same. When it came to weight changes, I found that all but one of the 12 patients lost weight while receiving Sintison (2–12 lb. (1–5 kg.) in 28 days) and one patient gained 2 lb. (1 kg.) in 28 days while receiving Sintison. A fact which emerged at the end of the evaluation was that the maintenance dose of Sintison calculated as prednisolone was lower than that of prednisolone.

On the basis of these findings there would appear to be at least two advantages in using Sintison: one the lesser water retention, and the other lower maintenance dose. I feel that if these findings can be confirmed Sintison may prove to be particularly useful in the long-term management of many conditions, not least the asthmatic patient.—I am, etc.,

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T. W. DAVIES.

REFERENCES

- James, D. Geraint, *Hosp. Med.*, October 1967 2, No. 1, p. 7.
- Sacchetti, G., Tosolini, G., Ezechieli, S., and Bergamini, N., *Lancet*, 1966, 1, 1329.

Aphthous Ulceration

SIR,—In your leading article (20 April, p. 131) you give a formidable list of suggested causes of recurrent aphthous ulcers. Now the odd thing about these ulcers is that they seem most common in healthy people with otherwise healthy mouths, and I believe there is one simple cause you did not stress—namely, trauma. In a comprehensive survey of this condition Sircus, Church, and Kelleher¹ mention that “local trauma seemed to play a part in some cases, but nothing definite of this nature had been observed by the majority of patients.”

I consider that three types of trauma can result in characteristically sited recurring mouth ulcers.

(1) Pressure from ill-fitting dentures, causing single ulcers in the buccal or lingual sulcus.

(2) Accidental biting of tongue or cheek, or irritation from a jagged tooth causing single or small groups of ulcers.

(3) Overenthusiastic use of toothbrushes, particularly the worn, curled, nylon type, causing crops of ulcers on the buccal mucous membrane, the lateral margins, and inferior aspect of the tongue (rarely in the midline of the dorsum except at the tip).

In this third group come many of the cases of recurring crops of aphthous ulcers seen in practice today, and I have found the simple cure is to advise the patient to use a natural bristle toothbrush. After being in use for some time nylon brushes become very hard and curl considerably. When the teeth are brushed with the correct rotating motion the curled very sharp nylon is directly pointed at and can easily penetrate the buccal mucosa or the tongue, each penetration site being a potential aphthous ulcer. The usual distribution of these ulcers corresponds closely to the areas of maximum contact with a curled nylon brush. The peculiar intermittent nature of these crops of ulcers may be explained by the fact that alleviation occurs with the purchase of a new toothbrush. Relief is obtained until the bristles harden and curl once more and again traumatize the tissues. Alternatively, when ulcers are present, brushing must be done

gently to avoid pain—this would also tend to produce a temporary remission. To date I have not observed the classical recurring crops of aphthous ulcers in edentulous patients or in those with badly neglected unbrushed teeth.

Sircus *et al.*¹ give no statistics about the dental condition of their patients, but their graph of the age of onset of ulceration shows a clear relationship to what might be called the toothbearing, toothbrushing age (highest incidence in the 10–19 years group, almost nil at 60 years).

I would be interested to know if these observations are borne out by experience in other practices. Meanwhile sufferers from this most unpleasant complaint might well be advised to try the change to a natural bristle toothbrush.—I am, etc.,

Walsall, Staffs.

A. J. MOORE.

REFERENCE

- Sircus, W., Church, R., and Kelleher, J., *Quart. J. Med.*, 1957, 26, 235.

Cervical Cytology

SIR,—I believe that it is generally accepted that ideally cervical smears should be taken not less often than every three years between the ages of 25 and 65. The conscientious general practitioner who works on this basis, once he has taken a smear from those patients on his list who are over 35, can never again collect a fee either for them or for his younger patients as they move into this age group, since the patient has to declare on the claim form that she is over 35 and has not had a smear taken for at least five years.

Now the fee has been increased by 100% from 7s. 6d. to 15s. (11 May, p. 361), which is a further incentive not to take a smear before the age of 35 and then only once every five years. Would it not have been wiser to retain the fee at 7s. 6d. and offer it every three years for the over 25's?—I am, etc.,

Marlborough, Wilts.

T. K. MAURICE.

Paediatric Patterns

SIR,—I enjoyed reading Dr. P. Henderson's article “Changing Pattern of Disease and Disability in Schoolchildren in England and Wales” (11 May, p. 329), but beg to query the statement that “responsibility for deciding the type of educational arrangement most appropriate for handicapped children rests with the local education authority; this is primarily an educational matter.” If by “local education authority” is meant the school health service administered by doctors I would have no quarrels with this statement, but would disagree if the primary professional person concerned is a teacher or psychologist.

The assessment—and on such an assessment depends the appropriate placement of any type of handicapped child, be the latter physically or mentally disabled—is largely a medical deliberation, and one simply cannot decide his form of educational placement primarily on educational grounds. I would concede that an educational opinion becomes ultimately necessary, but that it should not take precedence over a medical one. If this were to happen we might find a number of

handicapped children subjected to training and teaching techniques far beyond their physical and mental capacity, with the risk of ultimate breakdown. As to more study and research into the disabilities of children, I would wholeheartedly agree, but one finds sometimes that unnecessary obstacles are placed in one's way by some officials who seem to have little conception of what is involved and of methods used.

I am at present investigating the psychiatric disturbances of certain types of handicapped children of school age, and already from the beginning had some education authorities express their uneasiness about the investigation as being possibly too “traumatizing to the children and upsetting to the parents.” From personal experience I have not found it so. On the contrary, parents have almost invariably welcomed any study which tried to elucidate some of the disabilities which afflict their offspring, provided, however, that these examinations and inquiries were undertaken by the doctor himself.

One could well imagine that a number of research projects, and all medical people are agreed that these are essential for furthering our knowledge of handicaps, might be stifled by the education system if they were in sole or main control of establishments for disabled youngsters. Therefore I contend, Sir, that the evaluation of handicapped children is primarily a medical one, and let us keep it that way.—I am, etc.,

London N.3.

U. P. SEIDEL.

Two for the Price of One

SIR,—In his letter “Two for the Price of One” (11 May, p. 364) Dr. Hugh Gainsborough comments on and criticizes the Ministry's publication *Rationalization of Planning and Design, 1968*, issued in connexion with the twin hospital project at Bury St. Edmunds and Framley (13 April, p. 113).

A number of the matters he raises are questions of judgement or detail, and the publication sets out the consideration on which the Ministry's proposals, accepted by both the regional hospital boards concerned, are based. I do not propose in this letter to pursue these individual points, but I must emphatically repudiate his claim that the Department has misrepresented the position. On the contrary, all the points discussed in Dr. Gainsborough's letter are fully set out in the publication, and have been discussed with numerous professional and lay audiences. The Department has nothing to hide on this matter.

In general, however, I ought to point out precisely the terms of the main claim made on behalf of this project. To quote the words of the Minister of Health at his press conference on 1 April 1968: “It is likely that the *acute hospital requirements of these two areas* will be met by new hospital construction and the development of some existing facilities, costing in all little more than what would have been needed to provide on a more traditional basis for one such area.” Moreover, though the ward accommodation is, as Dr. Gainsborough says, based on an occupancy of two per 1,000, the treatment and diagnostic facilities are at least as substantial as would be appropriate for a traditional