

the need for scores or hundreds of operations for division or excision of thickened fibrous tissues?—I am, etc.,

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<sup>1</sup> Watson-Jones, R., *Journal of Bone and Joint Surgery*, 1949, 31B, 560.

<sup>2</sup> McKusick, V. A., et al., *Medicine*, 1965, 44, 445.

<sup>3</sup> Watson-Jones, R., *Surgery is Destined to the Practice of Medicine, Hunterian Oration Royal College of Surgeons of England*, Edinburgh. Livingstone, 1961.

### Smoking and Health

SIR,—Those of us who daily see the protracted misery and loss of life associated with cigarette smoking are appalled by the recent change of emphasis on cigarette advertising. The advertisement in the *Observer Magazine* (17 April, p. 17) shows a cricket bat and pads with a packet of Benson and Hedges Special Filter cigarettes, together with an announcement of the sponsored Cricket Competition Final at Lords. The invitation to save cigarette coupons to help our athletes win gold medals at Munich is equally noxious.

Must we, as a profession, stand idly by, attempting to persuade our younger patients not to start and our older patients to stop smoking, while such advertising attempts to nullify our efforts?

Letters to the national press on this matter are rarely published, which is understandable in view of the financial support they receive from tobacco advertising. But one of the strongest attacks comes from the magazine of the advertising industry *Campaign* (10 March 1972), "It is disgraceful that the tobacco industry is being allowed to violate—with seeming impunity—the spirit of its 'voluntary' agreement with the Government on cigarette advertising. . . . Smoking is not only a dirty habit, it is dangerous. Yet it would be impracticable and unreasonable to ban the sale of cigarettes completely. . . . But cigarette advertising, because it encourages the view that smoking is socially acceptable, must be banned.

The Council of the B.M.A. advised that a controlling body "should be appointed to vet all advertisements for manufactured tobacco products" (*Supplement*, 8 May 1971, p. 91), and this was accepted by the Representative Body.

Can we be assured that the B.M.A. is making strong representations to the Government on behalf of the profession, not only to control cigarette advertising but also to make the sponsorship of sports events by the tobacco industry illegal?—I am, etc.,

KEITH P. BALL

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SIR,—The question whether tobacco smoke can harm other people besides the smokers themselves has often been asked. One might assume that, if atmospheric pollution is harmful, then this form of pollution of the micro-climate within the home might also be harmful. In Hertfordshire we have had an opportunity to test this hypothesis during the routine school medical examination of 5-year-old new entrants, which is done during their second or third term. It is well known that these children tend to get increasing respiratory infections when they

first go to school, and we compared the incidence in children from non-smoking families with those from smoking families. From the records of 1,119 children, there was a clear indication that a history of respiratory troubles (coughs, colds, sore throat, earache, etc.) increases as the level of domestic smoking increases. In 341 heavy smoking families (that is, those with one or more persons smoking over 20 a day) 44.5% had such symptoms, whereas among 457 children from non-smoking families only 33.5% were sufferers. This difference is statistically significant. In families where the only smoke was from a pipe or cigar, the incidence of the various symptoms was roughly similar to families where less than 20 cigarettes were smoked, but still worse than the non-smokers. These results have been published recently in more detail.<sup>1</sup>

It is of course known that low-income families tend to smoke more than high income ones,<sup>2</sup> and a higher incidence of respiratory infection might be expected in lower income groups, so that this relationship is not necessarily due to cause and effect. However, general practitioners dealing with recurrent respiratory infections in children might care to inquire of the parents whether they are exposing their children to this form of irritation of the respiratory mucosae. It is one thing to ruin one's own health, but the possibility that one might be harming one's children in the process is quite another.—I am, etc.,

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<sup>1</sup> *Community Medicine*, 1972, 128, 32.

<sup>2</sup> McKennell, A. C., and Thomas, R. K., *Adults' and Adolescents' Smoking Habits and Attitudes. Government Social Survey*. London, H.M.S.O., 1957.

SIR,—I think it important to bring the attention of the profession to a current advertising campaign which unhappily marries two incompatible ideas, and may well impair intelligent health education about smoking.

I refer to the campaign "Help Win Medals for Britain" advertised in the press (for example, *Observer Magazine*, 17 April, p. 17) and seen by millions for long periods as part of the back-cloth to sporting events. It exhorts people to buy cigarettes with which they will receive tokens to help the British Olympic Appeal Fund to raise £200,000 needed to support the British Olympic team at the 1972 Olympic Games.

Sport has some dangers but is generally considered to improve health. Smoking, quite apart from arguments about its causal relationship to lung cancer, can certainly damage health in several ways.

The section of the public who smoke and cannot stop will presumably be only too delighted by something that not only suggests that smoking does not matter, but encourages them to smoke for a good cause.—I am, etc.,

NEVIL SILVERTON

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### Private Practice

SIR,—I read with astonishment Professor C. A. Wells's letter extolling the virtues of private practice as a necessary training for

consultants who teach medical students (6 May, p. 346).

Whether or not it is the case that the lessons that students "remember with most gratitude are those in personal human relationships unconsciously imparted by precept and example" is arguable. However, the suggestion that such relationships can be developed only in the arena of private practice, and the implication that to succeed in the National Health Service a consultant does not need "to establish a good relationship with general practice, be accepted by and give confidence to his patients, and to produce results" is one which to me and to many, many medical students shows a complete misunderstanding of the role of a health service dedicated to treating the sick rather than the sick who can pay to be treated.—I am, etc.,

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SIR,—Professor C. A. Wells (6 May, p. 346) is correct in stating that "the medical student may very well see less of his chief because of the latter's preoccupation with private practice," but in his other assumptions he attempts to "cite scripture for his own purpose."

I am not opposed to private practice, but it is important in discussion to be honest about its drawbacks (and advantages); it is wrong to imply that teachers of medical students should attend "the hard school" of private practice, so that they may learn "by experience to come to terms with their colleagues and their patients." Perhaps Professor Wells inadvertently omitted to qualify the word "terms" with "financial," in which case his letter would have made some sense.—I am, etc.,

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### Maternal Influenza and Perinatal Mortality

SIR,—The annual report of the Department of Health and Social Security for 1970<sup>1</sup> showed that the national perinatal mortality had risen from 23.2 in 1969 to 23.4 in 1970 owing to an increase in neonatal deaths in the second quarter of the year. The report suggested that this might be associated with the influenza epidemic in December 1969 and January 1970, but that no definite conclusions could be drawn. Nevertheless a causal relationship between maternal influenza and perinatal death was implied.

Information has been recorded on all the mothers delivered in the maternity units of St. Thomas's group since 1966.<sup>2</sup> In 1969-70 14 mothers were recorded as having had influenza during their pregnancy (of these nine had influenza in December 1969). All of these mothers and babies were discharged from hospital alive and well.

Dr. D. L. Miller and colleagues (27 February 1971, p. 475), however, reported that about a third of the sample of male population of Lambeth showed serological evidence of infection during the epidemic. In order to detect any influence that a mild

|                | Neonatal<br>Death Rate<br>per 1,000 live births | Total<br>Deliveries<br>1970 | Birth Weight<br>under<br>2.5 kg | Respiratory Disease |
|----------------|---|-----------------------------|---------------------------------|---------------------|
| 1st Quarter .. | 14.0<br>(5.6)*                                  | 904                         | 73<br>(8)‡                      | 19<br>(6)†          |
| 2nd Quarter .. | 15.8<br>(14.6)*                                 | 927                         | 81<br>(6)‡                      | 26<br>(4)†          |
| 3rd Quarter .. | 10.6<br>(12.5)*                                 | 1003                        | 79<br>(7)‡                      | 19<br>(4)†          |
| 4th Quarter .. | 14.2<br>(13.5)*                                 | 958                         | 66<br>(10)‡                     | 36<br>(7)†          |
| Totals ..      | 13.6<br>(11.6)*                                 | 3792                        | 299<br>(31)‡                    | 100<br>(21)†        |

\*1969.

†Neonatal deaths in this group.

‡Neonatal deaths in this group.

virus infection, which was not reported at antenatal clinic, might have on the infant a more detailed study has been made of the neonatal deaths at St. Thomas's. The highest neonatal death rate occurred in the second quarter of 1970, but there was also a rise in neonatal mortality rates in the first and fourth quarters of the year.

The neonatal mortality rate for England and Wales is usually highest in the last quarter of the year. The rise in neonatal mortality in the second quarter of the year in 1970 was exceptional. A similar rise in the second quarter of the year occurred in 1951 and in both these years an influenza epidemic had occurred in the preceding winter.

The Office of Population Censuses and Surveys has shown that the increase in neonatal deaths in the second quarter of 1970 was due to an increase in the number of deaths of infants with respiratory disease (Adelstein, personal communication). There is no evidence that low birth weight or respiratory disorders contributed to the increased death rate at St. Thomas's (Table).

An influenza epidemic might be associated with increased neonatal mortality either by giving rise to premature labour or by causing congenital malformation. In these conditions the rise in the death rate would be expected at the same time as the epidemic or be delayed by six months respectively, and not three to five months after the outbreak, which is the case in question. In addition, there is no evidence of an increased number of premature births in the first quarter at St. Thomas's, and the incidence of congenital malformations was spread evenly throughout the year.

We have examined our data in an effort to help analyse the national neonatal death rate. All the mothers delivered in the St. Thomas's group who reported influenza during their pregnancy had healthy babies. There was a small increase in low weight infants and infants with respiratory disease in the second quarter of the year. Although these changes are not statistically significant they suggest a trend which could be significant if it was supported throughout England. Nevertheless, any relationship that might exist between maternal influenza in pregnancy and neonatal mortality is small.—I am, etc.,

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1 Department of Health and Social Security. *On the State of the Public Health. Annual Report of the Chief Medical Officer, 1970.* London, H.M.S.O., 1971.

2 South, J., and Rhodes, P., *British Medical Journal*, 1971, 4, 32.

### Hospital Staffing

SIR,—The manpower problems involved in maintaining a 24-hour emergency service referred to by Mr. J. J. Shipman and his colleagues (29 April, p. 297) demand the most careful study and realistic action. It is not appreciated as widely as it should be that to keep one position filled for 24 hours a day, seven days a week, requires a minimum of 4½ people on the establishment if the demands for a 40-hour week are to be met. Maintenance of maternity services have depended for too long on excessive demands on those prepared to accept them.—I am, etc.,

JOHN STALLWORTHY

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### When is Dementia Presenile?

SIR,—Drs. C. D. Marsden and M. J. G. Harrison (29 April, p. 249) usefully emphasize that a proportion of demented patients have a potentially treatable cause for their dementia. It should be noted, however, that the 15% they refer to come from a highly selected group—but I agree that it could be useful to practitioners and relatives to know what success the National Hospital has, at present, in identifying remediable aetiologies.

The authors imply that patients admitted to the National Hospital with a presumptive diagnosis of dementia are all under the age of 65; perhaps this was not intended. But this raises the important question of how far one should investigate the elderly dement. Most of the tests mentioned by Drs. Marsden and Harrison have no morbidity and can be done as in outpatients; their only significant disadvantage is the expense of the tests. Air encephalography is the test having the highest chance of revealing a treatable condition (for example, space-occupying lesion or a suggestion of normal pressure hydrocephalus), but also it has a significant morbidity, which is likely to be greater in older patients and also in those with a treatable condition. I would suggest that unless there are reasonable grounds for suspecting an irreversible aetiology, and unless there are definite contraindications, an air encephalogram should be performed in all recently demented patients; the sooner the better.

There are good reasons, also for treating all demented patients, with antidepressants for a period. Firstly, because 25% of patients with dementia are depressed; and secondly, to discover those patients whose depression simulates dementia so well that they are

admitted to hospital (and it could be a long-term mental hospital) with the latter diagnosis.—I am, etc.,

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SIR,—My congratulations to Drs. C. D. Marsden and M. J. G. Harrison who have managed to present an engaging study concerned with dementia (29 April, p. 249) without actually revealing the ages of patients included. Presumably "presenile" in the title is a clue, but the concept of presenile dementia is controversial.

Subsequent information is confusing. "This paper describes the results of investigating 106 patients with presenile dementia who were referred to a neurological hospital" is immediately followed by "Altogether 106 patients were admitted to the National Hospital, Queen Square, between January 1968 and December 1969 with a presumptive diagnosis of dementia." Was any age criterion applied in selection? The age is given only of a man of 60 years, who was seen before the period of the study anyway. Is he to be regarded as senile, presenile, geriatric, or just getting on a bit? Regardless of any upper age limit for the patients included, the incidence of the onset of dementia due to, for example, arteriosclerosis and Huntington's chorea, will have an important relationship to the age range of the patient sample, and therefore the absence of the ages of the patients limits the value of the paper considerably.—I am, etc.,

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### Research in Psychiatry

SIR,—Your leading article "Research in Psychiatry" (8 April, p. 61) suggests further questions which need to be asked in order to explain why psychiatrists have contributed little to research. If it is accepted that a positive attitude to, and a readiness to engage in, research is most easily acquired early in a doctor's professional career, then it is important to know how many trainees in psychiatry are engaged in some form of research, and to try to ascertain what factors either facilitate or hinder them.

In the course of a survey of postgraduate education and training in psychiatry conducted in three regional board areas, done under the aegis of the Royal Medico-Psychological Association, I personally interviewed over 150 trainees—something over 95% working in the regions—and asked them whether they were interested in research, whether they were actively engaged in it either on their own or in collaboration, and whether they were receiving help and encouragement in this field from their consultants, local universities, and regional hospital boards. I also asked senior registrars whether they had sufficient time off for study and research.

Two fifths of all trainees and just over half of the senior registrars felt that they had a particular bent towards research. In practice, however, of the 133 S.H.O.s and registrars only 20 were engaged in research or clinical investigation either on their own