About 100 general practitioners on the research register of the Royal College of General Practitioners have agreed to take part in a larger study, which it is hoped will confirm these findings. This investigation is about to start, and documents to record data are being distributed.

More participants will be welcome. May I, through these columns, ask interested general practitioners to write to me for further information.—I am, etc.,

H. R. PLAYFAIR

47 Wolseley Road, Plymouth PL2 3BJ

¹ Blair, R. A., Gilmore, J. S., Playfair, H. R., Tisdall, M. W., and O'Shea, C., *Journal of the Royal College of General Practitioners*, 1970, 19, 22.

Insulin and Oral Therapy in Diabetes

SIR,—We were interested in the paper by Drs. A. M. Tomkins and A. Bloom (11 March, p. 649). Our own experience at the Diabetic Clinic, Kingston, Jamaica, suggests that insulin therapy too may be needed less often than is generally realized.

One hundred consecutive diabetic patients (average duration of disease 2.7 years) were given an intensive course of re-education in the principles of dietary control. Obese patients (that is, those over 110% of ideal weight), who numbered 51, were usually put on an 800-calorie diet initially. Once proper carbohydrate restriction was practised (usually for the first time in the diabetic's life), only 7% of patients needed insulin for satisfactory control (as adjudged by a two-hour postprandial blood glucose of under 170 mg/100 ml and regular sugar-free urine tests). This compares with Dr. Bloom's figure of 26% among United Kingdom patients.¹

Of course, it may be that the patterns of diabetes in the United Kingdom and in Jamaica differ markedly. We would ask that a physician who sees an apparently insulin-dependent West Indian diabetic for the first time should bear in mind the possibility that the patient might be controlled without need for insulin. This is sometimes practicable even when the diabetic is young, thin, and initially ketotic.—We are, etc.,

G. S. HUMPHREYS

University of the West Indies
Kingston, Jamaica

D. G. DELVIN

Chislehurst, Kent

¹ Bloom, A., *Postgraduate Medical Journal*, 1969, 45 (Suppl. May, p. 5)

Care of the Mentally Handicapped

SIR,—Dr. A. Kushlick (11 March, p. 686) unfortunately appears to have misunderstood my letter (29 January, p. 308). Far from regarding improvements of living conditions and provisional facilities in hospitals as "unnecessary luxuries," I have attempted to draw attention to unacceptable living conditions for patients, and to inadequate facilities in hospitals. I have tried, however, to make the point that in comparing the quality of different forms of care no valid comparison is possible unless the cost of providing it is the same.

The purpose of my letter was to sound a warning note about the way this policy was being implemented, leaving aside the

fact that I consider that the Department of Health and Social Security has committed itself to the provision of community care on inadequate data. If the hospitals are going to be run down, and all improvement in the quality of services in hospitals stopped before adequate alternative provisions are made (which appears to be the case at present), then the hospitals will not be able to meet their commitments to the community they serve, and the present hospital population is going to be condemned to continue living under unacceptable conditions. However exciting and acceptable this prospect may be to people planning services at a distance, they cannot but fail to frustrate and dismay clinicians who will have the continuing duty of caring for their patients.—I am, etc.,

A. SHAPIRO

Harperbury Hospital,
St. Albans, Herts

Cyclophosphamide and Pigmentation

SIR,—Alopecia and acute haemorrhagic cystitis are well recognized side effects of cyclophosphamide, but we would like to draw attention to a case in which pigmentation occurred in the nails and teeth.

A 3-year-old boy was admitted on 11 April 1971 with a six-day history of generalized oedema. A diagnosis of the nephrotic syndrome was made. Initially he was treated with prednisone, but he became severely hypertensive with a blood pressure of 180/145 mm Hg and developed a spontaneous femoral artery occlusion in the left leg just above the knee, which was successfully treated with anticoagulants. Five days later he was started on a six-week course of methylodopa 125 mg t.d.s., and in order to cover the urgent need to reduce the steroids, cyclophosphamide was given in a dosage of 80 mg/day, starting on 1 May. This produced alopecia, and had to be discontinued after one month due to the development of acute haemorrhagic cystitis; but a satisfactory remission was induced.

On 10 May it was noticed that a brown discolouration had developed at the base of the finger and toe nails (Fig.), and there was a brown line on the teeth at the junction with the gums. The changes in the teeth have persisted but those in the nails have grown out.

We can find no reference to methylodopa causing such changes, though the tyrosine/dopa/melanin metabolic cycle might possibly be influenced thereby. Three cases of generalized skin pigmentation occurring during cyclophosphamide therapy have been reported independently by Glazebrook,¹ Rose,² Gibbs,³ Solidoro and Saenz,⁴ briefly mention skin and nail pigmentation as a side

effect of the drug, and one case of generalized pigmentation with darker pigmentation of the nails occurring during treatment of a case of Hodgkin's disease is known to the manufacturers, W. B. Pharmaceuticals Ltd.⁵ We can find no references to pigmentation of the teeth.

We wish to thank Professor N. R. Butler for permission to report this case.

—We are, etc.,

B. MARY HARRISON
C. B. S. WOOD

Department of Child Health,
Royal Hospital for Sick Children,
Bristol

- 1 Glazebrook, G. A., in *Cyclophosphamide*, ed. G. H. Fairley and J. M. Simister, p. 128. Bristol, John Wright, 1964.
- 2 Rose, F. C., in *Cyclophosphamide*, ed. G. H. Fairley and J. M. Simister, p. 120. Bristol, John Wright, 1964.
- 3 Gibbs, A. E., in *Cyclophosphamide*, ed. G. H. Fairley and J. M. Simister, p. 130. Bristol, John Wright, 1964.
- 4 Solidoro, A., and Saenz, R., *Cancer Chemotherapy*, 1966, 50, 265.
- 5 Simister, J. M., personal communication.

Pyramid Plan for Eye Care

SIR,—Professor J. G. Russell (18 March, p. 739) writes that authorities must strive to achieve the best results with the amount of national income allocated, and brings convincing evidence to show that team effort in a pyramid plan will increase cost-effectiveness and job-satisfaction in the dental service. The eye service has much in common with the dental service. It has a community-based sector (general ophthalmic service) and a school sector; the ratio of community attendances to outpatient attendances to inpatients in dentistry is 370:38:1, in ophthalmology 56:24:1; (in general surgery the ratio is —:3.5:1); it requires expertise and instruments not available in the general medical service; and it is heavily involved in technical procedures which can be carried out by non-medical staff. In the eye service the unique conceptual skills of the ophthalmologist and the technical skills of the ophthalmic optician are squandered,

cost-effectiveness is low, and job-satisfaction is low. There is room for improvement.

In 1944 Squadron Leader Scoular wrote¹ that it was opportune to try to improve the eye service of the nation and suggested that eye clinics should be set up staffed by ophthalmologists and opticians. These clinics would provide sight tests, diagnosis and treatment of disease, and dispensing of glasses and only those requiring operations or special treatment would be sent to hospital. In 1947 the Eye Service Committee in its report² stated "We feel sure that in a service in which ophthalmologists and opticians work together as a team mutually satisfactory arrangements can and will be

made whereby ophthalmologists will delegate to opticians wherever practicable the bulk of refraction work, in the knowledge that such work will be carried out to the entire satisfaction of both professions." In 1948 the introduction of the supplementary ophthalmic service effectively prevented any collaboration between ophthalmologists and ophthalmic opticians, took from the ophthalmologist his right to diagnose and treat his patients, and created a demand for outpatient treatment which the hospital eye service has never been able to satisfy.

The time is again opportune to try to improve the eye service of the nation along the lines suggested by Scouler and Professor Russell. There would be a shift of emphasis from the hospital to a community-based service³ in which diagnosis and treatment would be provided as well as refraction, and ophthalmologists and opticians would work together as a team. At the apex of the pyramid would be the ophthalmic consultant surgeon in hospital; in the next tier would be four ophthalmic specialists (at present graded S.H.M.O., Medical Assistant, O.M.P., or Para 94 appointment) working mainly in the community but also in the hospital outpatient service; in the third tier would be some 16 ophthalmic opticians, and in the fourth dispensing opticians supported by frame stylists and receptionists.

Team effort and a pyramid plan would achieve the best results with the amount of national income available, would increase the sense of commitment of staff to the local population, and exercise the intellect of ophthalmologists and opticians to better advantage.—I am, etc.,

P. RICHARD DAY

Tonbridge, Kent

- 1 Scouler, L. G., *British Medical Journal, Supplement*, 1944, 2, 10.
- 2 Giles, G. H., *The Ophthalmic Services under the N.H.S. Acts 1946-52*. Appendix X. London, Hammond, 1953.
- 3 Office of Health Economics, *Building for Health*. London, O.H.E., 1970.

Prevention of Deep Vein Thrombosis

SIR,—I have followed the correspondence on this subject with interest, particularly on the question of intermittent pneumatic compression of the legs in the prevention of deep vein thrombosis. I would, however, like to put the record straight with regard to the statement made by Dr. N. H. Hills and others in their letter (1 April, p. 49) when they say that their series reported at the Surgical Research Society in July 1971 was the first report. On 21 November 1964 I reported a series of cases treated by intermittent pneumatic compression at the Surgical Research Society and subsequently demonstrated the same method at a symposium at the Liverpool Medical Institute in January 1965, and subsequently reported in the journal of that institute.—I am, etc.,

D. W. BRACEY

Peterborough District Hospital,
Peterborough

Coalminers' Pneumoconiosis

SIR,—Dr. J. P. Lyons and his colleagues (18 March, p. 713) reach a conclusion which is in conflict with the evidence they present. This is that "the excess emphysema in the pneumoconiosis cases, shown in our earlier

paper... is an integral and significant part of the disease." Yet the impairment of ventilatory function which they attribute to emphysema was greater in men without than in those with simple pneumoconiosis. Since there is now good evidence that the radiological category of pneumoconiosis is well related to the dust content of the lungs,¹ the evidence in this paper supports the conclusion that there is no relationship between disability and amount of dust in the lungs which has previously been established in epidemiological studies, and it counters their own conclusion that simple pneumoconiosis is a cause of emphysema.—I am, etc.,

C. M. FLETCHER

Royal Postgraduate Medical School,
London W.12

- 1 Rossiter, C. E., *British Journal of Industrial Medicine*, 1972, 29, 31.

Reduction of Pond Fracture

SIR,—An easy method of reducing pond depressed fractures in infants is described.

A boy aged 5½ months was brought to our paediatric outpatient department with a depressed pond fracture of the left parietal bone. The evening before he had been carried around on the back of a house maid, as is usual in African countries. In the morning the mother noticed a depression in the head. Although at first strongly denied, it was later admitted by the girl that the baby had fallen from her back.

The depression was about 4½ cm in diameter. Physical examination did not reveal any other abnormality; notably no neurological disorder was found. It was decided to use the vacuum extractor to reduce the fracture (Fig.). A suction-cup of 50 mm

diameter was applied over the depression. No anaesthetic was given. Negative pressure was quickly increased to 0.8 kg with the Malström-vacuum hand pump. Suction was kept on for four minutes, after which the cup was removed. No traction was exerted. As soon as the caput succedaneum had decreased, palpation revealed the fracture to be reduced and this was confirmed by one x-ray. After some hours the child was sent home. On subsequent visits the child was found to be perfectly well.

Pond depressed fractures are not rare in Africa because children tend to fall down from the backs of their mothers or nannies. In the last 18 months we have dealt with three cases, of which the first one, in a child of four months, was reduced according to the method described in Hamilton Bailey's

Emergency Surgery.¹ In the second case, an infant of seven months, the vacuum extractor was successfully used. Within the same period the vacuum extractor was used on three occasions to reduce pond depressed fractures sustained in labour. On each occasion a period of 24 hours was allowed to lapse before reducing the fracture. No complications were encountered. In the last of these cases two minutes' suction at 0.8 kg was sufficient.

Although the perforation traction method of reducing pond fractures is quite easy and satisfactory, it is considered that the method here described is even easier and safer, especially in circumstances prevailing in underdeveloped countries. Inadequate surgical asepsis and limited surgical experience of the attending doctor in tropical up-country hospitals could make perforation of the skull hazardous.

The dangers inherent to the use of the vacuum extractor are minimal because the time of suction is short and traction is not exerted.

I wish to thank Mr. C. B. Sedzimir for his encouragement to report the method.

—I am, etc.,

A. VAN ENK

Agogo Hospital,
Agogo (A.A.), Ghana

- 1 Bailey, Hamilton, *Emergency Surgery*, 8th edn., ed. T. J. McNair. Bristol, John Wright, 1967.

Suction Retractor

SIR,—It is difficult to cover the literature thoroughly. The suction retractor described by Mr. Michael Burke (8 April, p. 112) is similar to the one I described in the *Lancet* in 1964.¹ Its use was to retract friable tissue as mentioned in the letter.—I am, etc.,

JOHN SHIPMAN

Lister Hospital,
Hitchin, Herts

- 1 Shipman, J. J., *Lancet*, 1964, 1, 1424.

Recurrent Urinary Infections

SIR,—We think that for the sake of the record we should point out to Dr. H. G. Jones (8 April, p. 113) that Hugh and Andy did not advocate routine tomography at the time of an intravenous pyelogram. It was a chap called Henry (11 March, p. 688).—We are, etc.,

R. HUGH JACKSON
ANDREW SMITH

Children's Department,
Royal Victoria Infirmary,
Newcastle upon Tyne

The Doctor in Conflict

SIR,—Your leading article (25 March, p. 761) deserves comment. In it you state "Moreover, there is no reason to suppose, and no shred of evidence, that any doctor in the recent troubles has departed from the ethical traditions that guide the profession." Yet you do not quote the source of this information. Are we to use traditions as guidelines? If so what role do the Declaration of Geneva and of Helsinki, and the International Code of Medical Ethics, play? I and other doctors in Ireland signed a letter addressed to the General Medical Council requesting an investigation into the behaviour of doctors during the interrogation of detainees. In its reply it said it was not within the province