manner intended, as a reassurance to most doctors that prescribing habits are being observed in an effort to prevent drug abuse. I am sure Dr. Brown will continue to prescribe in his patients' interests, but I would remind him that suicide by ingestion of Mandrax is not unusual, whereas suicide with nitrazepam (Mogadon) is as yet unreported. The latter drug is generally considered to be as effective as Mandrax and is not subject to abuse.—I am, etc.,

ROBERT GREEN

Burnham, Bucks

Automatic Transmission Vehicle Injuries

SIR,—I should like to add a further account of a severe injury sustained by incorrect use of the automatic transmission in a car. A man aged 60 had left his car in order to open his garage doors; the automatic transmission was left in "drive" with the hand-brake applied. Unfortunately, the hand-brake must have slipped because the car edged forward and trapped him against the garage upright. He sustained a severe crushing injury to his leg which necessitated a through-knee amputation.

I would strongly support the plea of Mr. Malcolm Fidler (7 April, p. 25) that vehicles with automatic transmission should never be left with the gear in the "drive" position, irrespective of the application of the hand-brake. The only safe position is "neutral" or "brake."—I am, etc.,

M. A. NELSON

Leeds

Medical Staff Dining-rooms

SIR,—I am writing on behalf of my committee to draw your attention to a serious omission in the "best buy" hospital at Bury St. Edmunds.

There is no provision for a separate medical staff dining-room and all requests for this item have been met by refusal. My committee views with concern this omission in a hospital designed by the Department of Health and would like to bring this situation to the attention of other medical staff faced with a "best buy" hospital.—I am, etc.,

M. W. ROUT

Hon. Secretary,

Group Medical Advisory Committee,
West Suffolk Hospital Management Committee

Bury St. Edmunds

G.P.s and Health Visitors

SIR,—Dr. Stanley Ellison ("Personal View," 17 March, p. 673) states that "the prime duty of parents should surely be an appreciation of their child's temperament and the provision of an upbringing which prevents the formation of potentially harmful character patterns."

I am sorry to see that, while he considers that health visitors should be ideally placed to help parents with this duty, his impression is that they are not necessarily skilled in this work. It would be interesting to know why he has formed this opinion, how well he knows health visitors, how closely he has worked with them, and what knowledge he has of their training.

He also says: "Surely it is the general practitioner in his role as doctor to the family who has the greatest opportunity for influence." Unless, or until, doctors are prepared to include in their training something equivalent to the one-year postregistration course taken by the health visitor and to adapt their method of working along the same lines as hers, there is nothing sure about the doctor having the greatest opportunity to support parents in bringing up their children. The health visitor visits the home irrespective of declared needs, getting to know every member of the household, encouraging visits to the surgery or clinic that are not related to illness or disability, and undertakes all forms of health education.

Surely the health visitor is the only person whose training and method of working has, up to now, placed her in the best position to educate, influence, and support. Whether her attachment to general practitioners will modify the work of the family doctor in this direction, or restrict that of the health visitor, remains to be seen.—I am, etc.,

G. M. FRANCIS

Editor/P.R.O.,

Health Visitors' Association

London S.W.1

Outpatient Maintenance of Chronic Schizophrenics with Long-acting Fluphenazine

SIR,—The comparative trial of fluphenazine decanoate and placebo by Dr. S. R. Hirsch and others (17 March, p. 633) was one of the most useful contributions to research with long-acting tranquillizers. However, although the authors found the difference between drug and placebo to be much greater than was anticipated, they stressed the fact that these differences reflect a result in a specific population and that the study was not epidemiologically based.

We would question their estimate that 30% of patients cannot be controlled on fluphenazine decanoate on the following grounds: (1) The figure of 14-17% relapsed in 15 months might well have been much lower had more attempt been made to adjust the dosage, which in most cases was fixed at a level below the clinical average of 25 mg per three weeks. (2) The figure of 26-29% presenting management problems over 15 months, despite long-acting fluphenazine, included eight patients from St. Olave's Hospital who, according to the authors' table I, were excluded from the trial for reasons not related to long-acting fluphenazine. It also appears to be incorrectly calculated if it is based on the simple sum of three percentages of two different samples—10% of 93, 2.5% of 36, and 14-17% of 36. Following the epidemiological argument, recalculation of the sum of the percentages of the total number of patients considered (112), and including the 19 patients from St. Francis's Hospital, gives the much lower figure of approximately 17%.

In recent years a similar study comparing oral phenothiazines and placebo was conducted by Leff and Wing.¹ From this trial in as few as 35 schizophrenics selected from a base population of 116 they concluded that "maintenance therapy seems of little value in patients with a good prognosis and in

the severely ill, but it is of value in the indeterminate group between these two extremes." In their "severely ill" group all patients received phenothiazines and, although the majority relapsed, as many as 33% were still controlled. Furthermore, if they had received no drugs at all, many more would probably have relapsed. Moreover, since some do not absorb oral medication, a further group would have benefited from intramuscular medication. At the same time, 27% relapsed in the group with a good prognosis who received no drugs at all. Thus at least 32% of the so-called extreme groups can be added to the indeterminate group who would do well on phenothiazines. In practical terms, since clinicians were incorrect in their prognosis in one case in three in these extreme groups, it would seem that in our present state of knowledge it is unwise to deny any patient medication.

In summary, although we applaud the thought and effort put into these two trials, we regard it as a faulty assumption that the majority of patients who do not conform to a number of precise criteria for entry into a trial of medication and those who relapse on a tightly controlled dosage schedule are to be considered as inevitable therapeutic failures under normal clinical conditions.—We are, etc.,

G. R. DANIEL,
Medical Director

A. A. SCHIFF,

Medical Adviser

E. R. Squibb and Sons Ltd.

Twickenham

¹ Leff, J. P., and Wing, T. K., *British Medical Journal*, 1971, 3, 599.

Contraceptives on the N.H.S.

SIR,—I cannot imagine that the amount of £13 million, which is the estimated annual cost of providing contraceptives on N.H.S. prescription, will be sufficient to cover the actual cost to the taxpayer. I would have thought that an inflationary period such as the present was not the correct time to suggest such a plan to the general public. A cut in all Government expenditure is surely what other nations are looking for; having recently returned from abroad I am aware and conscious of what people abroad are thinking of this country.

What plans has the Department of Health and Social Security got to pay general practitioners who are prepared to do family planning if the Department is suggesting that the only charge to the patient will be the current prescription charge? I have not heard any figures mentioned and would be glad to hear the views of my colleagues on the matter.

I can visualize that there will be a sudden abandonment of general practice by some doctors, who may feel that they are not prepared to act as an agency to give away condoms to all who want them while those who are sick wait in the queue. Several M.P.s have already expressed concern about this aspect of the matter, and it will be necessary to arouse those who feel that the profession has not been adequately consulted about the matter so that their views can be presented when the Bill goes into the committee stage. I should be interested to hear what other doctors think on the subject so that a proper view can be put forward to those

in Parliament who wish to know what can be done to ensure that G.P.s are not overwhelmed with social work to the detriment of those who come for the treatment of real illness.—I am, etc.,

T. D. RICHARDS

Pucklechurch, near Bristol

Patient Delay before Treatment of Myocardial Infarction

SIR,—Before accepting the findings of Dr. I. C. Gilchrist's interesting study (3 March, p. 535) as valid indications of some of the reasons why many patients who suffer myocardial infarction at home do not call medical help immediately, it is important to point out that the 50 patients interviewed were all in the recovery stage of their infarction. This being so, these 50 patients may be representative of a group of patients, who are different in many respects (including reasons for, and delay in, calling medical help) from the group whose members do not manage to survive to this stage. The possible differences between these two groups may explain the very short median delay of one hour in calling medical help reported in this study.—I am, etc.,

ARTHUR FURST

Hebrew University-Hadassah Medical School, Jerusalem

Pityriasis Rosea in Sisters

SIR,—My 11-year-old daughter returned from boarding school in Yorkshire after a full term's absence from home on 15 December 1972. On 19 December she showed a herald patch on her chest which was followed by the typical rash of pityriasis rosea.

On 29 January 1973 my 5-year-old daughter showed a herald patch below the right axilla which was in time followed by the typical rash of pityriasis rosea. The two girls were in very close contact during the Christmas holidays, as the younger girl lay in the older girl's bed having stories read to her.

Possibly this indicates an incubation period of six weeks.—I am, etc.,

WALLACE WHITE

Great Baddow, Essex

Chondromalacia Patellae

SIR,—The way to treat chondromalacia patellae is to treat the foot. I have come to this conclusion after three years' experience as medical advice columnist for *Runner's World*, a periodical with 10,000 subscribers, mostly distance runners. This has given me a "constituency" peculiarly prone to this disease and allowed me the opportunity to evaluate various forms of treatment. Contrary to the optimism of Drs. J. Darracott and B. Vernon-Roberts (24 February, p. 491), my patients have not had promising results from quadriceps exercise and corticosteroid injections, nor from any other remedies listed in the literature. They have, however, had very gratifying results from podiatric treatment (custom-moulded orthotics) of the biomechanical difficulties of the foot that supports and stresses the damaged knee.

It stands to reason that normal, well-

conditioned runners have normal knees. What many of them do not have is normal feet. About 35% of a group recently surveyed had a short metatarsal (Morton's syndrome). Others had forefoot varus or narrow subtalar range. Determination of the exact pattern of foot abnormality causing chondromalacia will take more research; but my runners have convinced me that the principle is correct. The one-plane symmetry of the patella riding the groove between the condyles is altered to cause chondromalacia. This deviation is transmitted by structural abnormalities in the intricate architecture of the foot. And with 26 bones, three arches, and a complicated support system of tendons and ligaments there is much to go wrong.

Attention to the runner's foot has resulted in relief of symptoms (a reasonable test) and pain-free resumption of long-distance running (the only real test). The mystery of chondromalacia patellae seems close to solution.—I am, etc.,

Red Bank,
New Jersey, U.S.A.

GEORGE SHEEHAN

Mute of Malady

SIR,—In your comprehensive leading article on mutism (31 March, p. 755) it is mentioned that the condition is not uncommon among children up to the age of 3 or 4.

I have tentatively described a syndrome¹ in which mutism and withdrawal, not infrequently accompanied by rhythmical rocking movements, are the main features. It seems that this condition is confined to the young children of West Indian parents living in this country. Aetiologically, maternal depression, often aggravated by overwork and heavy material burdens, contributes to the young child being deprived from the beginning of emotional, verbal, and environmental stimulus. The prognosis appears to be poor.

These children are frequently misdiagnosed as suffering from mental defect, deafness, or infantile autism.—I am, etc.,

G. STEWART PRINCE

London W.1

¹ Prince, G. S., in *Social Work with Coloured Immigrants and their Families*, ed. J. Triseliotis. London, Oxford University Press, 1972.

Drug Data Cards

SIR,—It seems very wise that the Medicines Act, 1968 should legislate for data cards giving all the relevant details regarding ethical products. What seems entirely illogical is that we should receive them (as we have been doing in the past few weeks) in different shapes and sizes and with different forms of heading so that it is impossible to file them for easy reference.

I would consider it incredible that standardization for data cards was not recommended beforehand but, if this is the case, may I hasten to suggest (to save unnecessary expenditure on new filing systems) that a suitable size would be that of the present N.H.S. medical card, so that the same filing boxes could be used and, if necessary, details of a particular drug which a patient might be taking could be kept in his or her medical record envelope.

I pray that the envisaged change in size

of the medical record envelope will not materialize. All that is really required is that hospital letter paper should be standardized to a size which, folded once, would fit neatly into the present record envelope (convenient for use in the surgery and for carrying in one's hand or pocket when visiting patients). International size A5 paper, as has been suggested many times before, is suitable for this purpose and A6 paper (half the size of A5), used landscape fashion, would be convenient for short notes and pathology reports.

However, if there should be a change in the medical record envelope an "old size" filing box could at least serve a useful purpose for the storage of drug data cards if these were of the size I have suggested.—I am, etc.,

N. V. EDWARDS

Halstead, Essex

Assessment of Acid-base Disturbances

SIR,—The assessment of the acid-base status of patients in an intensive care unit described by Dr. A. W. Grogono (17 February, p. 381) was justifiably criticized by Dr. J. B. Stoker and others (31 March, p. 803) because the assessment was based on the Siggaard-Andersen nomogram, which is derived from the in-vitro CO₂ titration curve. On clinical grounds the article may also be criticized because of its apparent unquestioning trust in a biochemical analysis without reference to the clinical status of the patient.

Stoker *et al.*¹ proposed a new system for the analysis of acid-base disturbances on the ground that the current indices of base excess and standard bicarbonate were confusing and difficult for the average clinician to understand. This statement seems unfair when it is realized that the modern clinician has used these concepts in the day-to-day management of patients over the past 10 years. Instead of introducing yet another concept, "non-respiratory pH," it would be simpler to correct base excess from the in-vitro to the in-vivo situation as first described by Prys-Roberts *et al.*² and later elaborated by Siggaard-Andersen.³

The criticisms levelled at the in-vivo corrections suggested by Siggaard-Andersen can also be applied to the concept of "non-respiratory pH." Stoker *et al.*¹ stress that non-respiratory pH is only valid when acute changes of PCO₂ occur in a non-respiratory acidemia. This condition excludes the majority of patients with acute non-respiratory acidemia who develop a rapid swing to alkalemia on treatment. Patients with acute exacerbations of chronic bronchitis may present with an acute hypercapnia superimposed upon a chronic hypercapnia and a chronic change in non-respiratory acid-base status. In these patients the slope of the in-vivo CO₂ titration curve is uncertain.^{4,5}

We have found a close correlation between corrected in-vivo base excess measurements and "non-respiratory pH" in patients admitted to an intensive care unit who underwent marked changes of PCO₂ or non-respiratory acid-base status.⁶ These patients included chronic bronchitics. These findings suggest that if errors exist in the titration curves they were equally reflected by both methods. Thus no merit would be achieved