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.,

GEORGE SHEEHAN

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

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 syndrome[1] 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 CO_2 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 statment 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 P_{CO_2} occur in a non-respiratory acidaemia. This condition excludes the majority of patients with acute non-respiratory acidaemia who develop a rapid swing to alkalaemia 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 CO_2 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 P_{CO_2} 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

by replacing accepted and currently used concepts of non-respiratory acid-base status by "non-respiratory pH."—We are, etc.,

D. GEOFFREY LEWIS
J. C. STODDART

Royal Victoria Infirmary,
Newcastle upon Tyne

1 Stoker, J. B., Kappagoda, C. T., Grimshaw, V. A., and Linden, R. J., *Clinical Science*, 1972, **42**, 455.
2 Prys-Roberts, C., Kelman, G. R., and Nunn, J. F., *British Journal of Anaesthesia*, 1966, **38**, 500.
3 Siggaard-Anderson, O., *Scandinavian Journal of Clinical and Laboratory Investigation*, 1971, **27**, 239.
4 Flenley, D. C., Franklin, D. H., and Millar, J. S., *Clinical Science*, 1970, **38**, 503.
5 Goldstein, M. B., Gennari, F. J., and Schwartz, W. B., *Journal of Clinical Investigation*, 1971, **50**, 208.
6 Lewis, D. G., and Stoddart, J. C., *Clinical Science*, 1973, **44**, 297.

Obstetric Prevention of Mental Retardation

SIR,—In view of the remarks of Professor Philip Rhodes (17 February, p. 399) and Mr. D. B. Brown (10 March, p. 614) on the probably deleterious effect on perinatal mental capacity of either chronic placental insufficiency during pregnancy or acute fetal asphyxia during labour, it seems timely to remind readers of recent evidence showing the existence in experimental animals of sacral cholinergic vasodilator nerves supplying the uterine vasculature.[1]

These nerves are present in the dog and guinea-pig, but are absent in a variety of other species commonly used as preclinical obstetric models. Owing to insensitivity of the vascular muscle to acetylcholine at other times, these nerves are, in the guinea-pig, capable of exerting a dilator effect only under the hormonal conditions of pregnancy. Their importance in providing an adequate placental blood supply is supported by recent unpublished experiments in which it has been demonstrated that rendering the dilator nerves non-functional by ablation of the paracervical ganglia or by administration of atropine during pregnancy results in increased stillbirths and lowered birth weight and viability in the surviving pups. With regard to the dog, Toth *et al.*[2] reported some years ago that pelvic parasympathectomy during pregnancy caused a precipitous fall in placental blood flow and abortion.

Although obstetric opinion at present largely favours hormonal or haemodynamic origins for the uterine hyperaemia of pregnancy in the human, histochemical studies have shown the presence in the vascular supply to the human uterus of cholinergic vasomotor fibres.[3] It therefore seems advisable to be cautious in the administration of anticholinergic agents during pregnancy for either diagnostic or therapeutic ends. It is also possible that the finding that neonatal asphyxia after labour under spinal anaesthesia increases with the duration of anaesthesia before delivery[4] may be related to blockade of neural dilator influences on the uterine arterial supply.—I am, etc.,

CHRISTOPHER BELL

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1 Bell, C., *Pharmacological Reviews*, 1972, **24**, 657.
2 Toth, A., McEwan. R., and Shabanah, E. H., *Fertility and Sterility*, 1964, **15**, 263.
3 Bell, C., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1969, **76**, 1123.
4 Crawford, J. S., *American Journal of Obstetrics and Gynecology*, 1965, **93**, 37.

One Profession?

SIR,—The profession, like Gaul, can be divided into three parts and, once so divided, easily manipulated by politicians. However, for the present I am concerned with the two largest groups, hospital orientated doctors and general practitioners. When members of these groups meet with shared responsibilities their team work and mutual respect are good or excellent. When they do not so meet, inefficiency and mutual criticism are almost inevitable.

There are situations in which different long-term experiences will have established different priorities in our sense of responsibility. I and some colleagues have recently been approached twice by hospital research teams concerned with acute anxiety and epilepsy, with requests that some of our patients be subjected to very comprehensive questions and examinations. It soon became apparent that the hospital teams believed the tests could do no harm, but the G.P.s almost unanimously felt that they would involve "pulling their patients about" a good deal and were ethically quite unacceptable.

I emphatically pass no ethical or moral judgement, but draw attention to the fact that, with excellent communication and at least a measure of mutual respect, both groups held to their original points of view with considerable tenacity of purpose. I am always a bit frightened when two groups of good people have to agree to differ.

E. B. GROGONO

Woodford Green, Essex

Expansion of the Consultant Grade

SIR,—As a psychiatrist who has worked happily in the subconsultant medical assistant grade since 1967, may I add some observations to Mr. J. P. Turney's sensible letter (24 March, p. 745)?

We shall never staff our hospitals adequately until the planners face facts and kill off some sacred cows.

Fact no. 1 is that over half the beds in the hospital service are psychiatric, psychogeriatric, or geriatric, while only about 12% of consultants are in these three specialties. How do we fill the gap? Up to now we have done it with medical assistants, and before them with junior and senior hospital medical officers. An embargo has now been put on all these grades and we are told that we must have more consultants but for this expansion Mr. F. S. A. Doran (*Supplement*, 10 March, p. 71) proposes a "triple contract" system. In other words we are to put a junior sort of grade-3 consultant, with little back-up from non-consultant staff, into the shoes of the medical assistants. No wonder people are beginning to talk of the plight of the young consultant.

Fact no. 2 is that with the ageing of the patient population in hospital there will be more, not less, work for doctors to do on the wards. Who is to do it if not doctors in a subconsultant grade? As Mr. Turney so rightly says: "Not all vicars become bishops."

Sacred cow no. 1 is the belief that we must pay heed to the demands of the junior hospital doctors that they must all be able to become consultants and that therefore the numbers of registrar posts must be restricted. A lot of them are glad sooner or later to go into general practice. Why should they not also be glad to go into a subconsultant specialist grade if they like clinical work? The pay is good enough and there is more than a pious hope that they can have a chance to become consultants later on.

Sacred cow no. 2 is that all consultant specialties must be regarded as of equal status and must be paid equally. If we paid consultants in the relatively undemanding specialties less, there would be money to pay more to good subconsultants in the difficult specialties like medicine and psychiatry. And there would be no shortage of recruits. Plenty of bright G.P.s would be glad to join the hospital service, take higher qualifications, and become non-consultant clinical specialists if the pay, prospects, and conditions of work were right.—I am, etc.,

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Points from Letters

Strikes by Hospital Ancillaries

Dr. T. R. STEEN (Bristol) writes: Dr. W. A. Murray (31 March, p. 802) is right to object to the tendency of the B.M.A. to make and announce important policy decisions without prior reference to the periphery. . . . Without specific mandate from the periphery, the B.M.A. has urged the Government to set up an inquiry into the ancillary hospital workers' dispute. Dr. Murray may be right to think that, on this occasion too, B.M.A. members as a whole should first have been consulted, but personally I would disagree. After all, nothing more has been requested than an inquiry in the normal process of democratic administration, and it seems doctrinaire of Dr. Murray to regard this as evidence of a victory for the left wing in the B.M.A. Council. Most doctors would, I believe, consider it wise, as far as possible, to keep politics, which are not their professional concern, out of these deliberations. Surely no one can reasonably object to the B.M.A. giving this sort of lead; indeed it must be their plain duty to do so. . . .

Mr. J. B. WATSON (Broxbourn, West Midlothian) writes: As a co-ordinator of voluntary services it has been my privilege and at times my consternation to be in that no man's land between disciplines in the hospital during the recent dispute. From this vantage point, being viewed as friend and foe by both management and union, it has been my misfortune to see numerous gaps in personnel communications within the hospital. Whereas management on the one hand and nursing, medical, and ancillary staff on the other hand all have satisfactory channels of communication within their own disciplines, unfortunately there does not seem to exist a broad universal channel of communication which can bring to fruition any multidisciplinary meetings. The result seems to be that though much fruitful discussion takes place between disciplines it all fritters away with the morning mist because no one accepts responsibility for inserting the findings or the decisions into the appropriate communicating channels. Especially in the case of dispute there seems a need within the health service, especially in these days of multidisciplinary teams, for some individual to be responsible for communications —not those day-to-day communications which occur between departments, but communications of a more general nature giving voice to dissent and dissatisfaction. . . . Perhaps the answer lies within the role of the hospital chaplain, acting more like the chaplains now being appointed in industry, or perhaps the role lies with the co-ordinator of voluntary services, who is by definition also a co-ordinator between the disciplines within the hospital. . . .