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.,

CHRISTOPHER RUOSS.
Queen Charlotte's Maternity Hospital, London W.6.
JOHN M. BEAZLEY.
Jessop Hospital for Women, Sheffield.

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 hayfever 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.,

H. BLAIR.
I. M. ANDERSON.
Prince of Wales Hospital, Tottenham, London N.15.

REFERENCES

1 Smith, J. M., *Brit. med. J.*, 1961, **1**, 711.
2 Bray, G. W., *Recent Advances in Allergy*, 1937, 3rd ed. London.
3 Ciba Guest Symposium, *Thorax*, 1959, **14**, 286.
4 American Thoracic Society, *Amer. Rev. resp. Dis.*, 1963, **85**, 762.
5 Jones, R. S., *Brit. med. J.*, 1966, **2**, 972.
6 Trefor Jones, R. H., and Jones, R. S., *Brit. med. J.*, 1966, **2**, 976.
7 Harley, D., *Practitioner*, 1960, **184**, 421.
8 Blair, H., *J. Coll. gen. Practit.*, 1968, **15**, 317.

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 Brailsford[1] thinks, be due to injury of the chondro-osseous union between tuberosity and shaft from a sudden violent contraction of the quadriceps extensor muscles. Schlatter[2] 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

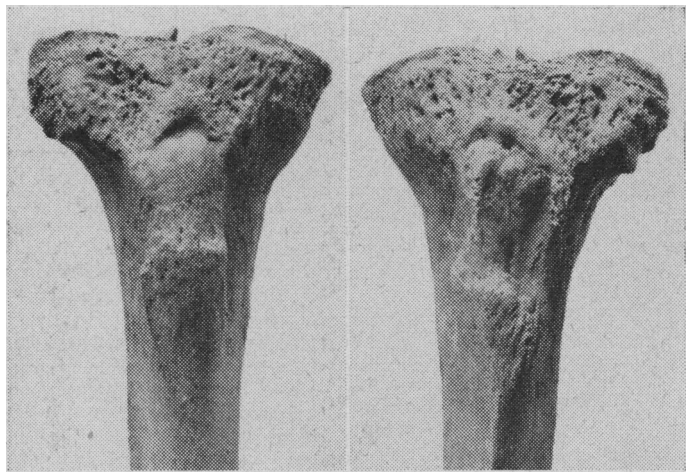

FIG. 1.—Right and left tibiae of Late Saxon date. The left tibia shows probable Osgood-Schlatter's disease.

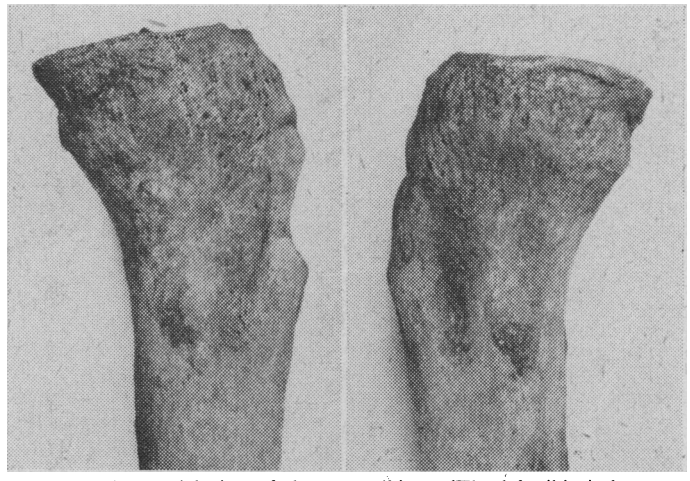

FIG. 2.—The medial view of the same tibiae. (The left tibia is here on the left of the plate.)