

Manipulation for low back pain

SIR,—The comments of your correspondents about our controlled trial of mobilisation and manipulation for patients with low back pain (11 November, p 1338) illustrate the many problems in obtaining objective data as to the results of treating such patients. Classification of back pain problems may be made on the basis of the precipitating cause, the type of history, the physical signs, or the radiographic changes. Didactic statements of who will benefit and which types of manipulation should be used (Dr J H Davidson, 9 December, p 1644) are unsupported by objective evidence. A major part of the reported study was the correlations between the presenting features and the prognosis. The absence of such correlations, except for length of history, indicates that the forms of classification generally used are inadequate. Many other parameters mentioned by your correspondents are essentially subjective and often diagnosed in retrospect after the back problem has run its course.

This trial was of one form of physical treatment of the back—namely, mobilisation and manipulation of the spine as described by Maitland.¹ This method is in widespread use in many countries and essentially consists of a programme of therapy which is modified according to the patient's progress. It is not possible to define the specific details of treatment for an individual patient at the outset, nor to use any individual component of the programme alone, as this is not the way by which this treatment programme is used. A trial of the single elements of the programme would be of no value. However, there are other forms of physical therapy used for spinal problems and further trials are indicated.

With regard to outcome measures, the results of this general-practice patient trial may be contrasted with a subsequent similar study based on patients with a more prolonged history of back pain seen in hospital rheumatology and orthopaedic clinics (to be published). In this group we were unable to identify any of the early benefit associated with mobilisation and manipulation. Such a result was predicted from analysis of the data of the GP study. It is always difficult to provide an appropriate placebo for physical methods of therapy, but the method used does seem adequate in providing contrasting results in the two studies. The objective methods for measuring spinal mobility were previously evaluated by Loebel² and Reynolds.³

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¹ Maitland, G D, *Vertebral Manipulation*, 4th edn. London, Butterworths, 1977.

² Loebel, W Y, *Annals of Physical Medicine*, 1967, 9, 103.

³ Reynolds, P M G, *Rheumatology and Rehabilitation*, 1975, 14, 180.

*.*This correspondence is now closed.—ED, *BMJ*.

Nice people with no manners

SIR,—The censorious letter from the Editor (23-30 December, p 1774) starts with an oxymoronic title and ends with what is called "a true account" of a knight not traceable in *Who's Who*, *Whitaker's Almanack*, or the *Medical Directory*. If this fictitious gentleman was

treated as stated it was a grievous sin. But it is impossible to be certain of all the facts. I recently received a letter from the secretary of a distinguished physician saying that he had not been paid. His wife unbeknown to him had paid the cheque into a building society. The secretary apologised. Perhaps "Lady Walpole Wilson" took similar action.

I have been a clinical tutor for many years. Let me say without equivocation that I have never met a single colleague who I consider had bad manners. This does not mean that Dr Stephen Lock has not met a few with no manners, but even so he had no right to use exceptions to accuse three hundred clinical tutors of having "no manners." I forgive him because the centre of his article contains sensible suggestions and brings to light the fact that being a good clinical tutor takes time. His eight suggestions are, I gather, open to amendments as he says he has thrown them into the debate.

The speaker should be thanked properly not by a "bread-and-butter" letter, which the *Concise Oxford Dictionary* defines as "of thanks for hospitality, sent by departed guest." I do not expect these, although the few which arrive are welcome. My practice is to ask the treasurer of the university to send the cheques to me so that I can forward them to all speakers with an appropriate letter. I have had difficulty in getting this done. At the moment I am awaiting cheques asked for on 6 December 1978, saying that I will forward them to the individuals with a covering note. I realise that this university department is understaffed.

I believe the correct practice is to estimate expenses and add the standard fee for a lecture. Suggestion seven (giving the lecturer something other than a cheque) should be used only in exceptional circumstances, such as for doctors from a few corporate bodies who do not accept a fee.

I fully agree that a code of manners is needed. I find it is very trying having to write two or three times for a reply and infuriating when, as has happened, I am told that the doctor is sorry he cannot come as he promised sometime ago to visit somewhere else. You will have achieved much if you get people to improve this aspect of manners.

Lastly, may I say that I thoroughly agree that the widespread postgraduate medical movement needs rethinking. I have been giving this serious thought and hope to have the courtesy of your journal to give my views about it in the reasonably near future.

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Nice people with splendid manners

SIR,—Having lectured at a number of postgraduate centres lately, and being at a loss to understand Dr Stephen Lock's article (23-30 December, p 1774), I would like to report my own experiences.

At Wrexham Postgraduate Centre the clinical tutor collected me from my hotel and entertained me to drinks and supper. I received a charming thank-you letter and my cheque four days after lecturing. My talk appeared in the *Wrexham Medical Journal* and, fully prepared to pay for them, I had asked for 100 reprints. No payment was accepted.

At Basingstoke Postgraduate Medical Society the clinical tutor wrote three days after the lecture: "I find it difficult to put my thanks into words. Many people remarked that it was the best show they have had for many a long day, so let me thank you on behalf of all of us and hope that on another occasion you can come and talk to us again." My cheque was included.

At Swindon, the district clinical tutor of the Postgraduate Medical Education Centre wrote less than a week from the day of the lecture: "It is no exaggeration to say that your lecture proved to be the highlight of our Spring Postgraduate programme." Enclosed was my cheque for fees and expenses.

At Frimley Park Postgraduate Medical Centre the organiser was waiting for me at the main gate. A cheque and thank-you letter came within a few days of the lecture. The Medical Centre for Postgraduate Education at the General Infirmary, Salisbury, entertained me to a splendid buffet supper; the clinical tutor as well as the secretary were most charming and efficient. Cheque and thank-you letter reached me within a week, and a pullover, which I had carelessly forgotten, was returned to my home address within 24 hours.

I wonder why Dr Lock's experiences were so completely different from my own?

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*.*Dr Lock writes: "My article was not solely about postgraduate centres. The answer to Mr Alexander's question is probably because nobody from these delightfully courteous centres (which I emphasised form the majority) has yet asked me to talk."—ED, *BMJ*.

Changing advice on vaccination

SIR,—I have been scanning your columns in vain for an authoritative reply to Dr J A Begg's questions about vaccination schedules for infants (14 October, p 1088). Although I may have some of the answers, I have no responsibility for policy decisions; so what follows is a purely personal view. I hope that, without being heretical, it may help him and our numerous colleagues who are likewise bemused.

Before 1968 it was common practice, and still is in many countries, to give three doses of triple vaccine at monthly intervals starting at 3 months—an "early" schedule. Concern was aroused in the early 1960s by the high proportion of vaccinated children who subsequently developed whooping cough, and several changes were made.¹ Manufacturers were asked to ensure that pertussis factor 3, absent from many of the earlier batches, was included in the vaccine so as to give full cover against all serotypes of *Bordetella pertussis*. That was good. Two additional steps were taken to enhance the immune response of the child: (a) adsorbed vaccine was re-introduced—that too was good, and is also safe provided that polio vaccine is given to counter the increased tendency to "provocation poliomyelitis"; (b) the Department of Health and Social Security recommended a "delayed" schedule in 1968, starting at 6 months and with intervals of about six weeks and six months before the second and third doses respectively. There was evidence that the delay might improve the already good protection against tetanus and