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 lift 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

arrangements. Although this figure accounted for only 11% of staff, it had grown from 3.4% in just over two years, and the trend appears to be continuing.

Pioneers naturally stimulate interest and enthusiasm and one should therefore be cautious about accepting their judgement of the value of their developments. However, detailed studies²⁻⁴ examining the work of local authority staff in attached and unattached situations, and in particular a study by this unit³ conducted simultaneously in Oxford (where there was general attachment) and other towns where there were no attachments, seem to bear out Dr. Warin's generally favourable conclusions about this method of working. The next step appears to be the link with hospital services.—We are, etc.,

J. A. D. ANDERSON.
PETER DRAPER.

Social Medicine Unit,
Department of Medicine,
Guy's Hospital Medical School,
London S.E.1.

REFERENCES

- 1 Anderson, J. A. D., Draper, P., Ambler, Mary, and Black, J. M., *Med. Offr.*, 1967, **118**, 249.
- 2 Brewin, P. H., *Med. Offr.*, 1968, **119**, 171.
- 3 Clow, J. T., *Med. Offr.*, 1968, **119**, 173.
- 4 Allen, W. H., and King, V. M., *Med. Offr.*, 1968, **119**, 177.
- 5 Ambler, Mary, Anderson, J. A. D., Black, J. M., Draper, P., Lewis, Janet, Moss, W., and Murrell, T. G. C., in press.

Exercise Tests

SIR,—Your leading article (13 April, p. 67) concisely puts the case for the use of exercise testing in clinical evaluation, and we thank you for your kind reference to our work.¹ We would, however, like to take issue with one passage which is a caricature of our approach. We do not make elderly patients ride a bicycle for half an hour to avoid a needle prick. In this sort of patient exercise rarely lasts for longer than 10 minutes. Furthermore, a properly conducted sampling of arterial blood requires at least half an hour for preparation, performance, analysis, and aftercare.

We agree that exercise tests should be reserved for those patients in whom the cause and degree of disability cannot be predicted from studies at rest, but the suggestion that a blood sample and a few spirometric tests can do this with reasonable certainty begs several questions.—We are, etc.,

E. J. MORAN CAMPBELL.
NORMAN L. JONES.

Royal Postgraduate Medical School,
London W.12.

REFERENCE

- 1 Jones, N. L., *Brit. J. Dis. Chest*, 1967, **61**, 169.

Poisoning by Oil of Wintergreen

SIR,—I wish to endorse Dr. R. R. Gordon's warning of the dangers of methyl salicylate liniment. His letter (23 March, p. 769) reminded me of an episode of 25 years ago, when I was surgeon on a cargo ship in the Red Sea. I was asked to see an Indian stoker one night, groaning in his bunk with abdominal pain. He was shocked and had board-like rigidity of his abdominal muscles. I was unable to get a useful history, beyond the fact that the pain had begun two hours previously. The wartime blackout made the quarters hot and stuffy, and I missed the characteristic smell. I considered he had a perforated peptic ulcer, so with much trepidation

I looked out my instruments, assembled the flimsy operating-table, and warned the second mate I would require him to give the anaesthetic. I had never previously opened an abdomen, and was almost as apprehensive as the patient.

I decided to wait a little while, and when I re-examined the patient I found to my surprise and relief that he had come out in a generalized urticarial rash and was itching all over. He was improving, and when I questioned him closely the next morning he told me he had bought a bottle of wintergreen oil at a previous port. He could not read the English label, but was told it said, "Take two drops on a lump of sugar for a cold." As he had a bad cold, he had decided to take half the 4-oz. (120-ml.) bottle.

He made a complete recovery. Dr. Gordon's letter reminded me of that warm night in the Red Sea during the last war and of how ill that patient had been. I could well imagine a similar dose in a young child being fatal.—I am, etc.,

Farnborough,
Hants.

J. N. A. PRITCHARD.

Prescription Charges and Tuberculosis

SIR,—Dr. W. D. Gray and Dr. E. L. Feinmann (20 April, p. 174) draw attention to a serious aspect of the new prescription charges, and their pleas are worthy of the support of the whole profession. The sufferer from pulmonary tuberculosis must be given every encouragement to persevere with the lengthy course of chemotherapy, usually amounting to two years, which will result in the eradication of his disease and thus prevent him from ever infecting another individual. Equally, he should not be subjected to any expense which might lead him to succumb to the temptation to relinquish what is frequently unpleasant medication and thus become infectious again.

In the interests of the public health the Minister of Health must be persuaded to include pulmonary tuberculosis in the list of diseases for which prescriptions are to be issued without charge. If he is not so persuaded he must surely realize that the only alternative is for chest physicians to advise general practitioners to issue prescriptions for quantities of drugs large enough to suffice for long periods of treatment. Should intolerance to any of these prescribed drugs develop, large amount of drugs, which in some instances are extremely costly (prothionamide at least £14 and cycloserine at least £17 10s. per three months), may be discarded by the patient.

I am taking Dr. Gray's advice by sending a copy of this letter to my Member of Parliament, asking him to use his influence in this matter.—I am, etc.,

JOHN HAMILTON GIFFORD.

Waterloo Chest Clinic,
Liverpool.

"Portraits of Guy's Men"

SIR,—I was surprised to read that "Thomas Addison was a Cumberland man of a long line of Cumberland yeomen" (3 February, p. 307). Certainly the Addison family had long been resident at Banks, near Lanercost, and Thomas is buried there near other relatives. But he does not seem to have been born there and he did not spend

his childhood there, for his father, Joseph, left Cumberland and settled in the village of Longbenton, four miles north-east of Newcastle. There he courted and married, at the age of 38, in February 1793, Sarah Shaw, the daughter of the village grocer, and later succeeded to the business. They had two sons, and the parish registers, verified by the courtesy of Canon P. G. Morgan-Dennis, the priest incumbent of the parish, gives the following dates for their baptisms:

1794, 13 April, John.

1795, 11 October, Thomas.

Thomas, the younger son, was brought up in Longbenton, attended the village school and later the Royal Grammar School in Newcastle before proceeding to Edinburgh to begin his medical studies. His connexions with Longbenton were noted by Drs. Wilks and Daldy in 1868 in the New Sydenham Society publication of Addison's work,¹ but at some time later appear to have been forgotten, together with the correct date of his birth, for Cameron in his history of Guy's Hospital² states:

"Thomas Addison (1793–1860) was elected Assistant Physician four years after Bright. . . . His yeoman forefathers had lived for generations at Banks, near Lanercost, in Cumberland, *where he was brought up* [my italics], a place which he always loved and where he was buried."

The late Dr. Charles Brooks, a practitioner in Longbenton, was greatly interested in Addison's association with his birthplace and published details in the *Newcastle Medical Journal*,³ and through this interest the nearby secondary school has been given the name of Thomas Addison. It seems his association with Northumberland and Newcastle upon Tyne should be more widely known.—I am, etc.,

F. J. W. MILLER.

Department of Child Health,
University of Newcastle upon Tyne.

REFERENCES

- 1 Wilks and Daldy, *A Collection of the Published Writings of the Late Thomas Addison*, 1868, p. X. London.
- 2 Cameron, H. C., *Mr. Guy's Hospital 1726–1948*, 1954, p. 130. London.
- 3 Brooks, C. M., *Newsc. med. J.*, 1963, **27**, 255.

** We have shown the above letter and others received on the subject to the Clerk of the Governors, Guy's Hospital, who writes: "Cameron's statement in *Mr. Guy's Hospital* that Addison was brought up in Cumberland is to some extent misleading, but it is generally known from the *Dictionary of National Biography* and other sources that he was born and received his early education in Newcastle. On this point Wilks and Bettany, in their *Biographical History of Guy's Hospital*, published in 1892, recorded that 'It was by accident of birth he was a Northumbrian, but in blood and origin he always regarded himself as Cumbrian.' I am, however, indebted to Dr. Miller for pointing out that Addison was born in 1795, and not 1793, the year given in the three works I have named."

"I would like to take this opportunity to add that, contrary to what was said in the text with which the *B.M.J.* was provided (3 February, pp. 307–308), Bright's younger son (by his second marriage) was a doctor practising in Cannes and not an Anglican vicar in the same town. Thus, one of his sons became Master of University College, Oxford, and another a doctor who practised in Cannes."—Ed., *B.M.J.*