macula was involved, but vitreous haemorrhages could be treated if the vessels could be seen. Dr. P. C. WETZIG (Colorado, U.S.A.) emphasized the value of angiography in demonstrating areas of maximal fluorescence where photocoagulation could be applied. In discussion, several speakers

urged the need for a controlled trial of photocoagulation in which one eye only was treated, and Professor D. W. HILL said that a multicentre trial was about to start in Britain. Professor ASHTON wondered whether photocoagulation acted by altering the retinal circulation or by destroying areas of retina

which were producing toxic metabolites. Dr. ALMARIC pointed out that diabetic retinopathy was less severe in a myopic eye and in patients with unilateral carotid occlusion, so that therapy might be beneficial by reducing arterial inflow, a problem that angiography might help to solve.

Medical Press Congress

[FROM A SPECIAL CORRESPONDENT]

The International Union of the Medical Press met in Lucerne from 18 to 21 June for its ninth biennial congress, under the presidency of Professor J. PÉQUINOT (Paris). The Union is a federation of national associations of medical journals and where such groups do not exist of certain individual journals. It serves as an international forum for the discussion of anything that may concern the well-being or effectiveness of the medical press. The recent congress attracted some 60 participants, mostly medical editors, coming predominantly from Germany, Switzerland, and France, though there were also several from Eastern Europe and elsewhere. Trilingual (French, German, English) texts were available and the discussions were translated in summary.

Side-effects of Drugs

The two main themes at this year's congress concerned the coverage by medical journals of advances in therapeutics and the impact on medical journals of modern methods of information processing. On the first theme there was a discussion on publicizing the side-effects of drugs. Some representatives of the industry charged the medical journals with dwelling unfairly on these and failing to give proper place to the good side of the picture. Editors replied that it was essential for doctors to know quickly about side-effects, and that they had a duty to print the information. In some countries, the meeting was told, governments had set up agencies for recording and reporting side-effects, but the consensus was that this did not supersede what the journals could do to give early warning of possible dangers. There was also some anxiety by drug firms about adverse publicity getting into the lay press, but the point was made that the therapeutic situation was when the

patient consulted his doctor and individual fears could be dealt with then. The thalidomide disaster had made the German medical press particularly keen to speed up the flow from one country to another of information about drugs and their effects.

Maitre J. MIGNON (Paris), a lawyer, in a paper on ethical and legal aspects of pharmaceutical advertising in medical journals, gave an account not only of current French procedure but also of the proposed Common Market regulations on the subject. These would require in all advertising to prescribers or suppliers of drugs certain minimum information—namely, the names of the manufacturer and product; the active ingredients; the main therapeutic indications, contraindications, and side-effects; dosage and method of administration; and duration of stability and instructions for storage. At the close of the congress Dr. W. TRUMMERT, editor of the *Münchener Medizinische Wochenschrift*, showed some of his collection of slides tracing the development of the technique of drug advertising in medical journals. His samples ranged from the most bare-faced testimonial, through every kind of pictorial aid to attention such as the cartoon, surrealist art, and sexual symbols, to the detailed presentations of drug actions now required of the firms in the U.S.A.

Indexing and Information Recall

In a paper read in his absence on the second main theme of the congress Dr. CLIFFORD A. BACHRACH, chief of the Bibliographic Services Division of the National Library of Medicine, U.S.A., urged authors to help indexers by using titles for their papers that accurately reflected their contents. "Titles," he said, "that arouse the reader's curiosity, or amuse him, instead

of informing him, work a hardship on the user of an index, and have no place in the responsible medical journal." He also was only cautiously welcoming about the use of "key words" in medical journals. Author-suggested terms, he thought, were too inconsistent to be of much direct help to indexers, though they might draw attention to aspects of an article that might otherwise be overlooked or draw attention to gaps in the indexer's thesaurus of terms.

Dr. DIMITRIE NANU (Bucharest) and (in his absence) Professor S. M. BAGDASARIAN (Moscow) described how computer techniques could help the digestion and recall of the now over one million articles that appear in 6,000 medical journals every year. In the last decades, said Professor Bagdasarian, a large network of information institutes had been developed in the Soviet Union, and tens of thousands of technical and scientific workers were collaborating in them. Each institute was allotted a special branch of knowledge and the one concerned with medical science, the Union Institute of Research in Medical Information and Medical Technique, was part of the U.S.S.R. Ministry of Health. It published 90,000 bibliographical reviews a year as well as *Meditsinskii Referativnyi Zhurnal*, of which Professor Bagdasarian is editor.

Dr. P. RENTCHNICK (Geneva), editor of *Médecine et Hygiène*, gave an account of Swiss medical journals, and Dr. ROSINE ANDREEV (Sofia) discussed the problems of the medical press in Bulgaria. At the business session it was decided that the Union's next meeting (in 1971) should if possible be held in a developing country and deal with the problems of the medical press in such places. It was also decided to see if some useful link could be formed with the international meeting of medical editors which is now a regular feature of the World Medical Association's annual assemblies.

NEW APPLIANCES

Adjustable and Detachable Ring for Thomas's Splint

Mr. J. O. IKPEME, assistant orthopaedic surgeon, Harrogate General Hospital, writes: An adjustable and detachable ring* for the Thomas splint has been made in two parts (Fig. 1). Each consists of a shaped semi-circular frame of mild steel 5/16 in. (7.9 mm.) in diameter padded with moulded rubber and covered with soft leather or plastic.

The steel frame of the lower half-ring is welded to the side-stems of a Thomas splint. At the proximal end of each side-stem there is a tubular steel socket. The inner socket

* Patent pending.

has an anteriorly placed knurled nut, or wing nut. (This position avoids contact of the nut with the opposite thigh.) The outer steel socket has a similar nut placed laterally (Fig. 1, right).

The steel frame of the upper half-ring descends on either side of its ring as vertical rods with sloping shoulders (Fig. 1, left). These rods are notched along their lengths, the position of the notches coinciding with the position of the nuts. The rods fit into the tubular sockets and are fixed there at variable levels (depending on the notches

used), thus giving the ring firmness and full adjustability (Figs. 2 and 3). The splint sizes and internal circumferences are shown in the Table. The rounded shape of the ring would be lost if wider adjustments were made from any one size.

Advantages.—(1) It is easier to place the limb on the lower unit rather than to "thread" it through a complete ring. The upper half-ring is fixed in position at a level that is most comfortable. (2) If the limb swells, as often happens, it is a simple matter

Inside Ring Circumference

Size	Closed		Open	
	in.	cm.	in.	cm.
1	14	36	16	41
2	17	43	20	51
3	21	53	24	61
4	25	64	28	71
5	29	74	33	84

to adjust the level of the upper half-ring without having to change the entire splint and without danger of losing the position of the fracture. When the swelling subsides the ring can be readjusted, so that it fits at all times. (3) The nuts fit tightly into the notches on the rods and prevent the upper half-ring being pulled off when suspended from a Balkan beam. (4) When knee flexion

exercises are permitted on the splint they are easier to perform without the upper half-ring than with a complete ring. (5) As few splint sizes are needed, less storage space is required.

I am grateful to H. W. Poole & Son, Appliance Makers, Leeds, for constructing the splint ring, and to Mr. P. Rowley of the same firm for his help.

FIG. 1

FIG. 2

FIG. 3

FIG. 1.—The two components of the ring. Left, upper half-ring. Right, lower half-ring with tubular sockets and nuts. FIG. 2.—Ring closed. FIG. 3.—Ring opened.

A Fibreoptic Colonoscope

Mr. J. A. Fox, senior surgical registrar, the Royal Free and Royal Northern Hospitals, London, writes: The development of flexible fibreoptic viewing bundles provides a method of extending the range of conventional rigid-tube sigmoidoscopy into the proximal colon. Flexible forward-viewing endoscopes are available for the oesophagus, bile ducts, and ureters, and a similar instrument has now been used for colonoscopy.

The main problem is one of guidance around the various bends of the mobile colon against peristalsis. Retrograde colonic intubation is satisfactory up to the splenic flexure and occasionally into the transverse colon (Fox, 1967). For total colonoscopy end-to-end intubation is necessary, provided that there is no intestinal obstruction, and the guide line can be used to pull instruments up from below (Provenzale *et al.*, 1966)

The colonoscope described here is designed to be used only after preliminary retrograde intubation with a special polyvinyl tube. It consists of a fibreoptic viewing bundle, a lighting bundle, and an irrigation/air insufflation channel housed in a polyvinyl sheath. The colonoscope is 250 cm. long and has an external diameter of 7.5 mm. (Fig. 1).

After inserting the colon tube under radiological control the colonoscope is introduced through it until its forward-facing lens is positioned just inside the end hole of the colon tube (Fig. 2). A complete guide channel is therefore provided for the colonoscope, which prevents it from coming into contact with the mucosa during insertion and makes for easy removal to clean the lens and reinsertion afterwards. The lens and colon can also be cleaned by warm water through the irrigation channel, which is then used for

local air distension of the bowel as in sigmoidoscopy. Satisfactory views of the transverse, descending, and sigmoid colon have been obtained, and both still and cine colour film can be taken if a special light source (FCB 1,000) is used.

An improved colonoscope with a greater depth of focus, a movable tip, and biopsy facilities is now being constructed. This instrument will also have a better quality fibre bundle to give more mucosal detail.

The colon tube (specification 76/2) is available from Portex Ltd., Hythe, Kent. The colonoscope and light source (FCB 1,000) are made and developed by the American Cystoscope Makers Inc., 8 Pelham Parkway, New York 10803, U.S.A.

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FIG. 1.—The colonoscope. Inset shows viewing lens, lighting bundle, and irrigation channel. FIG. 2.—Intubation of transverse colon by the colon tube with the colonoscope positioned inside it.