tary proteolytic enzymes. Each patient should ideally be assessed individually by measuring the optimum amount of protein they can manage to achieve positive nitrogen balance. Excessive protein in the large bowel may merely exacerbate the symptoms which the low-fat diet has been introduced to control.—We are, etc.,

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Side-effects of Phenindione

SIR,—I was interested to read Dr. D. C. Lyon's case report of intussusception complicating phenindione therapy (11 May, p. 345), and no doubt, as he suggests, the increasing use of long-term anticoagulants as an adjunct to the management of such common conditions as coronary thrombosis, cerebrovascular accidents, thrombophlebitis, and recurrent pulmonary embolism makes an awareness of the possible hazards of such therapy important.

Minor side-effects, such as fleeting skin rashes during the first 10 days, and discoloration of the urine, have been described since the early days of its use and can be ignored.¹ In 1966 three cases of paralytic ileus in patients on phenindione therapy were reported,² and later A. G. Nash reported a similar case.³ We could find no cause to explain the occurrence of paralytic ileus in these patients,² and it was suggested that the ileus was due to the toxic effect of phenindione, and may have relevance to the suggestion of Burns and Desmond,⁴ that sensitivity to phenindione may be due to the presence of a potentially toxic modified benzene ring in the compound.—I am, etc.,

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Ethics and Abortion

SIR,—As Mr. John Frampton has pointed out in your columns (4 May, p. 298), arguments among colleagues on their approach to social indications for abortion are inevitable. My colleagues in the professional unit here try to evolve "policies," but often there is honest doubt, and the patient is then admitted for full clinical examination and perhaps mild sedation to ensure sleep. The final decision is taken by a team starting with the family doctor, the gynaecologist, and usually a consultant psychiatrist. Full clinical appraisal takes note of the social pressures deemed to be making an impact on the patient's health. Just how much account is taken of these social factors naturally varies from one hospital colleague to another, and equally from one family doctor to another. In the final decision the gynaecologist must obviously be in agreement before consenting to operate. If the patient disagrees with the opinion of the medical team then she is directed to

another respected consultant, provided her family doctor is in agreement.

But even whole communities may differ considerably in their approach to abortion. Thus two cities, each offering a high standard of medical ethics and obstetrical care, may differ widely. For example, Aberdeen carries out abortion or abdominal hysterotomy in one in 50 pregnancies. In Glasgow¹ the rate is one in 3,750, and without doubt social and economic pressures in the slum areas of Glasgow overshadow Aberdeen. No doubt in ten years Aberdeen and Glasgow will have rethought their policies, and left to themselves, with their long-term results available, they will reach correct decisions for the future. But will they be left to work out the proper role of abortion as therapy? Already in the Midlands hospital and private abortion practice are in competition. A telephone number is freely available in Birmingham to a so-called "social worker" who in turn will pass the name and address of a "sympathetic doctor." This private group, headed by the local chairman of the Abortion Law Reform Association, also plan a private abortorium with surgical help imported from another city on a fee-for-service basis.

Thus my colleagues and I in hospital practice have outpatient appointments made by our colleagues in family practice with a postscript to the letter asking for an appointment as follows: "I do not expect she will turn up—she waved the Pregnancy Advisory Bureau pamphlet at me as she departed!" So we still have the Abortion Law Reform Association working hard in a new guise for easy abortion-on-demand for healthy women under social or economic pressure. If the N.H.S. will not provide this an abortion service (for suitable fees) can be arranged. All that is required is that the nursing-home or abortorium is duly registered at the Ministry of Health. Everything turns on this permission, and the medical fraternity in the Midlands is watching the position very closely.

To the Scots and Northern Irish (unaffected by the Abortion Act) all this must sound far removed from the cool academic approach of Aberdeen, where no fees change hands and all abortions are carefully weighed and when necessary carried out in hospital, not as a social service, but as part of medical care. But perhaps Glasgow should look out for its first abortion missionaries—one abortion in 3,750 will never do.—I am, etc.,

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REFERENCE

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Mastectomy Stand

SIR,—I was interested to see the apparatus described by Mr. G. R. Clarke and others (18 May, p. 431) to facilitate bandaging after radical mastectomy. For many years now we have used a very simple device for achieving precisely the same result as the mastectomy stand following such operations as mammaplasty or the grafting of chest burns. It consists of a length of board 42 in. × 6 in. (105 cm. × 15 cm.) covered on both sides with

nylon film. This is inserted from the head end lengthwise beneath the patient's spine, and when the free edge is raised by an assistant it supports the patient's back and head as on an inclined plane. The bandages are then applied round the chest incorporating the board. Once the dressings have been secured in this way, the board is withdrawn. Preliminary greasing of the board's surfaces with petroleum jelly ensures its easy and smooth withdrawal. An advantage of this simple board technique in plastic surgery is that it may also be used to facilitate bandaging the neck and shoulders following grafting of these areas or the axillae. A further advantage is the low cost, a few shillings compared with the £35 for the mastectomy stand.—I am, etc.,

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SIR,—Following the interesting solution to the problem of mastectomy bandaging by Mr. G. R. Clarke and others (18 May, p. 431), I am prompted to suggest an alternative dressing. Two suction drains of the Redivac or Sterivac type are employed, and the wound sealed with Nobecutane and a strip of ribbon gauze. This method avoids the problem of bandaging with its disadvantages of application, reduction of chest movement, and discomfort to the patient. It has the added advantages of allowing inspection of the wound and skin flaps without removing and replacing cumbersome bandages. There is less risk of cross-infection, and the suction ensures immediate and constant apposition of the skin flaps to the chest wall with consequent improvement in the rate of healing.

The method is also applicable to operations other than mastectomy.—I am, etc.,

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Paracervical Block with Bupivacaine

SIR,—With reference to Mr. D. H. Gudgeon's article on paracervical block with bupivacaine 0.25% (18 May, p. 403), we agree that this technique provides a valuable method for the relief of pain in labour. However, we would like to draw attention to several alarming episodes of foetal bradycardia following the use of the 0.5% solution (containing 1:200,000 adrenaline) which have caused us, like Mr. Gudgeon, to abandon its use. Several cases of extreme foetal bradycardia were seen following the injection of 2 × 10 ml. of 0.5% bupivacaine into the paracervical space, one of which culminated in intrauterine death 20 minutes after the performance of the block. Since this time we have used a 0.25% solution (containing 1:400,000 adrenaline), under strictly controlled conditions of foetal monitoring, but so far without any evidence of foetal distress, and with little decrease in duration of action. There would therefore appear to be no good indication for using the stronger solution, and indeed it may be positively contraindicated.

The suggestion that the adrenaline contained in the solution may be responsible for these effects, perhaps by interfering with the utero-placental circulation, is under investigation. It is of interest to note that analgesic solutions without adrenaline have also been shown to cause foetal bradycardia.¹

In view of the increasing popularity of this technique since the introduction of Marcaine (marketed in 10-ml. ampoules containing bupivacaine 0.5% + adrenaline 1:200,000) we feel that these effects should be more widely known and that the use of the undiluted solution should be actively avoided.—We are, etc.,

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REFERENCE

- ¹ Page, E. P., Kamm, M. L., and Chappell, C. C., *Amer. J. Obstet. Gynec.*, 1961, **81**, 1094.

Childhood Asthma

SIR,—Childhood asthma is a common condition. The incidence was 1.76% of Birmingham schoolchildren.¹ One-third of all cases of asthma have their onset during the first decade and in one out of four such sufferers the onset dates from the first year.²

At this age the diagnosis is entirely clinical. B.B.C.2's programme of 2 May, "Medicine Today," was most confusing. To the concept that asthma is variable airflow obstruction a new factor,^{3 4} the lability index, is now introduced.

Dr. R. S. Jones (1966)^{5 6} is to be congratulated on this test for latent asthma in hay-fever subjects and in the quiescent young adult asthmatic; but this is essentially a respiratory laboratory procedure, and, while furnishing further physiological evidence for the mechanism of asthma, does not benefit the practitioner in the sickroom, particularly as it can be performed only in children over the age of 6 years. Moreover, the complementary article on hyposensitization in childhood asthma (25 May, p. 478) further increases the confusion by reverting to clinical causation. It has been found in the paediatric department of the Prince of Wales Hospital, Tottenham, that skin tests can be of value from the age of 6 months onwards, and if the prick technique is adopted they are not upsetting either to the young or to the nervous child. Moreover, the results have not been affected in any way by the use of steroids. This too has been the experience of Harley.⁷ The article further stresses the removal of allergens in allergic asthma. This is indeed the most important of procedures and should precede any form of desensitizing. In children aqueous solutions or the alum-precipitated extracts are the only solutions to be used. There is no place for the repository method of desensitization in childhood. It is of value only in adults for pollen asthma, but in view of the local and general reactions which may occur it is doubtful whether it should be used at any time.⁸—We are, etc.,

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Osgood-Schlatter's Disease in the Ninth Century?

SIR,—The abnormal tibia described here was found in the Late Saxon burial ground of St. Catherine, Thorpe, Norwich, and can be dated on archaeological evidence to about the ninth to tenth century A.D. It is now in the Castle Museum, Norwich (Acc. No. 15.953(9)).

It comes from a well-preserved but incomplete body of a middle-aged man. Both tibiae are in perfect condition. The right one is normal, but the left has a defect at the tuberosity. This defect consists of an approximately rectangular trough about 30 mm. long by 20 mm. wide. Its floor is rough and irregular and at its deepest point is about 10 mm. below the normal level of the tuberosity. Distal and medial to this area the bone is somewhat rougher than normal, while the head of the bone anterior to the fibular articulation is exceptionally rough and craggy.

In the inevitable absence of a clinical history it is impossible to be absolutely certain what this lesion is, but several diagnoses suggest themselves. The tibial tuberosity develops from a downward projection of the proximal epiphysis. This may occasionally be detached from the shaft of the bone and develop as a separate ossicle which takes the insertion of the main part of the quadriceps tendon. It is possible that such an anomaly led to the condition found in

this specimen, but the appearance of the trough is against this explanation, because under a detached ossicle the bone is usually much smoother and more regular than is found here. Another possibility is that it represents a traction fracture of the tuberosity. In this a flake of bone is torn away from the shaft. Separation may be incomplete, however, and the avulsed flake, which is usually thinner than the depth of this trough would indicate, may remain attached to the rest of the bone by callus. Traction fracture seems an improbable diagnosis in the present case, even though the roughness of the floor of the lesion is compatible with it.

By far the most likely condition here is Osgood-Schlatter's disease. More than 60 years after its first description there is still uncertainty about its cause. In May, as Brailsford¹ thinks, be due to injury of the chondro-osseous union between tuberosity and shaft from a sudden violent contraction of the quadriceps extensor muscles. Schlatter² thought it was due to apophysitis of the descending process of the epiphysis. On this view it may perhaps be grouped with such osteochondritic lesions as those described by Köhler, Kienböck, Scheuerman, and others.³ Whatever the cause of the Osgood-Schlatter lesion, its clinical picture and morbid anatomy are clear enough. Its

FIG. 1.—Right and left tibiae of Late Saxon date. The left tibia shows probable Osgood-Schlatter's disease.

FIG. 2.—The medial view of the same tibiae. (The left tibia is here on the right of the plate.)