course passed) a rider from the chairman of the G.M.S. Committee which, because of its importance, we reproduce in full here:

> "That if, when the new scheme of distribution has been endorsed by both parties, it is found in the light of experience that certain groups of practitioners who under the terms of reference of the Working Party might have expected to have benefited have in fact not done so, it be left to the Working Party provisionally to allocate an appropriate proportion of the final settlement moneys for the purpose of remedying any obvious defects in the distribution scheme, such allocation to be subject to confirmation by the next Conference before it becomes a permanent feature of the scheme."

In addition Dr. F. Gray, chairman of the Assistants and Young Practitioners Subcommittee, effectively made the point that the young doctors he was speaking for had wholeheartedly endorsed the Working Party's recommendations. Even so, there may well prove to be here and there certain unusual types of practice which will not receive their due from the Danckwerts award. A remote rural area in Scotland was cited as an example. For these and others adequate safeguards seem to have been accepted.

Several speakers, among them Dr. Wand, emphasized the just claims of some assistants to a share in the back pay that the principals will receive. During the last few years many principals are believed to have been unable to pay their assistants what either considered to be a proper salary, so meagre was the remuneration provided by the Government in accordance with its faulty interpretation of the Spens Report. Now that the Danckwerts award is to obtain for principals what they ought all along to have received, it is only just that those who were compelled to underpay their assistants should make amends when the money is available. They will be greatly helped to do so by the Inland Revenue authorities, for back pay to assistants is to count as an expense for income-tax purposes.

The Working Party's recommendations combine with the Danckwerts award to make the financial prospects of general practice much more attractive to all types of general practitioner. The scheme undoubtedly ought to encourage partnerships and their usual corollary, the assistantship with view. The young man starting on his own is to receive substantial help from the initial practice allowance and, it is to be hoped, accurate guidance from the Medical Practices Committee about those areas where he is likely to succeed in establishing himself. Money is to be set aside for certain unusual types of practice. The policy introduced by the chairman of the G.M.S. Committee and endorsed by the Conference in the words quoted above gives that necessary latitude to remove any anomalies that experience of the scheme may reveal. Presumably the new method of distribution will begin early next year.

BANTI'S SYNDROME AND BANTI'S DISEASE

The practical man shares with Disraeli a dislike for definitions and has even been heard to express his contempt for linguistics. A hint of this attitude can be discerned in the two papers published in this issue of the *Journal* which include in their titles the name of Banti, the centenary of whose birth was recently celebrated. The casual reader might well have difficulty in relating the Banti's disease of Sir Henry Tidy's lecture to the Banti's syndrome of Mr. Alan Hunt's. This difficulty springs from the authors' widely divergent viewpoints.

Sir Henry defines Banti's disease, or splenic anaemia, in mixed clinical and morbid anatomical terms. He excludes those instances for which there is an evident cause, such as infective hepatitis, and is left with a small group of patients in whom the origins of the disease are obscure. It is not apparent whether this selection is made on the basis of clinical or morbid anatomical observation, but Sir Henry clearly assumes his patients to be the victims of a common disease process. This process, he maintains, is the result of maternal rhesus iso-immunization with damage to the infant's liver, spleen, and bone marrow by circulating antibody. In his view the changes in these organs are related only in being due to the same cause.

The suggestion that parental rhesus incompatibility might lead to hepatic cirrhosis is not new; the problem has been carefully examined by Gerrard,[1] who concluded that splenic and hepatic enlargement, if indeed it ever occurs, is a rare sequel of rhesus iso-immunization. Sir Henry Tidy's pronouncement about the cause of Banti's disease is therefore unlikely to prove generally acceptable, and other of his views run counter to contemporary opinion: few would agree that cirrhosis does not explain the splenomegaly; that there is no relation between the spleen and the blood picture; or that splenectomy is followed by only transient changes in the leucocyte and platelet counts.

Mr. Alan Hunt's approach is mechanistic. To him Banti's syndrome is the sum of the phenomena which result from damming back the portal blood flow, either by strangulation of the branches of the vein within a cirrhotic liver or by obstruction of its main trunk; these phenomena include splenomegaly with the "hypersplenic" blood changes, and gastro-oesophageal varices with the consequent liability to haemorrhage. His lecture is an important contribution to the surgery of Banti's syndrome, and the high level of technical skill which the successful conduct of such operations implies will command general admiration.

Commendably, the results of so much work and so many observations are included in a paper so short that he barely does himself justice. The theme changes

[1] *British Medical Journal*, 1952, 1, 1385.

rapidly from the control of portal hypertension to the value of splenectomy in "hypersplenism," and to surgery of the bile ducts in biliary cirrhosis. Sufficient material for several lectures is compressed into one, and at times it is easy to forget that it is the surgery of portal hypertension, and not of hepatic cirrhosis, which is under review. The point must be made that porta-systemic anastomosis can do nothing more than lower portal venous pressure and diminish the liability to haemorrhage. It is a method of relieving a mechanical disturbance which arises during the course of a variety of diseases; the underlying cause of this disturbance is not affected by the operation. "Cirrhosis of the liver" again is the end-result of a number of different disease-processes, each of which carries a different prognosis. Operation to relieve portal hypertension would clearly be officious in a patient dying of hepatic failure; Mr. Hunt's results support the view that surgery is inadvisable in the face of clinical or biochemical evidence of active hepatic disease. In patients, however, with extrahepatic portal obstruction or dormant scarring of the liver, repeated gastro-oesophageal haemorrhage is the main cause of invalidism, even if, as some contend, it is seldom fatal. Most of these patients will be eager to grasp the chance of cure offered by surgery.

SCABIES

The itch is said to have a great affection for heroes and a decided taste for military expeditions. We have experienced considerable epidemics of scabies in both world wars, though it may be, as has been suggested, that war merely accentuates a periodicity in incidence natural to the disease. Much has been added to our knowledge of scabies in recent years—to the life cycle of the sarcoptic mite and to the natural history of the disease and its treatment. There are few other affections in which the clinician can expect cure to follow a single treatment.

With very rare exceptions it is only the human variety of *Sarcoptes scabiei* that will burrow into the human skin. The infestation is limited to the horny layer of the skin, and it is unusual for there to be many burrows with mature female mites. Children tend to be more heavily infested than adults. Infestation reaches its height in about 100 days, and, though symptoms may increase, the mite population later falls away quickly and spontaneous cure may sometimes result.

Symptoms depend upon the development of sensitization to sarcoptic products, and this with the development of some immunity may directly or indirectly determine a reduction in the degree of infestation. The work of Mellanby[1] on scabies, with human volunteers for investigation, was one of the valuable consequences of war. It was shown that the disease is normally contracted only by warm and intimate contact with an infected individual and not from casual contact. It is essentially a family disease and is readily cured by simple treatment of the family without concern for clothes or bedding.

Norwegian scabies, however, disturbs this comfortable equilibrium which implies that scabies in the community can be completely controlled. It is usually unrecognized until it has given rise to a local epidemic. Böck,[2] describing the affection in a girl 100 years ago, observed that the nurse and all patients in her ward contracted ordinary scabies whether or not she had been in contact with them. Similar experiences have since been reported from time to time in the world literature. Calnan[3] and Ingram[4] reported ward epidemics from cases of Norwegian scabies, and elsewhere in this issue Dr. G. C. Wells reports epidemics in two hospitals where a single patient with the disease had lodged. It is understood that other similar epidemics have been observed in hospitals in London in recent years. Another single case is described by I. Anderson at page 25.

The diagnosis is difficult even for the expert; there is usually no itching, and the eruption bears no resemblance to ordinary scabies. There is a patchy, widespread, or generalized brownish scaling and scabbing which resembles the bark of a tree, and may involve head and face as well as trunk and limbs, the hands and feet often showing a gross fissured hyperkeratosis. With a lens, multitudes of burrows may be seen, and a microscope shows them to be layered one upon another but still limited to the horny layer of the skin. There is much desquamation, and the nails are often markedly thickened. Often there is grave disease or mental defect in the patient, and this perhaps predisposes to the unusual character of the disease. The ready spread of infection from these cases as compared with ordinary scabies may be directly related mathematically to the number of burrows and pregnant mites in the horny layer or to the presence of much scale and infected epidermal dust in the ward, or to both.

What of the factors of sensitization and immunity in such patients? Why does infestation not reach a peak and subsequently fall away? The millions of burrows and mature female mites may persist for years. It is hardly acceptable that the absence of scratching accounts for the unrestricted proliferation of mites producing this rare picture. Further study of patients suffering from Norwegian scabies might elucidate some of these questions and add to our knowledge of scabies.

[1] *Scabies*, 1943, London.
[2] *Dtsch. Klin.*, 1853, **5**, 20.
[3] *Brit. J. Derm.*, 1950, **62**, 71.
[4] Ibid., 1951, **63**, 311.

ABSTRACTS OF WORLD MEDICINE

The dividing line between medicine and surgery is becoming increasingly difficult to define, and, although the professional distinction between physician and surgeon remains as rigid as ever, each must know more and more of each other's subject in order to be able to practise his own. For this reason, then, the decision to merge *Abstracts of World Surgery, Obstetrics and Gynaecology* with *Abstracts of World Medicine*, which was announced in an issue of May 31 and was dictated by financial considerations alone, is in principle a welcome one in providing the opportunity to present medical and surgical aspects of the same subject side by side.

At the same time, however, in order to make room in *Abstracts of World Medicine* for this additional surgical material without increasing the size of the journal, something must be omitted, and the field to be covered by the combined journal cannot therefore be as wide as that covered by its predecessors. For example, it has been decided not to include abstracts of obstetrical and gynaecological papers except in relation to other subjects, notably endocrinology. Nor will there be separate sections on anatomy, physiology, or biochemistry, while in general the emphasis will be predominantly clinical. On the other hand, such subjects as human genetics and forensic medicine will still find a place in the make-up of the combined journal, as will the section on the history of medicine.

The process of remodelling *Abstracts of World Medicine* must necessarily be spread over several months if publication is not to be interrupted; with the publication this week of the July issue the first stage of this process is complete. It is hoped that those wishing to keep abreast of the mounting tide of published material will find *Abstracts of World Medicine* in its new form a practical, concise, and accurate guide.

ARBITRATION ON DURHAM DISPUTE

The protracted dispute with Durham over its closed-shop policy seems to be near its end. Last week the Joint Emergency Committee of the Professions and representatives of Durham County Council agreed that the Minister of Labour should set up a board of arbitration.[1] Both parties to the dispute have undertaken to abide by the decision of the board, and its first meeting has been fixed for July 15. Meanwhile the B.M.A. and other professional bodies concerned have withdrawn their various sanctions against Durham, and Durham for its part has suspended the regulation which gave rise to the dispute.

Under this regulation an employee of the County Council can apply for extended sick leave with pay only through a professional organization or trade union. The B.M.A. and the other professions contend that this is an indirect form of the closed-shop policy, in that the employee must belong to a professional organization if he is to apply for extended sick leave with pay. In an important preamble in the board's terms of reference Durham agrees with the professional bodies that its professional employees should not as a condition of employment be required to belong to a trade union or professional organization. The board is then to be asked whether the regulations causing the present dispute are in conflict with the principle of voluntary membership of a trade union or professional organization and should therefore be withdrawn or not.

This dispute has dragged on with a county council where there seems to be little understanding of professional ideals and little sympathy with them. The idea of professional freedom has been so submerged beneath the tradition of collective action in the minds of many Durham councillors that they have failed to appreciate its value to the community. In particular a few influential men there, engrossed in the sophistries of an unrealistic doctrine, did all they could to prevent a settlement and to overthrow the compromise suggested two months ago.[2] It is a tribute to the better sense of some of their colleagues and to the tenacity of the professions' Emergency Committee that a reasonable course is at last to be taken. Those doctors who have faithfully followed the Association's policy and suffered serious embarrassment deserve the highest praise.

[1] See *Supplement*, p. 5.
[2] Ibid., May 3, p. 225.

BROADMOOR

The Broadmoor Inquiry Committee, whose report[1] was published this week, was appointed "to inquire into the adequacy of the security arrangements at Broadmoor and to make recommendations." The committee came to the conclusion that in recent years patients have escaped because supervision was not always close enough. Such lapses in supervision are ascribed to staff shortages and to the fact that "the present staff is not wholly of the quality that the needs of Broadmoor make imperative." Two consequent recommendations are that the salaries should be increased so as to attract suitable applicants for training as student nurses and that the pay and conditions of service of the nursing staff should not automatically be linked with those of the National Health Service (presumably because the latter may not be sufficiently attractive).

Broadmoor was established as a criminal lunatic asylum in 1863, and until 1948 it was controlled by the Home Office. Under the Criminal Justice Act of 1948 the institution was vested in the Ministry of Health and put under the management of the Board of Control. The term "criminal lunatic" was at the same time changed to "Broadmoor patient." Nevertheless, it is still the Home Secretary's function to make orders for the removal of patients to and from Broadmoor. There are at present 891 patients in Broadmoor (701 men and 190 women). Many of these are dangerous, and it is not surprising that at one time detention was regarded as the primary function and treatment as secondary. But the committee quite rightly refers to the improved arrangements for treatment which have been made during the 14 years of management of the present medical superintendent, Dr. J. S. Hopwood. The public should take heart from the committee's statement that these improvements, which are such as the medical profession would wish, have not resulted in any relaxation of the security rules and its emphatic rejection of the suggestion that the control of Broadmoor should be returned to the Home Office.

We record with regret the death in London on June 30 of Sir Percival Horton-Smith-Hartley, C.V.O., M.D., F.R.C.P., consulting physician to St. Bartholomew's Hospital and the Brompton Hospital. He was 84 years of age.

[1] Report of the Broadmoor Inquiry Committee, Cmd. 8594, 1952, H.M.S.O., London.