longed infusions. In the absence of objective evidence that a 41-hour infusion was necessary in this case, may we suggest that a shorter infusion and smaller dose, preferably delivered via the central venous pressure cannula, would have been just as effective, probably safer, and certainly much less expensive?

The source of massive pulmonary embolism is always the iliofemoral segment (proximal to the profunda vein termination). In the absence of clinical signs in the legs the iliofemoral thrombus is non-occlusive, so that ultrasound examination, just as much as clinical assessment, is an inadequate method of investigation. In these circumstances only phlebography can give the information required as to whether there is further thrombus in the iliofemoral segments or not. Phlebographic assessment of the iliofemoral segments as soon as the patient's clinical condition allows (in this case presumably about eight hours after the period of streptokinase treatment) and thereafter at about one week, is in our experience necessary to define the risks of recurrent embolism and to deal with persistent residual or recurrent non-occlusive thrombus by its removal.

We wish to support the idea that streptokinase therapy is now probably mandatory in the treatment of major pulmonary embolism and would congratulate the authors on the successful outcome of their difficult antepartum case.—We are, etc.,

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Platform Nails

SIR,—I report a new and, I believe, increasing form of traumatic nail dystrophy.

I have seen four patients who presented with symmetrical haemorrhage beneath their big toe nails. They were unaware of any trauma having initiated the trouble. Their complaints included pain but the presenting symptom was the physical appearance of a blue-black discolouration of the nails in all four cases (see figure). Fungal and bacteriological examination and culture of clippings of the affected nails were uniformly negative.

All four patients had been wearing new fashion shoes with thick soles and heels. These "platform" shoes do not allow the normal rocking movement of the foot to be accommodated during walking. The result is that the patient's foot rocks inside the rigid shoe, so producing repetitive trauma of the most distal part of the foot (which is

usually the big toe) against the upper welt or vamp of the shoe. This effect is not seen if the shoe style is "peep-toe."

In the patients seen, the affected nails separated proximally and were lost. The new nails were normal. With the current vogue for this type of shoe it is likely that this problem will be seen more frequently.—I am, etc.,

JOHN ALMEYDA

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Making Hospital Geriatrics Work

SIR,—All who care for elderly patients in hospital will have been interested in the paper by Drs. H. M. Hodgkinson and P. M. Jefferys (2 December, p. 536). As they point out, the bigger the general medical ingredient in the geriatric case load, the easier and quicker the turnover. Also the quicker the patients are admitted the quicker (and the more likely) they will be discharged. This knowledge is the key to the unblocking of the beds, because it is clear that the likelihood of doing good medically diminishes rapidly with the length of wait for admission. Thus, when the waiting list builds up, the consultant in charge must for a time take only the most recently referred cases, and even then only if a reasonable degree of Isaacs's "therapeutic optimism"¹ exists. Once the turnover begins to improve he can work backwards cautiously through his waiting list and eventually take the least rewarding case (in therapeutic terms). This seemingly harsh form of management can restore the essential dynamism to an ailing department. Many elderly people who could benefit by admission will be denied treatment until the beds are unblocked. The sooner this takes place the better.

Well-staffed geriatric departments can achieve good medical results only to be frustrated by the lack of back-up services. The majority of patients become fit for discharge from hospital, but many of these are unable to manage without a well-protected home environment. If there is to be further expansion of care for the elderly, high priority must be given to the non-hospital sector.—I am, etc.,

WILLIAM DAVISON

Cambridge

¹ Isaacs, B., *British Medical Journal*, 1971, 4, 282.

Nurses for Nursing

SIR,—It appears that sniping at Salmon is replacing fly-fishing as the popular pastime for consultants. I was pleased to see the spirited and reasoned reply by Miss Rachel Worsley (23 December, p. 727). So often the case for Salmon has gone by default.

Many of my colleagues who yearn nostalgically for the days before the introduction of Salmon seem to ignore the simple fact that if all had been well in the nursing profession the Salmon Committee would never have had to be set up. The Salmon Committee has designed a nursing staff structure that will bring into the profession many men and women who formerly would not have been attracted by it. They have gone hitherto into other disciplines such as teaching, the law, medicine, and industry. The new structure will encourage others to remain in the profession who would other-

wise have sought to realize their ambitions elsewhere. All this will not happen immediately. It will take three, five, or more years before those attracted by the new structure enter the profession, qualify, and work their way up to positions of responsibility and influence. Meanwhile, some of those already in post have to acquire new skills of management and learn how these are best applied. They have to instruct their staff in techniques of communication and deal with the teething troubles that are inseparable from any radical change. The medical profession in its turn has to abandon some entrenched positions and learn to accept members of the nursing management on committees where they have not appeared before.

May I make a plea for an expectant attitude. Let us have a moratorium of criticism for three years, and if Salmon is not showing signs of succeeding in that time, then let the pens be taken up once more.—I am, etc.,

REX BINNING

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Wax in the Ear

SIR,—I was extremely surprised that your leading article (16 December, p. 623) failed to mention the part played by hair washing in the formation of wax in the ear, particularly with the more detergent-type hair shampoos now employed. Surely the seepage of soap and/or shampoo into the external auditory meatus must interfere with the composition of normal wax and upset its natural movement outwards.—I am, etc.,

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Duodenogastric Reflux and Pyloric Surgery

SIR,—Duodenal ulceration with stenosis is a well recognized cause of lesser curve gastric ulcer. In my own work 25% of gastric ulcer patients have had duodenal disease. McNeil, McAdam, and Hutchison¹ reported 30% with duodenal ulceration. Probably Messrs. A. G. Johnson and K. W. Reynolds (16 December, p. 667) would agree that vagotomy complete to the stomach with a good drainage operation would in these circumstances cure both lesions.

I have thought and written² that pyloric channel disease is the commonest cause of lesser curve gastric ulcer. I was therefore pleased to read that Messrs. Johnson and Reynolds recognized the existence of this forgotten disease of the pylorus and prepyloric stomach and that it could give rise to lesser curve gastric ulcer. If vagotomy cures pyloric channel disease (as it does) we should expect it to cure the secondary gastric ulcer when the operation is not followed by gastric retention. Pyloroplasty or gastrojejunostomy alone are irrational in the treatment of lesser curve gastric ulcer secondary to these two diseases at the gastric outlet. Neither cures duodenal ulceration and Serck-Hanssen³ reported many years ago that gastrojejunostomy did not cure pyloric channel disease. If, as I believe, all patients with lesser curve gastric ulcer have disease at the gastric outlet then proximal gastric vagotomy without drainage is a very logical operation in all cases, a drainage operation