routine internal examination deters many of the patients we should most like to see at the post-natal clinic. They avoid the doctor by attending the local authority clinic. Assuming a normal history, as already outlined, then I am not at all convinced of the value of a vaginal examination. What treatable condition am I supposed to discover? My limited experience leads me to believe my time would be more usefully spent pursuing some of my other obligations to the mother and child.

(2) I check her weight and give advice if necessary.

(3) I check her blood pressure and act accordingly.

(4) I take a routine venous specimen of blood for haemoglobin estimation.

This routine specimen of blood could be criticized on the grounds that it causes unnecessary pain to the patient; the local laboratory receive yet more quantitative estimations to perform; and that I should use my clinical judgement and do a haemoglobin on those "at risk"—that is, social class IV, those that lost above average amounts of blood during labour, and those with borderline haemoglobin prior to confinement (this is checked on first visit and at 32 weeks).

I would reply that I do not trust my eyes as far as haemoglobin is concerned, and that having discovered anaemia I can at least do something about it.

I do not examine urine routinely at the post-natal consultation (I do so at each consultation during pregnancy), but I do ask for a specimen of urine if there is any history of albuminuria.

(5) We discuss contraception and family planning. This often takes more time than the previous four procedures together — and deservedly so.

The ideal is seldom achieved and I would be grateful for comments on these routine measures. Are we concentrating on those things that matter most or are we spending time carrying out procedures motivated by teaching and habits rather than critical assessment of what is of greatest long-term value to the mother and child?—I am, etc.,

Middlesbrough.

IAN CAPSTICK.

Aphthous Ulceration

SIR,—As the aetiology and effective therapy for this common condition remain problematical, may I record experiences both as patient and physician.

Suffering from very extensive and recurrent aphthous ulceration as a student, I sought the advice of the late Mr. Cobb, of Sheffield, well before the era of antibiotics. He prescribed a mouthwash of a saturated fresh solution of chlorate of potash with the addition of a little phenol and glycerin, to be used before and after meals as well as night and morning, emphasizing that old solutions were valueless, as are tablets.

The treatment was rapidly effective and has been of great value to many patients, aborting attacks if used early and frequently enough.

The early lesion in the mucous membrane has the appearance of a small blood blister. Once it breaks down it rapidly extends into a painful ulcer, presumably by bacterial colonization.

I believe that freshly made solutions frequently applied, and of course as early as possible, will still be found to be very efficacious.—I am, etc.,

S. HOWARD FERGUSON.

Florida State Board of Health,
Jacksonville, U.S.A.

Price of Blood

SIR,—We agree with Dr. A. J. Zuckerman's arguments (20 April, p. 174) against the payment of blood donors, but we wish to draw attention to our own recent survey¹ of the incidence of anicteric hepatitis following blood transfusion in Birmingham. No case was found among 42 patients who received 128 pints of blood, suggesting that the incidence in this country may indeed be much lower than in the countries cited by Dr. Zuckerman.

We were unable to determine whether this relative immunity was due to a low incidence of viral hepatitis in the community or to the simple methods used to exclude donors who might be potential carriers. We feel, however, that it would be extremely unwise to adopt a system which has been shown to attract donors who display an increased incidence of abnormal liver-function tests,² and whose blood gives rise to serum hepatitis more often than that given by volunteers.³—We are, etc.,

W. D. STONE.

B. N. SOMAYAJI.

Dudley Road Hospital,
Birmingham 18.

REFERENCES

- ¹ Somayaji, B. N., Stone, W. D., and Glover, P. B., *Gut*, 1967, 8, 614.
- ² Norris, R. F., Potter, H. P., jun., and Reinhold, J. G., *Transfusion* (Philad.), 1963, 3, 202.
- ³ Grady, G. F., Chalmers, T. C., and the Boston Inter-Hospital Liver Group, *New Engl. J. Med.*, 1964, 271, 337.

Overcrowding in Psychiatric Hospitals

SIR,—In replying to my letter (13 April, p. 116) with regard to overcrowding in psychiatric hospitals, Dr. Martin Davies (27 April, p. 240) discusses the problem of community care. Surely the community doctor is the general practitioner? The hospital doctor should not be going out doing the general practitioner's work for him. If this is done an expensive duplication of care will follow.

I do not think that Dr. J. C. Barker (4 May, p. 300) should be unduly concerned about "revolving doors" at Rubery. Surely these are preferable to locked closed doors, and psychiatry is in the main concerned with recurrent illnesses. The patient should be kept in the community as much as possible and there follows an escalation into better mental health. This has been noted time and time again at Rubery Hill Hospital. And Dr. Barker is surely using wrong techniques in handling a large long-stay population by individual interview methods. He should be employing ward conference and group review methods and not the cumbersome time-consuming individual interview. Group methods have many therapeutic benefits, as has been shown in the development of therapeutic communities. At Rubery Hill in my own unit every ward is using ward conference and case conference review techniques with full use of group meetings. These methods have enabled every patient in the unit's 12 wards to be under full review and close medical supervision by the consultant. The results I described in my letter. I would add that in the last six years only 35 patients have become long-stay patients, and all of these have organic dementias. This is out of a total of about 3,500 admissions during this period.

One can only view with grave concern the practice of locking hospital patients into wards. There is absolutely no need for this dangerous obnoxious practice. In my own unit at Rubery Hill Hospital, which mainly comprises the male half of the hospital, there is not a single locked door.

The usual pleas for more and more staff have been made. It is my view that what is needed is better deployment of medical staff and more energy and enthusiasm on the part of consultants, who should mainly concern themselves with active patient management and care. It must be remembered that half of all hospital beds in this country are occupied by psychiatric cases. The general use of techniques now fully employed at Rubery Hill Hospital would save the National Health Service hundreds of millions of pounds every year and would rapidly produce an excess of hospital beds throughout the country.—I am, etc.,

CHARLES ENTWISTLE.

Rubery Hill Hospital,
Birmingham.

Design for Ambulances

SIR,—Mr. P. S. London (see leading article, 11 May, p. 318) and Dr. P. W. Bothwell (11 May, p. 366) it is hoped will have helped in their respective spheres to achieve the construction of an ambulance worthy of our era. We all know what "shocking" things they are now.

What is needed is not a better vehicle, but a designed unit installed in a vehicle, be it a Daimler suspension, a car (car ambulance), or a van. This unit should be installed as easily and cheaply as possible, and it should eliminate vibration, sway, shock, set, and drift, and have associated wide load range. Also incorporated should be adjustment for level travelling or head up or down position.

This is not a car manufacturer's problem or such a big problem as it seems. In fact there are available components to eliminate vibration, etc., but to my knowledge positioning needs some further research to make the unit a *fait accompli*.—I am, etc.,

Ryde,
Isle of Wight.

TREVAN HAMBLY.

Bacillary Dysentery

SIR,—It is regrettable that a comprehensive article on bacillary dysentery (4 May, p. 285) should have to be criticized on the grounds of omission. In discussing treatment, no mention is made of colistin sulphate, although a recent paper¹ reports a 73.3% success rate in eradicating *Shigella sonnei* or *Sh. flexneri*. The criterion used in evaluating these cases was the occurrence of six consecutive negative dismissal swabs. This substantiates previous work² demonstrating the efficacy of colistin sulphate against *Sh. sonnei*.

While these are encouraging therapeutic results, their importance is more apparent in the light of the findings of Smith and Armour.³ While studying the phenomenon of extrachromosomal transferable resistance (R factor) they observed that resistance to the polymyxins (of which colistin is a

member) was not in fact transferred from organism to organism. R factors carrying resistance to as many as six antibiotics (including streptomycin, neomycin, and sulphonamide) could, however, be transferred between species as well as between individual strains. R factor transference seems at the moment to be confined to enteric bacteria (*shigella*, *Escherichia coli*, salmonella), and the importance of having an antibiotic such as colistin sulphate, specific against such groups of organisms, is self-evident.—I am, etc.,

A. D. S. CALDWELL.

Pharmax Ltd.,
Dartford, Kent.

REFERENCES

- ¹ Lamb, R., *Scot. med. J.*, 1968, **13**, 9.
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Medical Examination of Immigrants

SIR,—In view of the letter from Lieutenant-Colonel H. C. M. Walton (18 May, p. 427) I would refer to my previous letter (8 April 1967, p. 111) and that of Dr. G. L. Robinson (25 December 1965, p. 1547). In both the problem of the medical examination of immigrants was presented and a remedy proposed in the form of "clearing stations" in this country through which immigrants would be channelled and to which they could return as necessary. Medical needs are only part of this problem, but a hospital staffed by those who have some knowledge and understanding of other races (and the Dreadnought Seamen's Hospital has already been mentioned as an obvious example) would form the right type of nucleus.—I am, etc.,

D. A. C. PRICE,
Secretary, Dreadnought Seamen's
Hospital Management Committee.

London S.E.10.

Safety of Chloral

SIR,—In your issue (18 May, p. 409) your contributor has, I hope, written something which will rescue chloral hydrate from undeserved oblivion as a hypnotic. He described it as relatively non-toxic. In fact, I wonder if a case of poisoning from an overdose of chloral hydrate has ever been reported. If it were possible I think I should have killed someone myself, so liberal was my usual dosage. As a single-handed doctor in the country about 40 years ago I used it as a routine in all confinements. Encouraged by the advice of Trousseau and Pidoux,¹ I gave 60 gr. (4 g.) at the commencement of the second stage and repeated 20 gr. (1.3 g.) every quarter of an hour until the patient was sound asleep, only half waking with each pain. This went on as long as labour lasted; 120 gr. (7.8 g.) was usually needed to keep the patient sleepy enough. In one prolonged labour lasting about 20 hours the total amount of chloral spread over that time was 380 gr. (25 g.). The woman woke quickly, like all the others, probably from the amount of water taken to dilute the chloral aided by the loss of blood in the third stage.

I have lived since to disguise the bitter taste of the stuff, which, unless freely diluted,

sometimes causes vomiting. Beer, bitter beer, the more bitter the better, was recommended to me by a friend much addicted to that fluid, and, luckily for my knowledge of chloral, suffering from insomnia. I rather think (but I am not sure) that this was the Micky Finn slipped into the beer of sailors in public houses in the days of the press-gang. In a pint of beer a gramme or two of chloral would hardly be tasted and for safety would be preferred to laudanum, as naturally enough the press-gang wished their prisoners to stay alive.—I am, etc.,

London W.1.

A. J. HAWES.

REFERENCE

- ¹ Trousseau, A., and Pidoux, H., *Treatise on Therapeutics*, 1880, 9th ed., trans. D. F. Lincoln. New York.

Nutritional Folate Deficiency

SIR,—Patients with chronic renal failure who have severe terminal renal insufficiency are maintained on prolonged dietary restriction, using low-protein intakes or modified Giovanetti diets, and can develop suboptimal folate stores. When these patients enter regular dialysis treatment programmes, and lose significant amounts of folate during dialysis they commonly develop megaloblastic marrow changes.¹

These findings have been confirmed in our department, and we feel that this group of patients should be included in a review of nutritional folate deficiency (18 May, p. 377). I am, etc.,

J. C. MACKENZIE.

Renal Dialysis Unit,
St. Bartholomew's Hospital,
London E.C.1.

REFERENCE

- ¹ Hampers, C. L., Streiff, R., Nathan, D. G., Snyder, D., and Merrill, J. P., *New Engl. J. Med.*, 1967, **276**, 551.

Vaccinia in a Professional Boxer

SIR,—A professional boxer, aged 25, on 9 April fought a contest with a boxer who had recently arrived from Canada. During the fight close physical contact occurred, especially during clinches. His past history consisted of chicken-pox during childhood but was otherwise unremarkable. There was no reliable history of previous vaccination against smallpox.

On 13 April he noticed pain in the left ear followed by a vesicular eruption over the left side of the face and scalp. Initially a diagnosis of herpes zoster was considered. When I first saw him on 17 April his face and neck were swollen and the eruption was more extensive than previously, involving the left arm. On questioning, the patient had noticed that his opponent had two scabs on his arm consistent with recent vaccination marks. A diagnosis of vaccinia was made, and the patient was admitted to Rush Green Hospital, Romford, under the care of Dr. G. D. W. McKendrick, consultant in infectious diseases.

On admission general condition was good; no jaundice. Glands in the left posterior triangle were tender. Few scattered, pustular, erythematous eruptions noted on face, neck, scalp, left shoulder, arm, and axilla. Pulse 80/min., regular. Blood pressure 130/70 mm. Hg. Tem-

perature 98.4° F. (36.9° C.). Nothing abnormal in heart, lungs, throat, and tonsils.

Investigations: Haemoglobin 92%. White blood cells 5,500 per cu. mm.; neutrophil polymorphs predominant. Erythrocyte sedimentation rate 5 mm. in first hour. Throat swab and midstream specimen of urine normal. On 18 April blood culture was sterile; it was likewise sterile after two weeks' incubation. On 19 April swab from left eye, pus from eruptions, and swab from pustules all showed *Staphylococcus aureus* on culture. Chest x-ray showed heart shadow enlarged and pulmonary vascular markings increased.

The diagnosis of vaccinia was confirmed on egg culture and by gel-diffusion test. No specific treatment was given, and the patient was discharged on 3 May. Most of the lesions had dried, scabbed, and the scabs had fallen off.

In this case the evidence is strongly in favour of a transfer of vaccinia virus from one person to the other through physical contact. It is suggested that contests of this nature should not take place if one of the persons involved has incompletely healed vaccination lesions. Furthermore, any form of contact with lesions of this type should be treated with great caution, and if such contact is inevitable appropriate measures should be taken to ensure that no possibility of inoculation of the virus into susceptible individuals can occur.

I acknowledge the help of Drs. G. D. W. McKendrick and J. M. Medlock for their co-operation in allowing the use of their findings and pathological report.

—I am, etc.,

D. D. COWEN.

Hornchurch,
Essex.

Drug Addiction Treatment Centre

SIR,—As is well known through reports in the national press, there is a problem in Welwyn Garden City of abuse of heroin and methylamphetamine by young people. The North-west Metropolitan Regional Hospital Board established at short notice a treatment centre in the town without any prior consultation with local general practitioners, the medical officer of health, the hospital consultants, or junior staff. The R.H.B. was presumably acting on instructions received from the Ministry of Health.

The matter was raised at the Annual General Meeting of the East Herts Division of the B.M.A. The meeting considered this blatant disregard of the opinions of the local profession in all branches of the Health Service to be deplorable, particularly as many of the doctors were already involved in treating and advising addicts and their families. In consequence this Division has forwarded a motion for debate at the A.R.M., as it was considered to be a matter affecting all branches of the profession. The latter will, no doubt, object to Ministry control by edict. The meeting also instructed me to send this letter to you, Sir, on its behalf.

The Division's representatives in the R.B. are anxious to know if other treatment centres have been set up in this manner elsewhere in the country.—I am, etc.,

J. A. HERSEY,
Honorary Secretary,
East Herts Division
of the B.M.A.

11 Whitehorn Lane,
Letchworth, Herts.