T wave in lead III. A tracing taken next day showed the mature picture of a posterior infarct.

There are a number of possible explanations for this phenomenon, but a failure to find any reference to it in the standard textbooks prompts the submission of this report.—I am, etc.,

Camberley, Surrey.

A. M. W. PORTER.

REFERENCE

- ¹ Solomon, R. B., and Shapiro, H. H., *Amer. Heart J.*, 1966, 71, 582.

Nursing Attachment Scheme

SIR,—In view of the possible increase in nursing attachment it may be relevant to consider the present schemes in more detail in order to determine their uses and possible abuses. The full value of any such scheme must surely be measured by the benefits it confers on those whom it serves in relation to its total cost and its efficient use of manpower, rather than by its power to shift a work load or its provision of job satisfaction for some of its participants. It is important to know if the improved communications described by Dr. J. F. Warin (6 April, p. 41) have resulted in improvement in local authority services, and, if so, whether improved communications could be introduced by less radical means or means less costly in terms of skilled woman power.

There is a shortage of general practitioners, and many of them are grossly overworked. There is also a shortage of health visitors, and many of these are also grossly overworked, but under the direct administration of the local health authority their work load can be planned so that priorities are met and deficiencies known and measured. If there is fault in the present system of health visiting this is not necessarily due to the health visitor, her work load, or the system itself, but to the lack of appreciation of priorities. Is the general practitioner in a better position to organize her priorities, or is there a danger that in an attachment scheme the health visitor becomes a buffer between those who contract to provide a medical service and those who are duty bound to provide ancillary nursing care for the community as a whole, with particular reference to disease prevention and health promotion?

Dr. Warin has pointed out that a successful attachment scheme revealed the need for an increase in the establishment of health visitors. This need has been felt by health visitors themselves for a very long time, but certainly not for the purpose of "regular visiting" of elderly patients or "follow-up visits in connexion with the common infectious diseases."

Of course this kind of work will lighten the work load of general practitioners, but is it the work for which health visitors are being trained? Does it lead to a more efficient health-visiting service, does it help to lighten the health visitors' case load, or is their work of so little importance that these questions are of no consequence?—I am, etc.,

MILDRED F. DAVEY,
Superintendent Health Visitor,

Health Department,
Town Hall,
Merthyr Tydfil.

Royal Malady

SIR,—When I read that Professor C. E. Dent was attempting to sum up the recent correspondence on the royal malady I expected an objective and fair summation of the various points of view, but in this I have been disappointed. It is for this reason that I write to you again.

It is quite unfair of Professor Dent to call upon physicians with experience in this field, as he did (3 February, p. 311), and then to throw out all the opinions with the exception of those of Dr. G. Dean (17 February, p. 443), in spite of the fact that I admire Dr. Dean's work in this field. It is of course unrealistic to state that "only one clinician has really adequate and reliable knowledge of variegate porphyria." This type of old-fashioned authoritarianism does an injustice to Professor Dent himself and takes no account of the clinicians in U.S.A. and in this country who have had first-hand experience of this disease, not to mention Professor L. Eales and Dr. E. B. Dowdle, of Cape Town, whose carefully reasoned letter (30 March, p. 841) I applaud, even though it comes out against the hypothesis. The variegate type of porphyria has become increasingly recognized in this country, and we have already sufficient knowledge of it to say that quite severe attacks can be provoked by factors other than drugs. There was no suggestion in my letter (24 February, p. 509) that acute porphyria and porphyria variegata are not two diseases, but they do share a common enzyme defect, and the clinical pattern of the acute attacks is the same in both conditions, as are many of the provoking factors.

By inference Professor Dent suggests that the proponents of the theory consider that this has been proved. My own position, stated in my previous letter (24 February, p. 509), and I sense that of many others, is that this is a hypothesis which has certainly not yet been proved, but which has been rendered more likely by the investigations of Professor C. Rimington and his colleagues (6 January, p. 7). Professor Dent states that he was "most distressed to note that one historian seemed to have swallowed the story hook, line, and sinker." May I reassure him that historians are a hard-headed lot, quite able to look after themselves in the jungle of historical theory.—I am, etc.,

Department of Medicine, A. GOLDBERG.
University of Glasgow.

Use of Amphetamines

SIR,—I must protest about the attitude of your "expert contributors" towards the amphetamines (20 April, p. 164). The statement "The amphetamines are of little use in any but the mildest cases of endogenous depression" could not have been phrased more dangerously. Are your experts not aware that mild endogenous depression is the commonest encountered by the general practitioners? As it is written, the statement made by the "expert contributors" suggests that amphetamines *should* be used for the treatment of mild depression.

Why on earth cannot these contributors say quite clearly that there is no place for the use of amphetamines in the treatment of depression? Do they in fact use amphet-

amines themselves? And if they do can they justify the risk of addiction?

Surely the time is long past when any of us can properly sit on the fence and watch a growing addiction problem.—I am, etc.,

Oldham, Lancs.

GARETH LLOYD.

Hiatus Hernia Box and Scoliosis

SIR,—Mr. J. Lister describes radial nerve palsy due to direct pressure from the edge of a plastic box used for the treatment of hiatus hernia (9 March, p. 643).

I am concerned about the possible effects of this hiatus hernia box on the vertebral column. Infantile idiopathic scoliosis is a lateral curvature developing in the first three years of life in a spine without demonstrable abnormality. It is commoner in boys than girls, commoner to the left than the right, progresses usually to 15° or 20° at the most, and then the great majority resolve spontaneously. Why most resolve is not known, but probably the normal development of power and tone of the spinal musculature plays a part.

We have recently reviewed 60 children with this diagnosis and found that 40 resolved within the first 18 months of life to become normal children. The 20 children whose curves had not resolved at 18 months are made up of 13 in whom a possible cause for non-resolution could be found (seven with mental retardation, two with congenital abnormalities, and four with double curves), and seven in whom none of these features were present. Of these seven three had oesophageal reflux in early infancy and had been nursed for long periods in a hiatus hernia box. Of these three two developed curves of 25° and did not resolve until aged 3½, and one deteriorated.

This one, a boy, is known to have had a normal spine when radiographs were taken at 2 months of age and revealed a hiatus hernia. He was nursed in a box until 9 months old because it was impossible to prevent vomiting any other way. His scoliosis then was 60°. At the age of 3, when his hernia was repaired by a transthoracic

approach, his curve was 90°. Thus, three spines out of a group of 60 with a similar condition were distorted by a hiatus hernia box, and all three are among the small proportion (7 out of 60) who failed to resolve without demonstrable cause within 18 months.

It is possible that prolonged "sitting" in the box acted against resolution of the curve. Whilst treating hiatus hernia in an infant one has no attractive alternative to using the box, but its use in normal children, which is becoming increasingly popular, should be watched.—I am, etc.,

N. J. BLOCKEY.

Orthopaedic Department,
Royal Hospital for Sick Children,
Glasgow.

Mothers and Children in Hospital

SIR,—The National Association for the Welfare of Children in Hospital welcomed the publication of Mr. D. J. Brain and Dr. Inga MacLay's work (3 February, p. 278). At last we have a scientifically controlled study to which we can direct those who still question the desirability of regarding mother and child as a single entity even when the child has to go into hospital.

Dr. G. Davison (9 March, p. 641) stresses the difficulty of selecting mothers to live in with their children, although the results of the study indicated that mothers themselves may well be the best judges of whether or not their children need them. This implies that one of the reasons why all mothers should not room-in is that nurses who have chosen to care for children can better fulfil their "strong mothering instincts" on unaccompanied children. Apart from the view that hospitals are run for the good of the patients rather than for the convenience of the staff, we think that this proposition needs closer examination. According to the Ministry of Health census of children in hospital¹ only 55–57% of patients in children's wards in general hospitals are nursed by at least one registered sick children's nurse. In children's hospitals the figure rises to 75%. Unfortunately, neither the sister, nor the staff nurse, where so qualified, can be on duty all the time, and even when they are, much of their time has to be spent on administrative duties, rather than "mothering." The other staff will mostly be general student nurses on the ward for twelve weeks. Unhappily we often receive letters from parents that reveal all too plainly the inexperience of these nurses. Thoughtless remarks, such as "Stop crying or mummy will never come back," spoken to a frightened toddler who is ill and has never spent a night away from his parents before, occur too often. In cases where we have been asked to take this up with the hospital authorities the parents' reports have been invariably substantiated and regrets expressed.

We agree with Dr. Davison that nurses' attitudes are vital. It would seem that there will always be some small children whose mothers cannot or will not be admitted with them, and surely it is with these children that nurses can fulfil their maternal feelings. At Rubery Hill it was noted that the nursing staff were sceptical about admitting mothers—this makes it clear that the practice was new to them, and it is greatly to their credit that it was the success it evidently was, for it takes time for ward staff to become accustomed to handling mother and child

together. We know that a few mothers are difficult, but find that they are usually either particularly anxious or simply do not know what they should be doing to fit into ward routine. Hospital staff tend to forget how nervous many lay people are when they find themselves in a ward, and clear guidance on how they can co-operate with the staff usually results in a relaxed atmosphere where the mother can be a positive help. This is one of the reasons why we have produced our hospital admission leaflet that aims to give basic guidance to parents visiting or living in with their children.—I am, etc.,

JUDITH PEAD,

Chairman,
National Association for the
Welfare of Children in Hospital.

London S.W.1.

REFERENCE

- 1 Statistical Report Series No. 2: *Reports on the Census of Children and Adolescents in Non-Psychiatric Wards of N.H.S. Hospitals*, July 1967. 7s. 6d.

Sales Promotion

SIR,—The following is a sentence taken from a letter which was addressed to the chief pharmacist of this hospital group and which referred to a drug said to be useful in urinary infection prophylaxis.

"Propaganda to the medical profession and hospitals has commenced, so we recommend that you take in stock to meet the demand."—I am, etc.,

Herdmanflat Hospital, C. C. MCGREGOR.
Haddington,
East Lothian.

SIR,—This week I went to a farm which had the notice "No Agricultural Representatives" painted on the gate. I felt a load lifted from my mind, and on arriving home I put a clear notice, "No Medical Representatives," on my waiting-room door. Probably I am not the first general practitioner driven to take this harsh step, but I trust this letter will encourage others to do the same.—I am, etc.,

Darlington,
Co. Durham.

C. G. FOX.

SIR,—Some months ago I decided to try to stem the flood of unwanted pharmaceutical advertising literature that daily thudded on to the doormat. I felt that, with the *B.M.J.* and the *Practitioner*, and with *Prescribers' Journal*, *Prop List*, and the Dunlop Committee warning notices arriving regularly, I had enough information about drugs coming in. Accordingly, I wrote to Medical Mailings Co. Ltd. to request the removal of my name from their mailing lists and was grateful to find that they courteously acceded to my request.

I now find that I no longer receive *Prop List*, *Prescribers' Journal*, or the Dunlop Committee warning notices, as these official publications are apparently distributed through the commercial mailing houses. It seems, therefore, that as a precondition to receiving them one has to voluntarily submit to a torrent of unwanted commercial advertising. Since the purpose of these official publications is to offset the bias of high-pressure advertising, it seems a bit mad.—I am, etc.,

North Harrow,
Middlesex.

O. W. SAMUEL.

Rigid Trachea

SIR,—In your leading article (6 April, p. 4) on tracheopathia osteoplastica (preferably called tracheobronchopathia osteoplastica)¹ reference was not made to my recent paper,² describing a further example of this rare condition in a woman aged 52 suspected of having a bronchial carcinoma. The bronchoscopic findings and naked-eye morbid anatomical appearances in this case were characteristic of tracheobronchopathia osteoplastica, but the histological feature of bony deposits (containing marrow showing active haemopoiesis) in the submucosa of the lower trachea and major bronchi was superimposed on a background of primary localized amyloid infiltration.

As your leading article pointed out, the pathogenesis of tracheobronchopathia osteoplastica remains obscure, despite various theories which have been proposed in the past. Ossification (containing marrow showing active haemopoiesis) is also a feature of primary localized tracheobronchial amyloidosis. In the reported descriptions of the bronchoscopic and histological appearances of tracheobronchopathia osteoplastica on the one hand, and of primary localized tracheobronchial amyloidosis on the other, there has often been a striking similarity and overlap between the two conditions. Thus in the case of tracheobronchopathia osteoplastica described by Shuttleworth *et al.*³ the bronchoscopic appearance was identical with that described by other authors in primary localized tracheobronchial amyloidosis, and amyloid was demonstrated histologically in their case. Similarly, in cases described by Prowse and Elliott,⁴ the bronchoscopic and histological appearance of primary localized amyloidosis appeared to be identical with that described by other authors in tracheobronchopathia osteoplastica.

I consider that the apparent overlap between these two conditions may well indicate a common aetiology, and I suggest that the condition of tracheobronchopathia osteoplastica is intimately associated with primary localized amyloidosis of the lower respiratory tract, and may well represent a late stage of that condition.—I am, etc.,

Redhill General Hospital, ALEX SAKULA.
Redhill, Surrey.

REFERENCES

- 1 Secrest, P. G., Kendig, T. A., and Beland, A. J., *Amer. J. Med.*, 1964, **36**, 815.
- 2 Sakula, A., *Thorax*, 1968, **23**, 105.
- 3 Shuttleworth, J. S., Self, C. L., and Pershing, H. S., *Ann. intern. Med.*, 1960, **52**, 234.
- 4 Prowse, C. B., and Elliott, R. I. K., *Thorax*, 1963, **18**, 326.

Comprehensive Care

SIR,—We welcome Dr. J. F. Warin's useful article (6 April, p. 41) on the development of general practice attachment schemes in the City of Oxford. We are sure that his comments will be helpful to the many people now considering attachments. It may not be generally realized that a "quiet revolution" is occurring in the working relationships between general practitioners and local authority nursing staff. This unit has now carried out two surveys¹ of the distribution of attachments in England and Wales, and at the beginning of 1967 there were no fewer than 2,375 health visitors, district nurses, and domiciliary midwives working in such