parents. It is a responsibility of the general practice team, by demonstrating a caring attitude to pregnant women and young mothers and being prepared to educate them, to encourage full, early, and proper use of the health services.—I am, etc.,

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SIR,—I was interested in Dr. F. N. Bamford and Professor J. A. Davis's recent article (*Supplement*, 20 January, p. 20) and especially in their comment regarding the future of full-time child health doctors, that "the appointments should not, as in the past, have low prestige nor should they be used as stepping stones to careers in administrative or environmental medicine." This comment ably crystallizes the views of many local authority medical staff, who have often felt that many medical officers of health could not understand anyone in the service wanting to remain mainly in the clinical field, regarding them as having little ambition or rather lazy, content to work relatively short hours at a dull routine job.

Possibly some of the comments were valid for some of the staff, but there are many doctors in the service who have devoted their lives to work with children and to an attempt to help the handicapped child and his family within the community. For a time it was felt that the hospital paediatricians did not appreciate the work being carried out and there was constant talk of a "take-over bid." The British Paediatric Association's book *Paediatrics in the Seventies*[1] cleared the air very much in its tribute to the work being carried out and suggested that some of the senior staff might be eligible by qualification and experience for consultant status in the new national health organization.

The School Health Service Group Council of the Society of Medical Officers of Health studied the future of the community child health services in some depth—the members in the main being senior school medical officers combining clinical duties with the overall practical administration of services under the general direction of the M.O.H. as principal school medical officer. The council considered that a department of community child and youth health should be included in every area health authority structure under the direction of an experienced medical officer, who would be responsible for liaison with consultant paediatricians, other community physicians, family doctors, and the education services in all matters affecting the health, well-being, and education of children and young persons.

The publication of *Management Arrangements for the Reorganized National Health Service*[2] resulted in deep depression. It perpetuates the present hierarchical structure in that the area medical officer can be the adviser to the local education authority, although it is *suggested* that a "child health specialist *subordinate*" (my italics) may take on the function. The Public Health Committee of the B.M.A. has already commented adversely on the document, following the line of the S.H.S. Group Council that a preferable concept would be that, at each level in the service, established specialists should work as a group within the framework of objectives set by the health authority, with the regional or area medical officer acting as general co-ordinator. There still remains an area of gloom among the staff, who fear that to continue to be a subordinate will perpetuate many of the deficiencies in the past, where the quality of the community service depended upon the enthusiasm or disinterestedness of the M.O.H. for clinical matters. How can the staff be regarded as specialists in their own right in their relationships with the other services if all decisions have to be referred to the administrator?

Future hopes have also been dimmed by the fact that senior medical staff in the local authority services below the level of M.O.H.s or their deputies have not been given places on the current courses in management of integrated health care as training for N.H.S. reorganization.

Many senior staff are seriously thinking of leaving the present service, and the care of the child within the community will suffer for several years if their accumulated expertise is lost in the period before the new "community paediatrician" concept of the B.P.A. can become reality in ten to fifteen years' time.—I am, etc.,

G. SIMPSON SMITH

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1 Court, D., and Jackson, A., eds. *Paediatrics in the Seventies* ed. for the British Paediatric Association. London, Oxford University Press 1972.
2 Department of Health and Social Security, *Management Arrangements for the Reorganized National Health Service*. London, H.M.S.O. 1972.

Blindness in Granulomatous Arteralgia

SIR,—May I, as one who has for very many years emphasized the polyarteritic nature of granulomatous arteritis cavil at the assumption which seems to be implied in the opening paragraph of your leading article on cranial arteralgias (20 January, p. 125) that this type of arteritis is essentially an extracranial disorder. The results of involvement of arteries within the cranium and elsewhere in the body have been many times described in this complaint.[1-5]

Retinal artery involvement with permanent loss of sight is a menace liable to follow very swiftly on the first recognition of temporal artery inflammation, and indeed well within the time that such procedures as procaine block and arterial ligation are being planned. The complaint is often more insidious than you admit, and includes general symptoms and a strong bilateral tendency. I beg all those who have a patient over 60 years of age whose cranial arteralgia is persistent and severe to determine at the outset whether it is accompanied by generalized malaise and associated with "rheumatic" symptoms elsewhere and a raised erythrocyte sedimentation rate. Then the finding of even slight temporal artery tenderness and thickening (at first unilateral) should lead to an immediate trial of corticosteroid therapy.

Such treatment gives much more rapid relief of the symptoms than the approach advocated in your article, and the response is even more diagnostic, for not only the severe headache but also the local signs and general symptoms are rapidly cleared. Furthermore, it will avert the onset of blindness; we cannot afford to temporize in the face of such a danger. Together with intracranial aneurysms, this disorder must be regarded as the most serious cause of cranial arteralgia.—I am, etc.,

G. H. JENNINGS

Northchapel,
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1 Jennings, G. H., *Lancet*, 1938, **1**, 424.
2 Gilmour, J. R., *Journal of Pathology and Bacteriology*, 1941, **53**, 263.
3 Cooke, W. T., Cloake, P. C. P., Govan, A. D. T., and Colbeck, J. C., *Quarterly Journal of Medicine*, 1946, **15**, 47.
4 Jennings, G. H., *British Medical Journal*, 1948, **1**, 443.
5 Jennings, G. H., *Practitioner*, 1969, **202**, 808.

Cause of Tennis Elbow

SIR,—The title of your leading article (3 February, p. 251) is misleading if you refer to constriction of the posterior interosseus nerve of the forearm. Six years ago I[1] drew attention to the vulnerability of this nerve as it passes between the tendinous sections of the supinator muscle. Even that is not a *cause*, but it does facilitate constriction if there are other causes for the neuritis—for example, cervical spondylosis, focal infection, overstrain, and repetitive misuse of the supinator.—I am, etc.,

NORMAN CAPENER

Dunchideock,
Exeter, Devon

1 Capener, N., *Journal of Bone and Joint Surgery*, 1966, **48B**, 770.

SIR,—I notice that in your leading article (3 February, p. 251) it is stated that a *new* cause of tennis elbow has been described by Roles and Maudsley.[1] I have been asked by one of my friends to write and correct the statement that compression of the radial nerve in its tunnel is a *new* cause for tennis elbow, as he has been using the operation I described for this condition for some years now with success. He reminded me that I read a paper on 3 December 1966 to the North Western Orthopaedic Club meeting at Bolton Royal Infirmary in which this syndrome was described and my registrar's confirmatory work on the anatomy was also reported. The credit for the dissections which established, to my satisfaction, the theoretical idea of the radial tunnel syndrome must go to Mr. G. Yakoub. However, as I said in the paper, the theory that the radial nerve, and especially its deep branch, is involved in tennis elbow was not new even at that time, for Sir Charles Bell so described the condition in a paper, written in 1824, on "Occupational Neuralgia."

I expressed my opinion in the following passages of the lecture. "The fact that so many different conditions have been described as representing the pathology in these cases is sufficient justification for seeking a unifying factor, and my belief that the important thing in this condition is irritation of the radial nerve and its terminal branches does not exclude the possibility that many causes on the original list shown [in the paper] are secondary causes . . . They point to the site where the nerve lies between the extensor carpi radialis brevis and front of the radiohumeral joint . . . . Summarizing, it would seem that the true cause of tennis elbow, whatever other subsidiary findings are present, is irritation and compression of the radial nerve and its branches as they cross the elbow joint under cover of the extensor carpi radials brevis and enter the muscles of the forearm . . . . The condition should

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