Coroners' Criticisms

Sir,—It seems to me that coroners often exceed the limits of their privileges. They are in the happy position of being wise after the event and can therefore indulge in the most obvious platitudes.

In the recently reported case of death during anaesthesia, the coroner's remarks were not only insulting to the anaesthetist but decidedly damaging to his reputation, notwithstanding the fact that no criminal negligence was found. To advise a doctor of 30 years' standing and experience to take a postgraduate course surely implies that he is incompetent. Similar remarks might be made about any doctor who gives evidence in a coroner's court.

A doctor who is duly qualified and possibly with many years of experience can only use his best judgment—in diagnosis and treatment. Most of us can read our journals and attend our meetings and thus keep pretty well abreast with current medical thought and practice. To be told that we should go back to school otherwise we don't know our job is humiliating and damaging.

It is unfortunate if there is no redress and if no action can be taken in these cases for defamation of character or to vindicate one's professional reputation. The public are quick enough to take an action against us and against hospitals. We all know how these actions have greatly increased since the inception of the Health Service. If the coroners are not to be restrained in their outspoken and damaging comments, life for the doctor will become a nightmare. Perhaps we shall be obliged to have a clause in our insurance policies to cover coroners' remarks as well as broken bones and surgical operations.—I am, etc.,

Chigwell. N. Beattie.

Hygiene in Public Lavatories

Sir,—I should like to confirm the experience of Dr. R. G. Wigoder described in his letter (*Journal*, September 14, p. 643). I regret to say that it is not only in villages that the state of public lavatories is often disgraceful. Indeed, in one county town not 50 miles from London the whole place was in semi-darkness, engrimed with dust and dirt, and, so far from washing facilities being available, not even toilet paper was provided. This public lavatory was in the central market-place.—I am, etc.,

Dereham, Norfolk. C. E. Harrison.

Merchant Shipping Medical Scales

Sir,—I have just completed one voyage as ship surgeon, and in Dr. R. E. Palmer-Field's eye (*Journal*, September 21, p. 713) must surely be a "blooming Hamatoor." Nevertheless, I should like to make the following observations on the medical supplies available in a small merchant vessel.

When I first joined the ship I admit that the fearsome array of instruments for every conceivable type of surgery, together with the absence of "made-up" preparations, filled me with misgivings. Perhaps due to the size of the vessel (73 "souls on board") I had no occasion for recourse to the former, and I soon developed an interest and pride in compounding recipes from the *National Formulary*—with my own additions and what I considered to be improvements. However, the patients requiring such tender care were few and far between. A more frequent visitor to my surgery was the European suffering from minor, but no less distressing, complaints due to the tropical climate, and a close second was the engineer with oil dermatitis.

I agree whole-heartedly with the previous correspondents that a review of the Merchant Shipping Medical Scales would be timely, and venture to suggest that in vessels bound for the tropics the pounds of Epsom salts could advantageously be replaced by an equal, if not larger, quantity of powder to alleviate "prickly heat," and the gallons of black draught by a canister of Lassar's paste supplemented with some of the newer proprietary skin preparations.—I am, etc.,

Dunmurry, Co. Antrim. Barbara C. Edwards.

Superficial Glandular Tuberculosis

Sir,—We enjoyed Drs. G. S. Kilpatrick and A. C. Douglas's report (*Journal*, September 14, p. 612) on superficial glandular tuberculosis, as it reflected our own experience during the past eight years. However, we would question whether it is really necessary, or desirable, to give *all* such patients "at least 12 to 18 months'" anti-tuberculous drug treatment. Periods of drug treatment of 6–8 months with surgical removal of caseous lung lesions where practicable has resulted in excellent and apparently lasting results. The same principle applied to tuberculous adenitis has given equally good and lasting results. Attempts to omit the surgical removal of persistently enlarged glands have almost invariably resulted in relapse sooner or later and not infrequently during a prolonged course of anti-tuberculous drug treatment, as was the experience of Drs. Kilpatrick and Douglas. Where removal of caseous glands is impracticable there is no alternative to a course of drug treatment of a year or more.

Anti-tuberculous drug treatment must include streptomycin unless the causative tubercle bacillus is known to be sensitive to P.A.S. Children tolerate drug treatment much better than adults, but it is undesirable to prolong the physical and mental strain of daily or thrice-weekly injections of streptomycin a day longer than is absolutely necessary. Following the type of treatment outlined above, we can only recall one patient, an Anglo-Indian male nurse with a primary lesion on his hand and axillary glands, who failed to heal his disease. Neither can we recall a patient in whom the surgical scar was a disfigurement.

Tuberculous adenitis is still a relatively common form of tuberculosis in this part of England, representing one-eighth of the total 1,200 notified patients.—We are, etc.,

G. F. Langley.
Ipswich. C. J. Stewart.

POINTS FROM LETTERS

Early Symptom of Parkinsonism

Dr. H. J. Hoyte (Birmingham, 33) writes: An elderly lady patient of mine who has put up a brave fight against slowly advancing Parkinsonism tells me that 27 years ago she was working as a dress designer. She was puzzled to notice that she was no longer able to keep her drawings square on the paper. The drawing sloped slightly from right above to left below. This and intractable headache made her seek medical advice, and her case was eventually diagnosed by Professor Cloake, of Birmingham General Hospital.

American Drugs

Dr. G. G. Thyne (Fareham) writes: It is becoming increasingly apparent that consultants have lost all faith in British drug manufacturers and have thrown the *British Pharmacopoeia* in the waste-paper basket. It is not suggested that the consultants have become thoroughly Americanized . . . but they do prescribe a plethora of American drugs, and it wastes a lot of my time looking up the British equivalent. Their behaviour seems to have the tacit approval of the Ministry of Health. In "Prescribers' Notes" they recommended that hydrocortisone should not be ordered by a named manufacturer. I wrote suggesting it would be to the benefit of the country that the British drug should be used, but they were unable to agree.

Intoxicated Children

Dr. G. L. Alexander (Bristol, 8) writes: I am at the moment relieving an old friend in his private practice in a West African capital city, on which the Asian 'flu descended on August 29. Whatever it may have been elsewhere, it is not a trivial infection here. One morning a man charged in with what looked like a dead child in his arms, aged about 4. It was not quite dead, but completely comatose and flaccid. Nothing obvious to account for this; it was not like a cerebral malaria. I asked the mother, "Could it have got hold of any sleeping tablets or other narcotics lying around the house?" She swore there was no such possibility. It was passed on to the central hospital. Later in the day I saw the medical specialist, who told me the child had come round quite soon after arrival there. The mother had then admitted that, thinking the child was sickening for the 'flu, she had given it a tablespoon of neat schnapps. It was merely dead drunk. Of course—I should have thought of that. But I still have such an innocent mind.