I would endorse very strongly that "there must be a close working relationship with the public health authorities" and that if the local hospital establishes this relationship, the "school eye clinic" becomes a "children's eye clinic" at which even very young children can be seen, sparing them the necessity of a number of hospital visits. In effect these clinics become outposts of the hospital; the staffing overlaps with that at the hospital and continuity of personnel, so essential to children, and consistency of treatment, so essential to obtaining a co-operative and understanding parent, present no difficulty.

With Dr. Ingram's objectives in view, this organization was set up some years ago in the London Borough of Barnet, though not without some administrative panic. The eye clinics in the borough are split between the consultant and his assistants at the hospital. In addition, the orthoptist at the hospital not only is the orthoptist at the children's eye clinics in the borough, but holds "open door" squint diagnostic clinics which have proved a great success in very early diagnosis. Hence no child born and bred in the borough can arrive at school with an undiagnosed squint or amblyopia except by serious neglect of the practitioner or parent. The rules under which she operates have been outlined.¹ Dr. Ingram emphasizes the importance of family history, and the orthoptist in these clinics is encouraged to see the siblings of known squinters as part of her duties.

I suggest that this type of organization should be positively aimed at in the future administration of the N.H.S. and not left to the unsupported initiative of enlightened ophthalmologists.—I am, etc.,

P. A. GARDINER

Guy's Hospital,
London S.E.1

¹ Gardiner, P. A., *Community Medicine* 1972, 127, 117.

Free Contraceptives

SIR,—I refer to your timely and well argued leading article (20 January, p. 130) and I fully support the case you have put forward for free contraceptives. The crucial question is how many unplanned pregnancies are there which must be eliminated for the common good? I will attempt to answer this.

In England and Wales in 1971 there were 783,155 live births, of which 65,678 were illegitimate. No one knows the number of illegitimate births which resulted from a planned pregnancy but the proportion must be small, and I consider that one-eighth is a reasonable fraction to use. One can assume that virtually all the 123,091 pregnancies which ended in legal abortion were unplanned, and 55,540 of these abortions were in married women.

There is good evidence that at least one-third of births within marriage are unplanned. Fraser and Watson¹ and Cartwright² showed this by their surveys, and a recent survey in depth of 350 couples for five years³ again showed that one-third of pregnancies within marriage were unplanned.

Applying these criteria in 1971 and not taking into account stillbirths and multiple pregnancies (they tend to cancel one another out), there were 718,000 live births and

55,000 abortions relating to married women—a total of 773,000 pregnancies. According to the surveys mentioned one-third (258,000) of these were unplanned. Therefore the unplanned pregnancies in 1971, which I feel are, if anything, an under-estimate, were as follows: one-third of pregnancies within marriage, 258,000; seven-eighths of illegitimate births, 57,000; and pregnancies outside marriage ending in legal abortion 68,000—a total of 383,000.

If the term "planned pregnancy" is confined to those where the couple engage in sexual intercourse with the avowed intention of starting a pregnancy as soon as possible then within marriage the incidence of unplanned pregnancy must be very high and sexual intercourse should not be confused with procreation. However, it would appear that in 1971 there were probably 523,000 pregnancies which were planned. This is substantially below the number of deaths (567,000), and if unplanned pregnancies could be eliminated our population would not only stabilize but would start to decline. This is what is vitally necessary in this the third most densely populated country in the world. However, we are making progress. In England and Wales the excess of births over deaths in 1972 was 130,931 compared with 218,121 in 1971 and 341,234 in 1964. Nevertheless, those who are opposed to family planning and population control should remember that this reduction has not just happened but is due to the unremitting, strenuous efforts of those dedicated doctors and nurses working in family planning clinics, an increasing number of enlightened gynaecologists working in the hospital service, and many general practitioners.

The case for a free family planning service is overwhelming. The local authority family planning service in Lincoln became completely free in September 1972 and the number of women attending in the first quarter was twice the average for the previous four quarters. This proves that although the cost of supplies may appear to be insignificant it is indeed a disincentive to many women, and particularly many of the women whose needs are greatest.—I am, etc.,

R. D. HAIGH

City Health Department,
Lincoln

¹ Fraser, A. C., and Watson, P. S., *Practitioner*, 1968, 201, 351.

² Cartwright, A., *Parents and Family Planning Services*. London Routledge and Kegan Paul, 1970.

³ Peel, J., *Journal of Biosocial Science*, 1972, 4, 333.

Rigid Footwear

SIR,—Dr. J. J. R. Almeyda's report (20 January, p. 176) on "platform nails" underlines the importance of the rocker principle in rigid footwear. For a normal heel-to-ball gait one must have either a flexible sole or a rigid sole which is shaped to allow the forefoot to rock on the ground. This principle is well illustrated in the traditional shape of the wooden-soled clog (fig. 1).

It is not always appreciated that this principle should be used when ordering cork raises for patients who have shortening and who are capable of a normal heel-to-ball gait. Not infrequently these patients are pre-

Fig. 1

Fig. 2

scribed a "universal" raise or a tapered raise. These patients should have the end of the sole rounded off to give a toe roll with the same contour as the clog (fig. 2).

It is a pity that the teenagers of today, as yet scarcely delivered from the tyranny of "exercise sandals," should now have to endure platform soles, which are a negation of the basic principles of footwear design.—I am, etc.,

A. W. FOWLER

Bridgend, Glam.

Nitrazepam and the Elderly

SIR,—Dr. F. O. Wells (27 January, p. 235) clearly prescribes hypnotics for his patients thoughtfully and with careful supervision. His experience thus puts him in no position to question the accuracy of our observations on the consequences of the way nitrazepam is generally used by the elderly members of a large urban population.

We recommended that, for the elderly, nitrazepam should be used only in carefully selected cases and imagine that Dr. Wells would be prepared to admit that this is exactly what he does. On the other hand, we have had no difficulty in managing in-patients and a large outpatient clinic for 12 months without using nitrazepam, and consider this to be a safer general policy.—We are etc.,

J. GRIMLEY EVANS

E. H. JARVIS

Newcastle General Hospital,
Newcastle upon Tyne

Soaking Beds

SIR,—On two successive days I encountered something occurring in two different hospitals which appears to me to be so important for the comfort of bed-fast patients that I feel I must try to attract the attention of medical and surgical staffs to what their patients may be having to endure. This is the covering of the mattress with a plastic cover.

The first of the two patients was a young man suffering from a bilateral haemopneumothorax after a car accident. He told me that in the morning he tried to inch himself across the bed to a dry spot. The second was a woman who was so wet with perspiration in the night that she had to ask to be dried down and changed. Her temperature during the evening before had not been raised. Removal of the plastic cover has left her comfortable ever since.

I am sure that physicians and surgeons on

their rounds are not aware exactly on what their patients are resting. For the comfort of those patients it may be worth while to ask.—I am, etc.,

J. W. C. LEECH

Watford, Herts.

Amoxycillin Rash in Infectious Mononucleosis

SIR,—Ampicillin when given in infectious mononucleosis is known to produce a morbilliform rash changing after a few days to a typical copper colour and clearing spontaneously after 10-14 days.

I wish to report that in two cases of infectious mononucleosis (blood film and Paul-Bunnell positive) in teenage girls a similar eruption resulted from the administration of amoxycillin (Amoxil).—I am, etc.,

RONALD MULROY

Chapelthorpe,
near Wakefield

Treatment of Dextropropoxyphene Poisoning

SIR,—Overdosage with compounds containing dextropropoxyphene is unusual, and the possibility of effective treatment with nalorphine is not widely recognized. The following case history records rapid recovery from a large overdose of Distalgic, each tablet of which contains 32.5 mg of dextropropoxyphene and 325 mg of paracetamol.

A 27-year-old hotel chambermaid was admitted to the Casualty department of this hospital after taking a deliberate overdose of 25/30 Distalgic tablets, together with half a bottle of sherry, within the previous hour. She was fully conscious on admission, with normal reflexes and no external stigmata of parenteral opiate addiction. During the preliminary interview she collapsed, becoming unresponsive with constricted pupils, and respiration ceased abruptly. Intubation and artificial ventilation were carried out, and after a non-productive stomach washout 10 mg of nalorphine was given intravenously. Spontaneous breathing returned immediately and she started to open her eyes. In a few minutes respiratory efforts were sufficiently adequate to allow extubation, although a further 10 mg of nalorphine was given over the next 10 minutes to counteract a fall in tidal volume. She then regained consciousness and, after a short period of restlessness, was transferred to the intensive care unit.

There have been a few reports of the treatment of dextropropoxyphene poisoning with nalorphine, with mixed results.^{1,2} In these cases the presenting features included generalized convulsions, which the above patient did not develop. The abruptness of her collapse and dramatic response to nalorphine emphasize the importance of identifying the causative agent in cases of poisoning, and where possible administering a suitable antidote.—I am, etc.,

VANESSA HUNT

Middlesex Hospital,
London W.1

¹ Karliner, J. S., *Journal of the American Medical Association*, 1967, **199**, 1006.

² Swarts, C. L., *American Journal of Diseases of Children*, 1964, **107**, 177.

³ Cawood, R., and Thirkettle, J. L., *British Medical Journal*, 1966, **2**, 1324.

Chambers and the Periphery

SIR,—I am constantly reading that the B.M.A.'s peripheral machinery will have to

be reorganized to line up with the reorganized N.H.S. The only reason I have been given for the need to do this is Sir Paul Chambers's assumption that the Association was going to provide the advisory medical machinery for the area health authorities. Surely no one believes this was ever a possibility. Already the shadow medical advisory machinery for the area health authorities is being set up. What do we find? It is not being drawn from the B.M.A. at all but from the local medical committees and hospital staff committees.

One may well ask what role can the B.M.A. play in all this? In my view, this should remain advisory and supportive. Most of the active members of the L.M.C.s and hospital staff committees will be B.M.A. members and, constantly provided with information on current issues from headquarters, will ensure that B.M.A. policy will be observed. The B.M.A. division is a good forum for doctors to meet and discuss their problems. With increasing specialization it is impossible for a division to possess sufficient accurate knowledge of the problems of any one specialty to be able to advise an area health authority. I think Sir Paul forgot that all doctors are not in the N.H.S.; in this part of the country we have quite a considerable number of retired doctors, all members of the B.M.A., but with little desire to become embroiled in medical politics.

Having been a member for many years, I readily admit the debt the profession owes to the handful of members who take up the cudgels on our behalf. They are indispensable in protecting the interests and honour of the profession in the presence of a monopoly employer. I fail to see the need to reorganize.—I am, etc.

A. H. HOLMES

Hon. Secretary,
North Wales Branch of B.M.A.
St. Asaph, Flintshire

Earnings of General Practitioners

SIR,—We note with interest and some surprise a report which appeared in the *Daily Telegraph* of 14 February. This contained remarks attributed to a spokesman of the Regional Hospital Consultants and Specialists Association referring, in passing, to family doctors' pay: "Although G.P.s . . . have a net average income of just over £5,500 . . . with special allowances for items like cars and telephones the average basic income is nearer £7,000."

There is no telephone allowance payable to general practitioners, nor, with the exception of a mileage allowance paid to certain rural doctors, is there a car allowance. In this district we are informed reliably that there is no doctor receiving such an allowance. As part of the trading expense incurred in the pursuit of practice both telephone charges and a proportion of car expenses may be offset against income tax. It is, however, difficult to see how these tax allowances could increase a family doctor's income by £1,500.

The report goes on to state . . . general practitioners were also able to increase their income substantially with extra work . . . The actual income of G.P.s may, therefore, be as much as £10,000."

There is no doubt that it is possible to supplement practice-derived income with

insurance examinations, lectures, and even private patients, but we find it impossible to believe that in a district such as this it would be possible to earn £3,000 per annum outside the National Health Service. It is, of course, possible that even the *Daily Telegraph* may have misquoted the spokesman concerned.—We are, etc.,

D. J. ANDERSON
G. S. CRUICKSHANK
N. KITCHING
R. D. MERSON
J. L. MERSON

J. A. L. MORRELL
J. S. RIDDELL
A. F. RITCHIE
B. SCAIFE
J. STOHLNER
M. TOWNEND

Queens Park Medical Centre,
Stockton-on-Tees, Teeside

S.H.M.O.s and Medical Assistants

SIR,—A review of senior hospital medical officers with allowances is currently going on with the object of personal upgrading to consultant status. It is therefore an ironic commentary on the state of mind of those responsible for the so-called new look in hospital staffing to read (*Supplement*, 17 February, p. 45) that the Medical Assistants' Subcommittee of the Central Committee for Hospital Medical Services has recommended that certain medical assistants should receive a special allowance and that the recipients should be eligible for personal upgrading to consultant status.

The criticism of persons like myself would seem to be justified that this grade would perpetuate long-standing evils and solve nothing. O tempora, o mores!—I am, etc.,

I. M. LIBRACH

Chadwell Heath Hospital, Romford

Points from Letters

Removing Obstructed Balloon Catheter

Mr. A. J. WARRINGTON (St. Luke's Hospital Malta) writes: The letter from Mr. S. C. Sood and Dr. H. Sahota (23 December, p. 735) prompts me to report a similar case which I encountered recently. A 76-year-old female patient was catheterized with a No. 18 latex rubber Foley catheter, the balloon being inflated with 10 ml of sterile water. On attempting to remove the catheter two days later, it was found that the balloon could not be deflated with a syringe. The catheter was cut across but no fluid emerged from the inflating channel. Like your correspondents I considered overinflation of the balloon and injecting ether or paraffin too dangerous. A simple manoeuvre was finally resorted to. Gentle traction was applied to the catheter stump and the balloon was located from the vagina. A fine sterile hypodermic needle was passed through the anterior vaginal wall into the bladder in order to puncture the balloon. The catheter was then easily withdrawn.

Smallpox Rash

Dr. W. F. JACKSON (Southampton) writes: It is customary to describe the rash of smallpox as "centrifugal" in distribution, and this description is perpetuated in at least two recent accounts. I think this is a potentially misleading description. Certainly the rash will appear more dense peripherally at any stage of the illness, but its progression will usually be centripetal. The rash tends to spread towards the trunk, and not away from it. In temporal terms the smallpox rash is never "centrifugal."