of my hobby pursuits inflicted two nasty wounds (certainly more than skin deep) with a high-speed circular saw. The results obtained exceeded the expectation both of the patient and his secretary, who performed the simple manœuvre.—I am, etc.,

Kuala Lumpur, Malaya. HUGH WAGNER.

SIR,—The two papers on sutureless skin closure (October 26, p. 1027 and p. 1030) and the subsequent correspondence are interesting not only for the technique, but also for the emphasis which they lay indirectly on the ability of tissues to heal with a minimum of foreign support.

A logical next step is to allow a skin incision to heal without the assistance of sutures *or* tape. I have done this on a few occasions with completely satisfactory results, though the case must be chosen carefully. Short incisions are more suitable than long, and better when made in the line of the skin crease. Transverse incisions at the base of the neck or in the iliac fossa where the edges tend to fall together in the natural position of the neck and abdomen may occasionally be retained in apposition by only a firm padded dressing. This disposes of the need for special preparation of the skin for the effective adherence of strapping, and can cope quite adequately with any ooze which might occur from the wound.

Mr. R. S. Murley (November 30, p. 1405) points out the bad cosmetic results following sutures which are tied too tightly and left in too long. Healing is a vital process which is assisted by mechanically narrowing the gap which new blood vessels and fibroblasts must bridge: the aphorism, "approximation and not strangulation" is perhaps not often enough remembered.—I am, etc.,

D. A. S. MARTIN.

Liverpool Thoracic Surgical Centre, Broadgreen Hospital, Liverpool 14.

SIR,—I feel a further point should be made about wound closure with adhesive tape with regard to casualty departments. Wound taping has the advantage that it is quicker, requires minimal instrument preparation and cleaning, and also does away with the need for a local anaesthetic. However, it is in this last point that a danger lies. The article on tetanus prophylaxis by Dr. Colleen A. Cox, Professor J. Knowelden, and Mr. W. J. W. Sharrard (November 30, p. 1360) stresses the importance of wound toilet in the prevention of tetanus. Adequate toilet of dirty wounds can only be done if a local anaesthetic is used.

I think that too wide a use of wound-taping in casualty departments may result in too many wounds being closed without adequate cleansing and excision.—I am, etc.,

J. A. LUNN.

Slough Industrial Health Service, Slough, Bucks.

Alcohol and Road Accidents

SIR,—May I add two points to the recent correspondence on "Alcohol and Road Accidents"?

At blood levels of 150 mg.%, or at even higher levels, there may be little or no evidence on clinical examination that the driving ability of any particular accused is impaired. On the other hand, as Professor E. J. Wayne says (December 7, p. 1467), exhaustive studies have established beyond reasonable doubt that everyone's driving ability is impaired at the level of 150 mg.% or even somewhat less. This variance confirms that the results of clinical examination and of chemical tests are two entirely separate pieces of evidence, neither of which can be dispensed with. For it is well known that in persons who are particularly susceptible to alcohol—either because they are not used to drinking or because of some predisposing ailment—a much lower content of alcohol in the blood might result in clear clinical evidence of being "under the influence."

My second point concerns the question whether the police surgeon should be given an account of all the happenings which lead to his being called to examine the accused. I agree with Professor Wayne that the knowledge whether or not an accident has occurred is of great importance, but even beyond this I consider that it will assist ultimate justice if the examining doctor is given a full account of all happenings, by both the police and the accused. A full history assists every doctor in every diagnosis. The same applies here, and there is no danger of an experienced police surgeon being influenced by a biased account. On the contrary, just as any highly coloured history given to him by patients or their relatives will put a doctor on the alert for any possible explanation other than the one suggested, so will such a history given to him at the police station. To know what is asserted by either side to have taken place before he sees the accused will prepare the doctor for any questions which might later come up in court, and will enable him to make sure that all possible investigations have been carried out to provide the answer to all such questions.—I am, etc.,

K. F. M. POLE.

Gillingham, Kent.

Chlorpropamide and Perinatal Mortality

SIR,—Last year we reported having found a high perinatal mortality rate in babies of mothers who had received chlorpropamide during their pregnancies.[1] Since we have been frequently misquoted, we should like to summarize our findings and conclusions:

(1) Our study was far from ideal, being retrospective and based largely on perusal of hospital records. Nevertheless:

(2) There were 16 perinatal deaths from a total of 25 pregnancies during which chlorpropamide had been used.

(3) The comparable perinatal death rate in all other pregnancies in diabetic women, whether treated with diet alone, tolbutamide, or insulin, was around 20%. Admittedly these pregnancies did not constitute a perfect control series since they were not specially matched with the chlorpropamide group.

(4) All the chlorpropamide deaths were associated with doses of 500 mg. daily; in three instances where only 250 mg. had been used live births resulted. The death rate associated with 500 mg. of chlorpropamide daily thus became 73%.

(5) Necropsies were performed in only a few instances, but the high perinatal mortality rate did not appear to be associated with congenital anomalies. There were, in fact, two infants with multiple congenital abnormalities—one the stillborn child of a mother who had received tolbutamide; the other a live child, apparently normal at birth, who was subsequently found to have microcephaly and a spastic quadriplegia. However, we have particularly stressed that the apparent danger to the foetus from the sulphonylureas as found by us does not seem to lie in the production of congenital malformations; in fact, any harm to the foetus associated with chlorpropamide seems to be mediated by some other mechanism.

(6) In conclusion, it would appear to us advisable to eschew the use of chlorpropamide in full doses during pregnancy. Doses of 250 mg. or less might be safe. If chlorpropamide is used, certain precautions seem reasonable: (i) That it should be used only under close supervision. (ii) That the dosage should be limited to 250 mg. daily. (iii) Perhaps the drug should be stopped ten days before delivery, and insulin substituted if needed.

We certainly do not advocate the avoidance of chlorpropamide in all women of child-bearing age—we ourselves use it quite extensively in such women.—We are, etc.,

W. P. U. JACKSON.
G. D. CAMPBELL.

Department of Medicine, University of Capetown Medical School, and University of Natal.

REFERENCE

[1] Jackson, W. P. U., Campbell, G. D., Notelovitz, M., and Blumsohn, D., *Diabetes*, 1962, **11**, Suppl. p. 98.

Post-partum Damage to the Pituitary

SIR,—Your annotation of June 22 (p. 1627) and discussion (September 7, p. 623) of the intra- and post-partum haemorrhage as the cause of acute or chronic hypopituitarism prompted me to present this problem from a different angle.

A careful history of three patients with Sheehan's syndrome revealed the presence of symptoms of a mild hypothalamic and/or hypophyseal inadequacy before marriage and prior to the critical pregnancy. Thus, the metabolic derangement accounts for the intra-partum haemorrhage and does not arise as the result of it. The clinical condition becomes more precisely evident in the post-partum period and misleads the clinician in the assessment of pathogenetic sequelae. A brief history of one patient demonstrates the sequence of pathological events.

A woman of 35 developed a typical pituitary insufficiency following term delivery.

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However, a careful history revealed that mild symptoms of endocrine dyscrasia existed before the development of a full-blown hypopituitarism. Menarche at 15 was followed by sporadic bleedings of varying duration (from a few hours to 14 days), always with scanty flow. Frequent spells of depression were explained by the family physician as a "minor defect self-correctable by marriage." Marriage at 22 somewhat regularized oligomenorrhoeic menses. Married life, however, was unsatisfactory. She experienced no orgasms and coitus was regarded only as a necessity for reproduction. After marriage, the "moody" spells became more frequent and alternated with mild euphoria.

After prolonged therapy with chorionic gonadotropins the patient achieved pregnancy in the sixth year of marriage. The uneventful pregnancy ended by low-forceps delivery. However, a mild haemorrhage followed the manual removal of the retained placenta. A complete absence of milk prohibited breast-feeding.

Menses never returned after birth of the child. The spells of deep depressions with periodic psychomotor outbursts required institutionalization. Several courses of insulin and electric shock therapy over a five-year period did not alter the course of the disease. Eventually the endocrinological work-up established the true picture of the metabolic derangement.

Physical examination revealed a short and obese female with peri-orbital oedema, scanty pubic and axillary hair, B.P. 90/60, pulse 58, slow tendon reflexes, and no clitoral and vaginal reflexes.

Laboratory studies: urinalysis normal; complete blood count showed mild hypochromic anaemia; syphilis serology negative; blood creatinine 0.6 mg./100 ml.; uric acid 6.8 mg./100 ml.; insulin tolerance test ended in an acute hypoglycaemic reaction with 20 mg./100 ml. glycaemia. Glucose tolerance test also ended in hypoglycaemic reaction at 35 mg./100 ml. glycaemia. P.B.I. 1.8 μg./100 ml. rose to 6.8 μg./100 ml. after stimulation with 10 units T.S.H.; radioactive I^{131} uptake was 7% with the conversion ratio 5%; sedated basal metabolic rate minus 46% and minus 48%; urinary gonadotropins reduced; 17-ketosteroids in 24-hour urine=3.7 mg.; 17 hydroxysteroids=0.1 mg.; pregnanediol and pregnanetriol were absent; E.C.G. showed low voltage in all leads, otherwise normal; *x*-ray of the skeleton unremarkable; vaginal epithelium showed poor cornification.

The diagnosis was established as pan-hypopituitarism with accompanying syndromes of hypothyroidism, hypocorticism, and hypo-ovarism.

Replacement therapy consisted of tri-iodothyronine with tetra-iodothyronine, prednisolone, and oestrogens supplemented with thyroid, adrenal, and ovarian tropic hormones (T.S.H., A.C.T.H., F.S.H.). A complete remission with an establishment of a regular menstrual cycle occurred within six months.

In the other two patients with Sheehan's syndrome several spontaneous abortions preceded the critical pregnancy, which was followed by the development of acute pan-hypopituitarism.

In appraising these three patients it is important to note that all possessed a mild hypothalamic inadequacy with poor contractility of uterine muscle leading to the delayed expulsion of the foetus and/or detachment of the placenta, and atonic haemorrhage. In other words, the dramatic events of the delivery in the form of haemorrhage are the result of a hormonal insufficiency brought about by pre-existing disease in the hypothalamus and/or hypophysis. The symptoms then became more pronounced after the post-partum haemorrhage and so have led to an erroneous interpretation of the exact nature of the disease.—I am, etc.,

Chicago 2, Illinois, U.S.A. Z. Z. GODLOWSKI.

Penicillin in Milk

SIR,—Two years ago I reported the case of a woman who developed dermatitis which proved to be a hypersensitivity reaction to the minute amounts of penicillin in normal bulked milk supplies.[1] Two attempts at desensitization had failed. Subsequently she was treated by adding penicillinase to her milk. When she had remained free of her eruption for 14 months a further attempt was made to desensitize her, which was entirely successful. Soluble penicillin G was given by mouth, beginning with 0.1 unit daily and increasing over a period of five months to 15,000 units a day. Over the final two months the addition of penicillinase to her milk was gradually discontinued. She has now remained completely well for a year on a full normal diet.—I am, etc.,

London W.1. P. BORRIE.

REFERENCE

[1] Borrie, P., and Barrett, J., *Brit. med. J.*, 1961, 2, 267.

Ingrowing Toenails

SIR,—Mr. A. W. Fowler in his letter (November 2, p. 1131) has, I am sure, explained why toenail surgery remains in the doldrums. I am less certain that he has suggested the correct cure. Our thesis[1] is that the conservative management of ingrowing toenails can be carried out by the patients themselves, under the supervision of their own general practitioner, the casualty department of any hospital, or under the care of a chiropodist.

It cannot be denied that very variable results have been obtained with all methods of nail-bed ablation, including the method described originally by Quenu,[2] in which the germinal matrix alone is excised. I would agree with Mr. Fowler that this operation can give excellent results, but it requires interest, a meticulous technique, and experience. If, therefore, toenail surgery is to be lifted from the doldrums, I am convinced that this can only be achieved by supervision and teaching of those who carry out any form of operation on the nail bed.

Until nail-bed ablation becomes a more universally satisfactory technique I am convinced that the ingrowing toenail should be treated energetically by conservative means, and any patient requiring nail-bed ablation, for which there are undoubted specific indications, should have a carefully planned and carried out operation, and hence a good end-result.—I am, etc.,

R. W. LLOYD-DAVIES.
Kent and Canterbury Hospital, Canterbury, Kent.

REFERENCES

[1] Lloyd-Davies, R. W., and Brill, G. C., *Brit. J. Surg.*, 1963, 50, 592.
[2] Fowler, A. W., ibid., 1958, 45, 382.

Training for General Practice

SIR,—In a recent monograph entitled *Doctor and Patient. Ethics, Morale, Government*[1] and given prominent publicity in *The Times*, Sir Robert Platt has drawn attention to the necessary post-graduate training prior to entry into general practice. He suggests a period of three, and preferably five, years' post-graduate training, whereby "the whole status of general practice would improve and the public have direct access to a higher quality of medical care."

There must be many of us who agree with Sir Robert Platt, but has adequate consideration or encouragement really been given to those who would wish to embark upon such a course? Granted the fact that the first year's pre-registration post should be treated very much as a provisional period, what of the following years? A midwifery appointment is essential; a casualty, paediatric, and further medical appointments are certainly desirable, to say nothing of psychiatry and the "minor specialties," all important in general practice.

One has therefore to exist on, at the most, £1,200 per annum (senior house officer grade), or if the job is particularly good and therefore receives many applications, £980 (house officer grade). If one is married, a separate home for wife and perhaps family has to be provided out of this income. Added to that, one is often doing work or taking decisions that one feels general practitioners would have taken had they been similarly trained.

Why, therefore, penalize so heavily those who wish to provide in the future what is at present described as "the best form of general practice"? Can one wonder that one's contemporaries seek the relative security of general practice at the earliest possible opportunity?—I am, etc.,

JEREMY BARTLETT
South Devon and East Cornwall Hospital, Plymouth, Devon.

REFERENCE

[1] Platt, R., *Doctor and Patient. Ethics, Morale, Government.* 1963. The Rock Carling Fellowship Lecture. Nuffield Provincial Hospitals Trust, London.

Mental Retardation

SIR,—The correspondence about appropriate terms to describe individuals with intelligence less than "normal" implies that there is agreement in the United States about the use of the term "mental retardation." This is not reflected by the

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