CORRESPONDENCE

Sticky Eye in the Newborn E. M. C. Dunlop, F.R.C.P. 333	Postoperative Management after Thymectomy A. B. Loach, F.F.A.R.C.S., and others 336	Review Body Report T. B. W. Phillips, M.R.C.S.; J. Dalglish, M.B.; A. George, M.B.; J. M. Finnerty, M.B.; 339
Cold Hypersensitivity; Weather and Eclampsia H. B. Goodall, F.R.C.PATH. 333	Working of the Abortion Act E. Wilkes, F.R.C.G.P.; P. Carter, B.A., and others 337	Effect of Work-to-Contract on Accident and Emergency Departments J. K. Gosnold, M.B. 339
Manipulation in Treatment of Low Back Pain J. H. Cyriax, M.D.; A. G. Boag, M.B.; Sir Eric Riches, F.R.C.S. 334	Iron Treatment of Dialysis Patients D. M. Chaput de Saintonge, M.R.C.P., and others 337	Position of Consultants in the Hospital Service K. F. R. Schiller, D.M. 340
A Health District Courier Service I. J. Y. Cook, F.I.M.L.T. 335	Treatment of Paracetamol Poisoning N. Wright, M.R.C.P.ED., and L. F. Prescott, F.R.C.P.ED. 337	Junior Hospital Staff Contract M. H. Yardley, B.M. 340
Treatment of Eye Injuries from Bomb Explosions J. S. Hillman, F.R.C.S. 335	Practolol and Sclerosing Peritonitis Winifred Halley, M.R.C.PATH., and J. D. S. Goodman, M.B. 337	Medical Certification J. N. Docherty, M.B. 340
Malaria Vaccines P. H. Silverman 335	Cigarette Advertising C. M. Fletcher, F.R.C.P., and K. P. Ball, F.R.C.P. 338	Practice Premises B. L. D. Phillips, M.B. 340
Royal College of Radiologists W. M. Ross, F.R.C.R. 336	Geriatric Admissions Mary Inglis 338	Purchase of Added Years E. O. Evans, F.R.C.G.P. 340
Congenital Defects of the Anterior Abdominal Wall D. W. Ryan, F.F.A.R.C.S. 336	Consultant Negotiations G. H. Jantet, F.R.C.S.; W. S. Dykes, F.F.A.R.C.S. 338	Qualifications of Trainers J. Cox, M.B., and P. A. Creighton, M.B. 341
Colour Disturbance as a Symptom A. G. Freeman, F.R.C.P. 336	Change of Heart? A. H. Grabham, F.R.C.S. 339	Points from Letters Risk of Gold Therapy (C. F. Hawkins); Short-stay Maternity Unit (W. O. Goldthorpe); Battered Babies (D. H. Judson); Uterine Rupture in Labour (J. R. Sutherst); Requests for Reprints (H. D. Johnson); Labelling of Medicine Bottles (A. Busuttill) 341

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are now being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Sticky Eye in the Newborn

SIR,—The comments by Drs. Elizabeth Rees and D. Hobson (14 December 1974, p. 656) about your expert's views (10 August, p. 406, and 26 October, p. 222) were pertinent but might be extended.

Because each variety of ophthalmia neonatorum may be mild, moderate, or severe¹ the term "sticky eye" should not be applied to mild cases of conjunctivitis in order to avoid the diagnosis of ophthalmia neonatorum and the investigations that this makes necessary. Not uncommonly babies suffering from ophthalmia neonatorum due to TRIC agent or the gonococcus have been treated for "sticky eye" with a preparation such as chloramphenicol eye-drops B.P.C. This is inefficient treatment and it may make diagnosis difficult or impossible. The detection of TRIC agent or the gonococcus in such a case diagnoses genital infection of the mother; thus it indicates appropriate examination and treatment of her and her sexual partner.

If a baby develops a "sticky eye" conjunctival material should be examined by smear and culture. If the smear contains pus ophthalmia neonatorum is diagnosed. Because the advance of gonorrhoea may be fulminating, if Gram-negative intracellular diplococci are found effective treatment is started immediately. The diagnosis is explained to the mother as "inflammation" until sugar fermentations have confirmed gonococcal infection. Effective local treatment is with penicillin in high concentration (1 MU/ml).² The eye is flooded each minute for 15 minutes, then after each feed for three days. Because gonorrhoea may cause systemic complications the baby should also be treated with penicillin by injection, even if gonococci are recovered from the conjunctiva only. If the smear contains pus and

organisms other than Gram-negative diplococci neomycin eye ointment B.P.C. 1% is indicated. This acts on most bacteria but not on TRIC agent; hence if conjunctivitis persists tests can be taken for that agent.

Your expert knows of no evidence that TRIC agent "causes more than temporary illness." Strong evidence exists. Babies may develop trachomatous scarring and pannus^{3,9} unless treatment is prompt and effective (say, with chlortetracycline eye ointment B.P.C.).^{8,9} Moreover, the mothers have genital infection and may develop salpingitis,^{8,11} and the fathers commonly have urethritis.¹¹ TRIC ophthalmia neonatorum is, indeed, not really "of a similar order of rarity" to the gonococcal form; in London it is over five times more common.¹²—I am, etc.,

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- 1 British Medical Journal, 1949, 3, 587.
- 2 Ridley, F., Transactions of the Ophthalmological Society of the United Kingdom, 1958, 78, 335.
- 3 Jones, B. R., Al-Hussaini, M. K., and Dunlop, E. M. C., Revue Internationale du Trachome, 1965, 42, 27.
- 4 Freedman, A., et al., Transactions of the Ophthalmological Society of the United Kingdom, 1966, 86, 313.
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- 6 Collier, L. H., Sowa, S., and Sowa, J., Lancet, 1969, 1, 101.
- 7 Forster, R. K., Dawson, C. R., and Schachter, J., American Journal of Ophthalmology, 1970, 69, 467.
- 8 Mordhorst, C. H., and Dawson, C., American Journal of Ophthalmology, 1971, 71, 861.
- 9 Goscinski, P. J., and Sexton, R. R., American Journal of Diseases of Children, 1972, 124, 180.
- 10 Dunlop, E. M. C., et al., British Medical Journal, 1972, 2, 575.
- 11 Dunlop, E. M. C., et al., American Journal of Ophthalmology, 1967, 63, 1073.
- 12 Dunlop, E. M. C., in Recent Advances in Sexually Transmitted Diseases, ed. R. S. Morton and J. R. W. Harris, p. 290. London, Churchill Livingstone, 1975.

Cold Hypersensitivity; Weather and Eclampsia

SIR,—I would like to comment on your leading articles (22 March, p. 643 and 12 April, p. 53) on these related problems and to suggest how the presence of an excess of cold-precipitable fibrinogen (cryofibrinogenemia) may be of importance in both.

As you pointed out, antibodies active in the cold (agglutinins or lysins) and cryoglobulins (IgG or IgM) may cause cold hypersensitivity. Cryofibrinogen, however, is a much more frequent hazard to the chilled than these apparently better-known predisposing factors because excess of cryofibrinogen may be associated with a wide range of infections, thrombotic disorders, neoplasms, collagen diseases, and metabolic upsets.

In a pregnant woman with cryofibrinogenemia associated with megaloblastic anaemia and urinary tract infection exposure to cold led to a general collapse and to necrosis of the head of the femur,¹ and among 33 elderly patients with accidental hypothermia only one of 20 with normal or equivocal levels of cryofibrinogen died during hypothermia whereas six of 13 with excess cryofibrinogen died hypothermic.² It is important, therefore, that the investigation of patients with cold sensitivity should include the examination of plasma (heparinized or oxalated) as well as serum for cold-precipitable proteins and for hyperviscosity induced by cooling.³ Furthermore, in severe climatic conditions ability to survive may possibly be impaired by the presence of excess of cryofibrinogen from, for example, a respiratory infection.

Cryofibrinogenemia is known to occur in pre-eclampsia.⁴ Thus the increased frequency of eclampsia on cool days may also be related to excess of cryofibrinogen. The chilling of pregnant women with this substance in excess may lead to hyperviscosity of the blood and thus to impairment of the microcirculation, particularly in the brain. The hyperviscosity of pre-eclampsia is also

associated with a rising haemoglobin level due to loss of plasma into the tissues or stimulation of erythropoiesis from renal ischaemia. Future investigations on the geographical distribution of eclampsia should therefore test the effects of altitude and secondary polycythaemia.

Finally, there is another aspect of low temperature and high humidity in the tropics—namely, that such conditions may be associated with thunderstorms. The paper you quote from Colombia mentions that there are "no reports of electrically charged mountain winds" but does not give a quantitative record of thunder or lightning. It may not be entirely fortuitous that the first of nine eclamptic fits in a German woman on 21 June 1902 was at the height of such a storm ("*erster Anfall im Augenblick eines in der Nähe niedergehenden schweren Blitzes*").⁵ Whether from the cooling of an abnormal plasma or the intense visual or auditory stimulation of an ischaemic cerebrum by a nearby thunderbolt, the weather may still give clues to the pathogenesis of eclampsia.—I am, etc.,

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Manipulation in Treatment of Low Back Pain

SIR,—Dr. D. M. L. Doran and Professor D. J. Newell (26 April, p. 161) have performed a public service in conducting a trial which has shown manipulation to have little effect when the cases are selected at random. This finding should be brought to the attention of those enthusiastic laymen who manipulate all comers on a panacea basis. All effective treatments have indications and contraindications. For this reason, pp. 511-522 of my textbook¹ are devoted to just that—when and when not to manipulate the lumbar joints. I can assure Dr. Doran that criteria do exist, and what should now be done is a further controlled trial of alternate cases of backache, on the face of it amenable to manipulation, treated by this means and in some indifferent way.

There is real danger, however, that misinterpretation of the results of the present trial, fully justified though they are, will enormously benefit lay manipulators. If the conclusions are regarded as showing that spinal manipulation is useless in all circumstances, they must indeed be jubilant. Their successes, and their high remuneration for performing a few simple twists, depend wholly on spinal manipulation remaining virtually unobtainable throughout our Health Service. Every doctor knows of patients treated for months under the best medical auspices who finally secure immediate relief at the hands of some bonesetter. I say "simple twists" advisedly; for it has been estimated that there exist about 3000

manipulating laymen in Britain, and the osteopathic list contains only some 300 names. Yet this majority of untrained persons count many satisfied clients—clear evidence of how little difficulty spinal manoeuvres present.

In the past decade doctors and physiotherapists have been veering towards my logical policy of manipulation for a small fragment of annulus lying displaced within an intervertebral joint. This increasing tendency and their many instantaneous successes have naturally caused lay manipulators much concern, for they see their monopoly, and hence their livelihood, threatened. This justified economic apprehension became so acute in Canada last year that the chiropractors paid physiotherapists the unprecedented tribute of petitioning the Minister of Health of Ontario to bar them from manipulating the spine. It would prove a retrograde step if the results of this trial were to be regarded as extending to manipulation in suitable cases. Such an error would further delay the adoption of a rational method of treatment, and the osteopaths and chiropractors would cash in again. Moreover, quite apart from the relief of patients' pain, one avoidable drain on sickness benefit funds would be perpetuated and laymen given gratuitous opportunities for scoring off the medical profession.

I shall hope to see the results of a further trial of manipulation in suitable cases, carried out by personnel instructed in the methods of orthopaedic medicine.—I am, etc.,

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- Cyriax, J., *Textbook of Orthopaedic Medicine*, vol. 1, 5th edn. London, Ballière Tindall, 1970.

SIR,—In their trial of manipulation in the treatment of low back pain for the British Association of Rheumatology and Rehabilitation (26 April, p. 161) Dr. D. M. L. Doran and Professor D. J. Newell conclude that "nothing found at the initial assessment enabled us to identify in advance the relatively small number of patients who benefited from manipulation." The authors tell us the features they recorded at clinical examination. They do not, unfortunately, tell us what factors they recorded from the patients' histories nor, perhaps, what "characteristics of the present attack" they noted. It would be from these observations that any possible preselection of patients suitable for manipulation must be made.

In your leading article on the same subject (p. 158) you draw the conclusion that though some patients respond dramatically to manipulation, the difficulty of selecting the responders reduces the value of the treatment and makes the more widespread provision of facilities for manipulative treatment inappropriate in the foreseeable future. It seems to me that these opinions are analogous to concluding from a clinical trial of ergotamine in headache that it was of marginal value. For such a trial would inevitably show a small number of excellent responses, similar in number to the predicted placebo response, and a large number of failures. If, in this hypothetical trial, the history, pain characteristics, and associated symptoms had not been recorded in such a way as to identify the pattern we know as

migraine such a conclusion might indeed be appropriate.

In my opinion the proper course of action is to make a fresh attempt to identify patterns of acute low back pain. In anticipation of the result of the B.A.R.R. trial I have prepared for the British Association of Manipulative Medicine a survey introduced at present in draft form. Doctors who see patients aged from 15 to 34 within three days of the onset of an attack of acute low back pain are being asked to complete an extensive history and examination proforma. Treatment, if any, is at the discretion of the doctor and progress will be recorded.

This is not, therefore, another clinical trial. It is an attempt to identify recognizable patterns of low back pain from very detailed observations of the remote and recent history, progression of the pain, and additional clinical examinations. From a study of the results I hope that it may be possible at least to identify the large group of patients whose symptoms will settle within a week with no treatment other than rest. The inclusion of such patients in any therapeutic trial can only fog the results. Are we quite sure that to treat such patients might not delay their recovery?

I am quite sure, therefore, that further attempts to assess the undisputed value of manipulation in some cases of acute low back pain must await the results of further detailed observations of the phenomena accompanying such attacks. There is little point surely in trials of the treatment of any condition identified only by a single symptom.—I am, etc.,

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SIR,—Though low back pain is not uncommon it is a symptom, not a disease; it merits more diagnostic detail than is given by Dr. D. M. L. Doran and Professor D. J. Newell (26 April, p. 161).

Forty years ago, after 18 months as surgical registrar to Mr. Blundell Bankart, I followed up his patients who had undergone manipulation of the back; they numbered 113 in the period 1921-9, but I based my account on 75 patients treated during my appointment. The diagnosis rested more on clinical findings than on x-rays and included six different conditions which could be readily distinguished. The follow-up confirmed our previous impressions and gave us a prognostic guide even without the widespread facilities mentioned in your leading article (p. 158). Patients with sacroiliac strain were the most successful, with 23 out of 25 improved (92%); in chronic back (erector spinae) strain 26 out of 30 improved (86%); while in lumbosacral strain only one out of three improved and we had given up manipulating them. Manipulation was done under a general anaesthetic and was a vigorous procedure; it included the "osteopath's twist" learned from Sir Herbert Barker. Bankart did not despise a method used by an unorthodox but successful practitioner.

Our figures from a single centre were small and might not bear the scrutiny of statisticians today, but they told us which patients would benefit from manipulation.—I am, etc.,

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