on all matters concerning nursing that are controlled by governing bodies; to present to those governing bodies the profession's concept of nursing policy; and as far as possible . . . to decide policy." By this concept alone can we ensure that the future of our profession remains in our own hands.—I am, etc.,

MARJORIE W. MUDGE
Chief Nursing Officer

Westminster Hospital,
London S.W.1

¹ Ministry of Health, *Report of the Committee on Senior Nursing Staff Structure*, London, H.M.S.O., 1965.

SIR,—I read with interest the letter from Professor R. Y. Calne (3 July, p. 45) and further correspondence (17 July, p. 181) criticizing the Salmon Report.¹

I agree with all that is said about the position of the ward sister. She is indeed the key person in the clinical situation, she always has been and will, I know, continue to be. There is no question of any change in her status. I would also support the view that those wishing to remain in the clinical field should receive suitable financial reward for knowledge and experience. At the present time the Royal College of Nursing is looking at some form of clinical career for the nurse. This has until now stopped at the bedside.

I am perhaps now in a stronger position than in the past to stress the importance of the ward sister, having left the ward after 23 years in order to become a nursing officer. I took this step after considerable thought and because I believe in the implementation of the report. I do not regret this decision and find it challenging and stimulating and it still gives me contact with patients and student nurses.

To answer some of the criticisms made: I would not wish to see lay administration in charge of nursing services. I can only speak from personal experience, but it is obvious that our senior nursing administrators are very concerned to provide the best possible patient care. Nurse administrators have the necessary understanding of the many problems that occur at ward level. This is very comforting for those working with the patients. The ward sisters are responsible for the nursing care of the patients to the matron and the nursing officers are available to assist them on this vital task, as well as to help train the student nurses. Ward sisters are on duty approximately one third of the 24 hours, and inexperienced staff nurses and senior students need help in her absence.

It is still early days for so much condemnation of Salmon; all new innovations are suspect. Indeed Machievelli (1446-1567) made this point and goes on to say ". . . the innovator has for enemies all those who did well under the old conditions, and luke-warm defenders in those who may do well under the new." With the implementation of the Salmon scheme it is hoped we shall achieve better communications and understanding and shall therefore continue to give and even improve the bedside care of our patients, of which we in Britain are justly proud.—I am, etc.,

MARY WHITTOW
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¹ Ministry of Health, *Report of the Committee on Senior Nursing Staff Structure*, London, H.M.S.O., 1965.

Kveim Test

SIR,—Your leading article on the Kveim test (12 June, p. 604) challenging the specificity of the test is interesting and will not surprise many physicians who are working in the field of pulmonary disease. I have some further evidence of the non-specificity of this test which indicates that the Kveim antigen is unnecessary to produce a typical skin nodule in early cases of sarcoidosis.

In 1957, when I was a medical officer in the R.A.F. Medical Service working on a pulmonary disease unit, I became exasperated by the difficulty in obtaining Kveim antigen and began to look for an alternative.

I found that the intradermal injection of 0.20 ml of the standard typhoid paratyphoid vaccine would produce a typical nodule in early cases of pulmonary sarcoidosis in a 4 to 6 week period. Biopsy of these nodules showed that the reaction was similar to that obtained using Kveim antigen and the biopsy material was read as "a positive Kveim reaction" by several pathologists. I tested six patients and had positive results in all of them. They were, however, all young R.A.F. servicemen with early pulmonary lesions and hilar lymphadenopathy and I did not have an opportunity to conduct tests in more chronic cases of sarcoidosis. I regarded my results as an incomplete study, which was not published, and did not have an opportunity to continue this investigation after I left the R.A.F. Medical Service. I did discuss my findings with several specialists in pulmonary diseases, but I do not have information that the use of the typhoid paratyphoid vaccine was investigated any further.

I think my results were interesting in the light of subsequent studies of the Kveim test reported in your leading article. They also challenge the specificity of the Kveim antigen, and, in addition, they indicate that a positive Kveim test is not dependent on an antigen prepared from a lymph node. It is also possible that there is a readily available antigen in the typhoid paratyphoid vaccine which is not expensive and much easier to produce than the Kveim antigen.

I am writing this letter in the hope that it will stimulate someone working in pulmonary diseases to carry out further investigations with intradermal typhoid paratyphoid vaccine. I think it could be a very interesting and informative clinical research project.—I am, etc.,

JOHN GILROY

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Wayne State University,
Detroit, Michigan, U.S.A.

Glove Powder

SIR,—I would like to confirm the experience of Mr. D. F. Ellison Nash with regard to the serious effects of starch powder on the tissues (17 July, p. 183).

As a hospital pathologist in Canada I encountered granulomatous inflammatory lesions due to corn starch glove powder frequently on microscopic study after surgical operations on the peritoneum and pleura. This condition is difficult to diagnose grossly; an excess of fluid exudate, small grey nodules, or dense fibrosis with adhesions are the main features. Microscopical examination of surgical or postmortem material shows an inflammatory reaction of histiocytes, lymphocytes, and foreign body giant cells with the starch granules easily

identifiable as spherical or polyhedral, birefringent bodies, 10-20 microns in diameter, with a basophilic appearance in H. and E.-stained sections and a brilliant red appearance after staining with periodic-acid-Schiff.

My experience of the clinical results of this condition may be summarized under the following headings: (1) ascites soon after an abdominal operation (starch granules and neutrophils are seen in large numbers on cytological examination of the exudate); (2) recurrence of abdominal symptoms following abdominal surgery; (3) miliary peritoneal nodules mistakenly diagnosed as tumour metastasis until microscopic examination; (4) undue peritoneal fibrosis. I examined abdominal adhesions histologically at post-mortem in cases that had previously had an abdominal operation, and found residua of a starch powder reaction in several cases.

Experiments carried out with the late Mr. Robin Poole, in 1968, who was then chief of surgery at Sudbury General Hospital, Canada, showed that after careful rinsing of gloves in a bowl of water after putting them on, much starch was still demonstrable with Lugol's iodine solution. Even after a second careful rinsing starch was still present between the fingers, but it seems likely that there is now much less danger of a serious inflammatory reaction and I would suggest that such a double rinsing be carried out before operations on the peritoneal and pleural cavity.—I am, etc.,

LESLIE MICHAELS

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Lymphocyte Sensitization

SIR,—The report of Drs. J. M. T. Willoughby and D. N. Mitchell (17 July, p. 155) that blood leucocytes from two thirds of their series of patients with Crohn's disease showed sensitization to Kveim reagent correlates well with recent findings in this unit on lymphocyte sensitization in sarcoidosis (17 April, p. 143). All 19 of a series of sarcoid subjects had blood lymphocytes sensitized to a variety of antigens including Kveim reagent and P.P.D. Among controls for our series were two cases of Crohn's disease and two subjects (apparently healthy) who had remained consistently Mantoux negative after repeated B.C.G. vaccination. All four showed the same cellular sensitization as frank cases of sarcoidosis. Our findings, like those of Drs. Willoughby and Mitchell, suggest a link between sarcoidosis and Crohn's disease, but also raise the possibility that unexpected lymphocyte sensitization to Kveim material (as well as a number of other antigens) may occur in subjects who are apparently normal. It would thus seem possible that either "normal" people may have a sarcoid pathological process in some non-obtrusive region of the body—that is, they may be cases of latent sarcoidosis and betray themselves by their cellular sensitization, or the cellular sensitization to multiple antigens is not really fundamental to either disease.

It must be added that similar sensitization is found in disseminated lupus erythematosus and in erythema nodosum. We have as yet studied ulcerative colitis in only two patients (females aged 15 and 44) and both showed lymphocyte sensitization of a degree intermediate between that customarily found

in sarcoidosis and the normal levels. A further study of this interesting condition is called for especially in view of the evidence (reviewed by Drs. Willoughby and Mitchell) that Crohn's disease and ulcerative colitis may sometimes share so many features that the distinction between them has become blurred.—We are, etc.,

E. A. CASPARY
E. J. FIELD

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Safety with Lasers

SIR,—With reference to your leading article on "Safety with Lasers" (3 July, p. 3), may I be allowed to make the following points?

A determination of damage threshold has been carried out in a human eye using a 1 msec ruby pulse and found to be 2.6×10^{-4} joules incident on the iris. Unfortunately the ophthalmic surgeon failed to note the iris aperture area and so this figure cannot be converted into joules/cm² incident energy.

You mention the need for immediate examination following laser injury. May I point out that several cases of delayed lens cataract have been reported and that a need for follow-up examination may exist. The source of cataract generation has not, to my knowledge, been determined, but is most likely shock wave polymerization.

Cases have arisen of laser laboratory personnel having congenitally defective vision in one eye. For their safety, we have recommended a change of occupation. The co-operation of ophthalmic surgeons carrying out the preliminary eye test is of paramount importance in such cases.

The present cost of regular ophthalmic investigation precludes the widespread commercial use of lasers to some considerable extent. In many cases, methods can be devised for complete separation of personnel from lasers but a need does arise for a simplified code of practice if the laser is to become a commercial viable tool.—I am, etc.,

D. W. GOODWIN

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University of York,
York

Pregnancy Advisory Services

SIR,—There can be no doubt that the Abortion Act is variously interpreted by doctors, and conditions which satisfy one that termination of pregnancy is required will not satisfy another. Since the operation is actually performed by gynaecologists their differing opinions are of most consequence and make for widely differing opportunities for abortions under the National Health Service in different areas. Many patients have to have the operation carried out privately in cities far away from home.

I feel there is a need for local authorities to set up advisory services on the lines of the Birmingham Pregnancy Advisory Service, a voluntary organization. Here all women with an unwanted pregnancy can seek advice, either through referral by their general practitioners or directly. If the patient fulfils the necessary conditions for termination the required forms are completed and she is referred to a sympathetic

gynaecologist, privately if necessary. The doctors who staffed such a service would obviously become familiar with the views of the gynaecologists in the area, and if necessary with those in surrounding areas and those running private nursing homes for abortion cases.

Where termination of pregnancy was not recommended, any necessary arrangements for social support could be put into action.

There must be many doctors who believe in the ideal of the Family Planning Association "every child a wanted child" and would be willing to staff such a service. By referring to gynaecologists only cases where two medical recommendations for termination of pregnancy have been obtained gynaecologists would be spared much form-filling, which I believe many find irksome. In rural areas and small towns the service could well be combined with a local authority family planning service.

The turnover of the Birmingham Pregnancy Advisory Service is ample proof of the demand for an advisory service. There may well be other such voluntary organizations in existence of which I am not aware. They would all no doubt be only too happy if statutory bodies would take over their function. The service need not necessarily be free. I am sure that patients would not be discouraged by a fee.—I am, etc.,

BARBARA BRUMBY

Lincoln

Working of the Abortion Act

SIR,—The arguments over termination of pregnancies following the passage of the Abortion Act continue unabated. I have long found that the public have no knowledge that certain criteria have to be fulfilled before a pregnancy can be legally terminated, and where there is any doubt I have always asked patients to read the four clauses on the green form and requested their personal opinion. Whenever they have considered one of these clauses to apply to them I have referred the patient to the appropriate specialist, be it medical social worker or psychiatrist or physician, though I have always believed that there is practically never a purely obstetric or gynaecological indication for the termination of a pregnancy.

I feel that, in view of the present committee which is investigating the working of the Abortion Act, the time has come when gynaecologists should only have to include in their routine hospital practice those cases where there is a true medical indication for the operation. If Parliament really accepts that the public should have the service provided by the private nursing homes surely it would be more politically honest that they should alter the wording of the Act to indicate this, and at the same time provide the centres where this can be done. If they consider that some fine or deterrent is needed to dissuade people from becoming pregnant irresponsibly then they could impose a charge for the operation, perhaps adjusted by a means test. Operations carried out in other institutions could then be made illegal and so we might eradicate from our profession the stigma that has attached to us.—I am, etc.,

A. L. DEACON

Edgbaston,
Birmingham

Starvation Therapy in Obesity

SIR,—Dr. F. Cavagnini and others (29 May, p. 527) support starvation therapy in obesity.

As a prisoner of war in the second world war I dealt with malnourished men, and was myself subjected for a period to almost complete starvation. The main consequence of lack of food was infection, particularly pulmonary tuberculosis. Deaths probably did occur from malnutrition per se, but emaciation in such cases was extreme.

Here we are also faced with the problem of gross obesity and have used complete starvation up to a period of 90 days in a number of cases. It must be realized that these patients are at risk, as most of those we have seen have E.C.G. changes suggesting myocardial ischaemia and some have presented in heart failure. However, we have had no fatalities. Postural hypotension has been the main side effect, which on reflection probably affected me as a prisoner of war. The serum uric acid has risen to levels of 20 mg/100 ml and we now use allopurinol. Ketosis has not been a problem, nor have we encountered hypoglycaemia. No electrolyte disturbances have been observed. Most of these patients have difficulty at times in excreting water, and we commonly use a diuretic, taking care to avoid potassium depletion.

While I should avoid this treatment in hepatic or renal failure and perhaps in diabetes mellitus, heart failure in our experience is not a contraindication. In fact, this is the reason we have used this regimen in several patients.—I am, etc.,

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Congenital Hip Dislocation

SIR,—I was most interested to read Mr. Geoffrey Walker's cogent article on "Problems in the Early Recognition of Congenital Hip Dislocation" (17 July, p. 147). I wish to support his views wholeheartedly and, if I may, to underline some of the points he raises.

Many of us practising paediatric orthopaedics are concerned about the continued presentation in our clinics of patients suffering from dysplastic hips, despite the widespread belief that early neonatal screening has solved this problem once and for all. We feel that the Department of Health and Social Security's publication on this topic is due for early revision, particularly in view of the possible medicolegal implications. The following relevant points need emphasis.

(1) There exist two main aetiological types of congenitally dysplastic hips. Firstly, the relatively common unstable hip at birth, due to hypermobile joints and hypotonia, which responds well to neonatal splintage, and secondly; the rarer primary acetabular dysplasia, probably genetically determined. This latter is often a difficult group to diagnose and does not necessarily benefit from the regimen of early splintage.

(2) One source of misdiagnosis by inexperienced and even experienced observers is the small group of babies who have fully dislocated, irreducible hips where the von Rosen sign is negative and indeed the limited abduction sign is negative, too.

(3) We consider that a child reported by