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,
Redhill, Surrey.

ALEX SAKULA.

REFERENCES

- 1 Secret, 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