children consequent upon arteriolar obstruction worsens both the natural and operative prognosis and is, of course, a stage to the development of the Eisenmenger situation. The development of right ventricular outflow muscular obstruction, which requires resection during operative closure of the ventricular septal defect, adds to the operative mortality, postoperative morbidity, and impaired longterm prognosis for these children.

Your choice of the term "improvement" can hardly be justified as an editorial comment in the *B.M.J.*, which is frequently regarded as "gospel." I think this particular comment should be modified.—I am, etc.,

P. J. MOLLOY

Cardiac Surgical Unit,
Royal Victoria Hospital,
Belfast

Spontaneous Fractures of Pelvis in Rheumatoid Arthritis

SIR,—I was interested in the article by Dr. R. T. Tavlör and others (11 December, p. 663), having had experience of a similar case two years ago.

The patient, a woman of 77, had seropositive (differential agglutination test 1:64) rheumatoid arthritis of 10 years' duration for which she had not received steroid therapy.

She felt a sudden, severe pain in the left groin when she stumbled on her way upstairs, following which she was unable to take weight on the left leg. On examination the hip moved freely but x-ray showed an ovoid fragment of bone measuring 5.5 x 2.5 cm lying above and lateral to the hip. It appeared that the anterior inferior iliac spine had been avulsed by the pull of the rectus femoris. The pain quickly settled down with bed-rest, but ambulation was hampered by pain and instability of the left knee, and it was two months before she could be discharged from hospital.—I am, etc.,

B. A. LATHAM

Royal Sussex County Hospital,
Brighton, Sussex

Hospital-based Social Workers

SIR,—The letter from Drs. J. A. Harrington and P. A. Barker (27 November, p. 562) is a timely warning of a difficult situation which is likely to get worse. They rightly draw attention to the salary discrepancy between hospital and local authority-based social workers and recruitment problems which must inevitably follow.

We are concerned to stress the importance of another look at the continuing need for social worker establishment in the hospital field, and particularly in specialist departments such as child psychiatry where the social worker is an important member of the therapeutic team. Long-term secondment can never be a satisfactory alternative to a whole-time commitment and involvement.—We are, etc.,

G. L. DAVIES
A. G. CHISHOLM

Department of Child and Family Psychiatry,
St. Luke's Hospital,
Middlesbrough

SIR,—The important letter of Dr. J. A. Harrington and Dr. P. A. Barker (27 November, p. 562) deserves the close attention of every hospital doctor. The social worker is an "essential and integral member of the team" precisely because she is hospital-based; it is a question of accountability to and involvement in the employing authority.

Are consultants, as leaders of the team, fully alive to this threat to their medical programme?

My object in writing this letter is to point out that the decision regarding the position of social workers has not yet been made, so that there is still time for consultants to show their concern through their negotiators.—I am, etc.,

C. F. J. CROPPER

Knole Hospital,
Farnham, Hants

Urinary Infection and Jaundice

SIR,—Professor S. P. Dundon (18 December, p. 748) claims that neonatal urinary tract infection in the absence of malformation is free from any tendency to relapse. The fact is that relapse occurs much less often than with urinary tract infection in later life, but I have seen four examples of it.

A series of 35 babies with neonatal urinary tract infection has been followed over the

past few years. There was no radiological evidence of malformation and all but one were boys. Relapse occurred after one month (two cases), three months, and 11 months. The last of these had unilateral ureteric reflux up to the kidney. This was absent when the cystogram was repeated two years later.

These findings may reflect the stringency of our follow-up arrangements. We plan to see children with neonatal urinary tract infection every month until such time as the urines have been free of leucocytes for a period of 12 months. Our screening test is microscopy for leucocytes, done by the clinician; if there is leucocyturia diagnostic urine is obtained by bladder puncture. A considerable proportion of these children have been followed for longer periods, but we have not seen any instances of recurrent leucocyturia after the children have been cleared according to the above criteria.—I am, etc.,

N. J. O'DOHERTY

West Middlesex Hospital,
Isleworth, Middx

Hepatitis Contracted in the Course of Employment

SIR,—The article by your Legal Correspondent (4 December, p. 632) is to be welcomed for underlining the far from generous compensation offered to the widows of doctors who die from disease contracted in the course of their duties.

We would point out that the impression is given in the article that a discretionary injury award up to two-thirds of the officer's average remuneration can be made. While this is true if he does not die but is totally disabled (an unlikely event with serum hepatitis), in the event of his death his wife can only receive one-third of this—that is, two-ninths of his average remuneration.

These facts again underline the very poor cover offered to N.H.S. employees by the superannuation scheme. We believe that many doctors, especially the more junior ones, are quite unaware of how little their widows will receive if they die, and these facts should be more widely known by all N.H.S. medical staff.

We agree that there is a strong case for the acceptance of serum hepatitis as a prescribed disease under the Industrial Injuries Acts and for an immediate increase in the injury allowance paid to widows and dependants.—We are, etc.,

PHILLIP HARRIS
Chairman,

D. B. SCOTT
Secretary,

Medical and Dental Staff Committee
Royal Infirmary,
Edinburgh

Consultant Grades and Continuity of Care

SIR,—Once more I read (*Supplement*, 11 December, p. 73) of a conference which overwhelmingly threw out a proposal for a subconsultant grade.

I wonder how many psychiatrists attended the meeting. Whatever may be true of patients in other specialties, psychiatric patients need continuity of care and do better with therapists who are available in terms of time and place rather than in terms

of status. Rotating registrars cannot satisfy this need. Maybe this is why psychiatric nurses, who get to know their patients well, are so important. It is not brilliant diagnostic skill most of our clients require; it is an informed, concerned relationship that continues long enough to produce change.

Moreover, the medical assistant grade (foolishly named as it is) provides the relative permanency and level of salary which a number of doctors are happy to accept. Married women who have acquired skill and experience, but do not seek the responsibilities and burdens of consultancy, are an important case in point.

Can I make a plea for rational re-appraisal of these needs and suggest that we retrieve the baby from the bath water?—I am, etc.,

J. K. W. MORRICE

Ross Clinic,
Aberdeen

Humidifiers in Anaesthesia

SIR,—Dr. J. N. Lunn and his colleagues (11 December, p. 653) describe as "inherently safe" a gas humidification procedure during anaesthesia in which the water reservoir is maintained at 40°C. Though the apparatus they describe may indeed prove satisfactory in preventing heat loss, it will create ideal conditions for the proliferation of *Pseudomonas* and other opportunistic pathogens.

The importance of anaesthetic apparatus as a reservoir of infection, especially with Gram-negative bacilli, has now been fully established,^{1,2} yet Dr. Lunn and his colleagues do not even mention the problem. As an interim measure, all humidifiers should be equipped with small immersion heaters, so that the water can at least reach boiling point at frequent intervals. Medical microbiologists who have to cope with the consequences of infection from ventilators and other anaesthetic equipment however look forward to the millenium when all such equipment will at last be built completely out of heat-sterilizable materials, and when no patient has to breathe through apparatus which has been used and contaminated by others.—I am, etc.,

S. SELWYN

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Westminster Medical School,
London S.W.1

¹ Phillips, I., and Spencer, G., *Lancet*, 1965, 2, 1325.

² Bassett, D. J. C., *Proceedings of the Royal Society of Medicine*, 1971, 64, 980.

Obesity and Smoking Habits

SIR,—I read with interest Dr. T. Khosla and Professor C. R. Lowe's communication on "Obesity and Smoking Habits" (2 October, p. 10) and the ensuing correspondence (30 October, p. 298; 4 December, p. 625).

In a recent M.R.C. project (undertaken jointly with the Hebrew University, Jerusalem, under the auspices of the International Biological Programme) anthropometric and physiological studies were carried out in Israel on immigrants from the Yemen and from Kurdistan. The subjects were aged 20-30, and the proportion of cigarette smokers was similar to that in the U.K. or America. Among both Yemenite and Kurdish men smokers (all levels of consumption) were taller than non-smokers, but

there was little difference in weight. The non-smokers did, however, have a higher value for upper arm skinfold thickness (mean of readings over biceps and triceps). The numbers here were small, and it would be interesting to know if any quantitative assessment of leanness-fatness has been made in a larger series of smokers and non-smokers compared for "obesity." Such measurements might be of greater relevance than "overweight" based on standard tables or a weight-height ratio in assessing the risk of "obesity" associated with smoking status.

Incidentally, might I be permitted gently to challenge Dr. G. Pincherle's description (30 October, p. 298) of smokers of 1-19 cigarettes per day as "those who exhibit moderation in non-smoking." Surely no-one in that category is a non-smoker, and 19 a day is hardly moderation.—I am, etc.,

JOHN A. LOURIE

University College Hospital Medical School,
London W.C.1

Respiratory Syncytial Virus in Hospital Cross-infection

SIR,—Dr. R. K. Ditchburn and others (18 September, p. 671) writing about the spread of respiratory syncytial (R.S.) virus in a hospital for children open a debate on a very serious problem—namely, how to reduce the risk of cross-infection of children hospitalized because of any infectious disease, and especially one caused by viruses.

We have reported an outbreak of acute respiratory illnesses caused by R.S. virus in a home for infants consisting of three ward rooms.¹ All the infants (15 aged 1-13 months) as well as the 12 staff members were healthy during the week before the outbreak.

The first infant who became ill (4 April, 1964) was a 13-month-old boy from a room where there were six other infants between 5 and 8 months old. He had been away from the home for five weeks, and the day after his return he fell ill with fever, nasal discharge, and a cough. Chest x-ray showed bronchopneumonia. Paired sera from this child showed a significant rise in complement fixing (C.F.) antibody titre against R.S. virus.

From 6 to 10 April all the infants in this ward developed acute respiratory illnesses. Between 11 and 16 April a further three infants (aged 1-1½ months) in one room on the second floor showed clinical signs of acute respiratory illness, and between 18 and 30 April all the five infants (aged 1½-5 months) in the other room on the second floor also became ill in succession. When this outbreak of acute respiratory illness had passed, all of the 15 children had been ill with fever, nasal discharge, and coughs. One-third had had signs of lower respiratory tract disease, such as bronchitis, bronchiolitis, and bronchopneumonia. These last mentioned infants were all seriously ill but survived. The incubation period for R.S. virus infection was estimated at 3-5 days. R.S. virus was recovered from nasopharyngeal and/or throat swabs from 13 out of 15 infants. Complement fixation tests against R.S. antigen showed at least four-fold rises of antibody in seven out of 15 paired sera, including sera from two children from whom virus was not isolated. R.S. virus was recovered two days before the onset of illness as well as nine days after onset. There was no rise