Failed Smallpox Vaccinations

SIR,—During the past two years I have collected 88 cases of toddlers (aged 2–5 years) and schoolchildren (aged 5–15 years) who had been unsuccessfully vaccinated on two or three occasions by other doctors. Thirty-five of these revaccinations were performed within one month of the previous attempt—the others at longer intervals, varying from one month to three years. I offered revaccination to this group of children, and, using one quarter-inch (6 mm.) linear bloodless scratch, was surprised to obtain in 83 of the 88 cases a typical positive reaction—that is, a primary vaccinia with a maximum reaction on the 7th–10th days. One 13-year-old boy "took" on the fourth attempt (my second), making a total of 84 "takes" out of 88 cases.

Given a satisfactory technique and using vaccine of known potency, there are still some apparently inexplicable failures. These could be of a temporary nature, perhaps due to such factors as virus interference. It seems important, therefore, that failed vaccinations should not be accepted as proof of immunity to smallpox, and that vaccination should be repeated at reasonably long intervals—say six-monthly or yearly—until a "take" is obtained.—I am, etc.,

Enfield, Middlesex. MARY ROLAND.

Spontaneous Cerebrospinal-fluid Rhinorrhoea

SIR,—Dr. A. M. Nussey (25 June, p. 1579) indicates that this condition is still very much of a collector's piece, which prompts me to describe a similar case and draw his attention to the method of localization of cerebrospinal-fluid fistulae described by Crow *et al.* in 1956,[1] and now an accepted investigation in this hospital.

A woman, aged 66, was seen at the end of March 1966 with a six-months history of right-sided rhinorrhoea. The fluid was clear and watery and dripped in response to stooping, coughing, and straining, though she had occasional days free. There was no past history of head injury. She had had a coronary thrombosis 10 years previously with residual insufficiency and was arteriosclerotic with hypertension (blood-pressure 200/100). Neurological examination was entirely normal and skull x-rays, including tomograms, showed no fault. Examination of the fluid demonstrated less than 1 cell per c.mm., protein 35 mg./100 ml., and sugar 62 mg./100 ml.

Five weeks later she was admitted. Under general anaesthesia identifiable pledgets of cotton-wool were placed in predetermined nasal and nasopharyngeal sites on both sides. Via the cisternal route 10 microcuries of radioactive sodium (^{24}Na) in 1 ml. was injected into the subarachnoid space. Thirty minutes later the pledgets were removed and analysed. On the left side no count was higher than 224, the level of background irradiation, while all counts on the right side were high, ranging from 5,313 in the spheno-ethmoidal recess to 1,619 in the anterior ethmoid.

This technique has proved accurate and reliable not only in the confirmation of C.S.F. rhinorrhoea but in its localization. Being a very sensitive test it is more likely than others to identify the less obvious leaks. Despite the ever-present risk of meningitis, craniotomy has not been performed in this patient because of her cardiovascular insufficiency.—I am, etc.,

The London Hospital, London E.1. A. W. MORRISON.

REFERENCE

1 Crow, H. J., Keogh, C., and Northfield, D. W. C., *Lancet*, 1956, 2, 325.

Osteomalacia in Asian Immigrants

SIR,—Recent reports of Asian immigrants with osteomalacia presenting in gynaecological and orthopaedic clinics (18 June, p. 1521 ; 30 July, p. 300) prompt me to report the appearance of such a case in a psychiatric out-patient clinic.

The patient was a 31-year-old Hindu married woman, with three children aged 11, 9, and 3 years, who had lived in England for five years. She was referred because no physical cause had been found for her symptoms and the possibility of a "functional overlay" was queried. Her complaints were low back pain for two years, pain in chest, hips, and thighs for several months and difficulty in walking. She also mentioned nausea, anorexia, general weakness, and a queer feeling "like needling" all over her body. On physical examination she appeared well nourished, but a striking feature was her waddling gait, which produced the false impression that she was in a state of advanced pregnancy. In addition she was tender on pressure over the ribs, vertebral column, and pelvis. There was no definite psychiatric abnormality. Radiographs of the skeleton showed a slight generalized loss in bone density, and Looser's zones were seen in inferior and superior pubic rami. A fracture of the right third metatarsal, which had been known to be present a year previously, remained ununited. Relevant investigations were serum calcium 6.8 mg./100 ml. (diffusible 3.1 mg./100 ml.), phosphate 2 mg./100 ml., alkaline phosphatase 12.6 King-Armstrong units/100 ml. Treatment with calciferol and calcium supplements was started and within four weeks she was greatly improved and after eight weeks symptom-free. Her serum calcium is now 9.8 mg./100 ml. (diffusible 4.3 mg./100 ml.).

Investigation of her diet revealed that she ate mainly bread and vegetables, and did not like meat, eggs, cheese, or milk. She has now begun to eat these foods. She also stated that when living in India she was troubled with low back pain every year in the late winter and early spring.

This case resembles closely those already reported. The waddling gait would seem to be an important physical sign.—I am, etc.,

Newcastle General Hospital, Newcastle upon Tyne. K. DAVISON.

Diagnosis of Tuberculosis in Childhood

SIR,—All physicians concerned with the control and diagnosis of tuberculosis will agree with the points made in your leading article (9 July, p. 65) on the early diagnosis of acute tuberculous lesions in infancy and childhood. The value and limitation of the tuberculin test are rightly stressed. Drs. A. J. Keay and Elizabeth Edmond in their letter (23 July, p. 237) mention the use of the comparative tuberculin test as an aid to the diagnosis of tuberculosis and anonymous mycobacterial infection. This test is currently under investigation in many centres. Its limitations need stressing. It is unlikely that anonymous mycobacteria will cause acute disseminated lesions in children except possibly as a complication of some other serious debilitating illness. I believe that none have so far been reported. Acute suppurative lymphadenitis in the neck is the usual lesion caused by anonymous mycobacteria, whereas lymph node lesions due to *Mycobacterium avium* are more chronic and occur elsewhere. These lesions are uncommon and are rarely seen even in specialized departments. Pyogenic suppurative lymphadenitis is still the commonest lesion. In this country up to 8% of children will give a positive reaction to the 5 T.U. Mantoux test. There is therefore a fair chance of the child with pyogenic lymphadenitis giving a positive reaction (5 mm.+).

We like others have found the comparative tuberculin test of little value in the acute phase of a tuberculous illness, and as your leader stresses a state of tuberculin anergy frequently exists at such times. As an aid to the diagnosis of a more chronic lesion the comparative Mantoux test is of some value, but it has limitations and is not infallible. Our experience suggests that a 3 T.U. dose of P.P.D. is preferable to a 5 T.U. dose, and I would not accept a reaction of less than 10 mm. diameter as being of significance and certainly no substitute for the identification of the causative micro-organism.

Finally the British Weybridge P.P.D.s, both the mammalian and avian, are comparable quantitatively and in specificity with P.P.D.-S. and the corresponding avian P.P.D.—I am, etc.,

CHARLES J. STEWART.

St. Helen's Hospital, Ipswich.

Innocent Systolic Murmurs in Childhood

SIR,—Dr. E. Goldblatt's excellent article (9 July, p. 95) would be a very helpful guide to school medical officers. It was time that an authoritative voice was heard against the ritual of annual re-examination of children with "functional" heart murmurs.

During 1965–6 I have tried to assess the incidence of innocent heart murmurs while examining infants at the child welfare clinics and schoolchildren at routine medical inspections in Lancashire. The following Table shows the results.

Age	No. of Children	No. of Children with Heart Murmur	%
Under 1	202	4	1·9
5–6	102	13	12·6
12–14	495	36	7·2
Total	799	53	6·6

In spite of my eagerness to record the faintest murmur I have only found one in about 7% of all children examined. From the school records I could compare my findings with those of previous examinations. From 36 murmurs I heard in the age group 12–14 only nine had been reported previously, while in seven instances where murmurs had been reported previously I

could hear none. All the murmurs were loudest at the left sternal border except two, which were best heard at the right of the sternum.—I am, etc.,

Rochdale, Lancs. BOTIO KALCEV.

Ischaemia and Smoking

SIR,—Eastcott[1] has emphasized the rarity of ischaemic disease of the lower limbs in non-smokers. Surely, therefore, Mr. N. L. Browse (16 July, p. 157) should advise cessation of smoking before considering surgery for this condition ?—I am, etc.,

Yeovil, Somerset. JOHN ANDERSON.

REFERENCE

[1] Eastcott, H. H. G., *Lancet*, 1962, **2**, 1117.

The Diathermy Quiver

SIR,—I was sorry but not surprised to see that another case of diathermy burns had been reported from the use of an antistatic rubber quiver. (Mr. D. C. Bodenham and others (23 July, p. 237).)

A further recent case has also occurred in London. I would suggest that the use of such quivers should now cease, and I understand that the original pattern of thick bakelite which I had made up before the war can still be supplied by A. L. Hawkins & Co. Ltd., of 15 New Cavendish Street, London, W.1. I would also suggest that it is time that the Ministry of Health's " Safety Code " for hospital theatre equipment should be amended in the sections dealing with rubber articles.—I am, etc.,

London N.6. C. LANGTON HEWER.

Preclinical Curriculum

SIR,—I completely endorse the sentiment expressed by Dr. J. H. Scott in his letter (2 July, p. 50). I have no doubt that the first two years at university should be spent on the teaching of functional anatomy, physiology, biochemistry, statistics, and biophysics.

It is a complete waste of time to spend the first year in the study of chemistry, physics, and biology. These subjects are adequately covered by the A level course of the G.C.E. The A level G.C.E. in these subjects is much more comprehensive than the first professional examinations of some universities. It was possible for a very ordinary medical student to obtain 100% in chemistry and physics at the end of the first undergraduate year.

The third year in university could profitably be spent on a degree course in the basic medical sciences. On this foundation of basic knowledge it would then be possible to spend the next two years in the study of abnormal physiology and the principles of medicine and surgery.

There is no necessity for medical students to learn the details of operative procedures, the clinical features of obscure and rare diseases, the details of pathological histology, etc. Junior hospital medical staff and registrars are taught the techniques and the relevant facts in their selected specialty, and their knowledge assessed by appropriate postgraduate examinations.—I am, etc.,

ROBERT J. KERNOHAN.

Waveney Hospital,
Ballymena, N. Ireland.

Labelling of Drugs

SIR,—As science and medicine have advanced a much more realistic attitude has been adopted concerning making the patient aware of the nature of his illness.

Could this more fundamental approach now be applied to the dispensing of medicaments as a routine procedure rather than only when the prescription is marked N.P. (nomen proprium). The days when it was necessary to hide remedies in Latin and the hieroglyphics of the apothecary scale need not be perpetuated now that we have drugs that actually work. To know what a patient is taking can be life-saving and a great help in the diagnosis (and even prevention) of drug eruptions. The fact that patients mix tablets together in one bottle can be partly overcome by making it a requirement of a printed label that a facsimile of the tablet be included. For the occasion where secrecy is necessary, then an agreed abbreviation such as S.N.P. (sine nomine proprio) would be needed.—I am, etc.,

Beaumont Hospital, Lancaster. R. H. SEVILLE.

Salaries of Specialized Technicians

SIR,—Discussion following your leading article (30 April, p. 1061) and the subsequent correspondence (21 May, p. 1302, and 2 July, p. 53) has led us to agree that in general terms there is no great disparity between the skills required of cardiological and electroencephalographic technicians. Recruitment is inadequate in both fields ; this is very largely due to the existing salary scales, which do not sufficiently recognize the skill and training required of these technicians.

It is our earnest hope that the Ministry of Health will take steps to remedy this situation at the earliest possible opportunity.—We are, etc.,

D. C. DEUCHAR,
President,
Society of Cardiological Technicians.
S. NEVIN,
President,
Electrophysiological Technologist Association.

Guy's Hospital,
London S.E.1.

Hall or Barn?

SIR,—It is a cliché to say that Rome was not built in a day, but it would be a fact to state that B.M.A. House was not built in half a century. Started by Sir Edwin Lutyens in 1913 and still unfinished when bought by the Association 10 years later, it lacks a ceiling in the most important room of all, the Great Hall. Black rafters, golden girders, and an empty void are a poor reward for those attending meetings in the Great Hall and who are moved to lofty thoughts and so, while meditating, gaze upward.

Please could we have the architect's original design of a coffered vaulting completed at last, or some other design if this is too expensive. Perhaps our new Chairman of Council will be moved to mark his accession to high office by completing, at last, a project started almost before he was born and ensuring that the Great Hall does not remain the Great Barn.—I am, etc.,

London W.13. R. E. W. OLIVER.

Merit Awards

SIR,—A postal ballot on the subject of merit awards was requested by the Swindon Division of the B.M.A. and agreed by the Annual Representative Meeting at Exeter (16 July, *Supplement*, p. 59). There is no doubt that the views of the hospital staffs with 18 years' experience of the system would be invaluable in helping general practitioners faced at this time with the choice of accepting merit awards or not.

While the aura of secrecy surrounding merit awards makes constructive criticism or even appraisal difficult, some of the relevant factors militating against the merit-award system would appear to be:

(1) The incompatibility of secret monetary awards with the spirit of the times, in which we are constantly exposed to criticism in both the press and public debate. It is therefore especially important that the medical profession should be seen to conform to the highest ethical standards. It is perhaps relevant that no other profession of standing will countenance this type of payment for its members.

(2) The unnecessary and disruptive jealousies engendered between professional colleagues by such awards.

(3) The possibilities that awards are not unbiased by personalities and other improper factors may in time come to give regional boards and their merit-award committees an unenviable reputation.

(4) Merit awards, at any rate in the provinces, appear to be given mainly for committee work. This tends to attract some men away from their clinical duties and results in their burden of hospital duties being thrown on to colleagues and junior hospital staff, for coping with which the non-committee-minded men are then deprived of their chance of merit awards.

(5) The recent pay awards by the Review Body were disappointing to the hospital staff as a whole. This has resulted in the feeling that negotiators with merit awards may be so divorced from the economics of their basically paid colleagues that claims for an increased basic rate are not pushed with necessary determination.

We think that a system of seniority payments would probably be much fairer to all ; especially to those working away from the great centres. We think also that if the system were common to hospital staff and to general practitioners it would tend to act as a unifying factor in the profession as a whole.

We urge that the resolution for a postal ballot to ascertain the views of hospital medical staff on the merit award system be implemented without delay. We would, if it is possible, also like to find out what the profession's views are on the question of seniority awards in the same ballot.—We are, etc.,

C. REMINGTON-HOBBS,
Chairman,
DONALD BURRELL,
Secretary,
Winchester Division of the B.M.A.

Winchester.