Miracle Cures

SIR,—With reference to the opening paragraph of your leading article (5 July, p. 1), a much more likely diagnosis than Parkinson's disease in the case of the woman commemorated in St. Luke's Gospel would seem to be some affection of the spine such as ankylosing spondylitis or congenital kyphosis. In the authorized version it says (Chapter 13, v. 11) that she "was bowed together and could in no wise lift up herself," and, after her cure (v. 13), "immediately she was made straight."—I am, etc.,

JOHN CAPWELL

Aylsham, Norwich

Hypertension—Which Arm?

SIR,—The following problem was encountered recently during blood-pressure screening men aged 50-54 in general practice. The blood pressure was measured in both arms in 33 patients and in 25 (76%) of them the diastolic pressure consistently differed between the two arms by at least 10 mm Hg. There was a corresponding variation in systolic pressure. The pressure was usually higher in the right arm than in the left, whichever was monitored first.

This seems a generally unrecognized problem both in defining mild hypertension and in monitoring treatment, unless all doctors concerned with the patient use the same arm for all readings. Five men out of 160 were clearly and consistently hypertensive, with diastolic pressures above 105 mm Hg. All were asymptomatic. A further 21 had one high reading.—I am, etc.,

R. A. SWALLOW

Burton-on-Trent,
Staffs

N.H.S. Reorganization

SIR,—Glancing through your report of your Chichester conference on the reorganization of the N.H.S. one is struck by the extreme good sense of Dr. A. Paton (28 June, p. 729) and the density of the brick wall he is facing. The only reorganization which would command respect would be a commitment to reduce the administrative staff by 10% per annum. Round here we used to have a secretary for each hospital plus an area secretary. We have retained all this but have added another group of secretaries who apparently control two hospitals each, and six quite adequate social workers have mushroomed to 64 in three years.

As your contributor from Australia, Dr. D. Meyers (21 June, p. 677), said, the private sector does its administration on the side, the public sector employs a corps of administrators. Central direction is clumsy, inefficient, and destructive of morale. We put up lockers, curtains, and day rooms for our geriatric patients as soon as we could get the money. What we did not need was someone from the centre to tell us about it.

Sometimes after a busy surgery in general practice or a ward round in the hospital, when I have seen a great number of patients, I say to myself that this is what it is all about—the actual consultation, the actual contact—and that all the rest—the administration, the committees, the learned sociologists, the theorists—are something that

I and men and women like me are carrying on our backs. Like it or not, we are paying them. Perhaps we should stop doing so.—I am, etc.,

W. H. FLADÉE

Maidenhead, Berks

SIR,—We have read with great interest the reports of your Chichester conference on N.H.S. reorganization (28 June, p. 729, 5 July, p. 22, and 12 July, p. 81), but we feel that what has not been sufficiently stressed is the financial cost.

Our health district is already deprived of adequate clinical services, and yet on 10 July, at a special meeting of our district medical committee, we were asked to consider plans for cutting these services further in the light of "guidance" from our area and region, asking plans to be made for possible cuts of 3½% in real terms over the next three years.

At the same time the money being spent on the administration of the N.H.S. has enormously increased. In our case both the regional and district administrative staff are slightly larger than before, but in addition there is the new and rapidly expanding structure at area level. Not only is this additional tier very expensive but the new structure appears to have reduced the efficiency of the service. There are so many more people to be informed of every move, so many more committees, that the process of making decisions has become more nebulous instead of more clear cut.

We hear it said on every side "Yes, there is one tier too many." If this is so the sooner serious consideration is given to the practical and political difficulties involved in dismantling either the regional or area tier the less damaging will be the change. Our district medical committee was so concerned about the money being diverted from clinical services to administration, particularly in the new area structure, that it asked us to try to raise the matter by all available means at national level: hence this letter.—We are, etc.,

TOM DUNN
Chairman,

ARNOLD ELLIOTT

Vice-chairman,
East Roding D.M.C.,
Redbridge and Waltham Forest Health Area

Doctors as Managers

SIR,—Your leading article (5 July, p. 6) queries the value of the co-ordinating role of the community physician. The questions which must therefore be answered are whether there is need for a co-ordinator and, if so, is the community physician the best person to fill this role? Those efficiency experts who wrote the management document upon which the reorganization of the National Health Service is based (the "Grey Book") had no doubt that the keystones of the new planning system were to be the health care planning teams, which would crystallize the needs of the districts. For the health care planning teams to work effectively they must have the advice of a trained epidemiologist who can point out the gaps between the needs and resources, and this is the role of the community physician.

Multi-disciplinary management is here to stay and in the absence of the community physician the clinical members of the district

management teams may find that the medical needs of the Service become subordinated to the intricacies of finance and administration. The community physician has the duty of defining what are the urgent priorities in each district and suggesting any alternative ways in which these needs can be met.

The history of the N.H.S. is littered with white elephants of the planners. If the community physicians can help prevent repetition of those expensive mistakes then their co-ordinating role is clearly worthwhile.—I am, etc.,

H. BINYSH

Truro

Deaths from Non-accidental Injuries in Childhood

SIR,—Dr. Catherine S. Peckham and Megan Jobling (21 June, p. 686) rightly quote the Registrar General's statistics when they question the speculative estimates of over 700 infant deaths a year from non-accidental injury. Statistics abstracted from the Registrar General's statistical reviews, supplied by the Office of Population Censuses and Surveys, and presented for discussion at the 24th Annual Conference of Police Surgeons of Great Britain (Eastbourne, 7-10 May), show that since the beginning of this century deaths in children aged under 5 years due to "homicide and injury purposely inflicted by other persons (not in war)" have steadily declined. In 1910 115 such deaths were recorded but by 1972 the total had fallen to 80. The population of England and Wales during this time had increased from 36.07 to 48.59 millions. These figures were not challenged.

The term "battered baby" is unknown to the law. The law is concerned with assault or with cruelty of a specific kind. Criminal proceedings for assault are brought under the Offences against the Person Act, 1861 (SS. 18, 20, and 47), and those for cruelty of a specified kind under the Children and Young Persons Act, 1933 (S.1). Such proceedings are not common. In Birmingham, where between seven and 12 adult and two juvenile courts sit daily, between 12 and 24 such cases are brought annually.¹ Dr. A. White Franklin, of the Tunbridge Wells Study Group, wrote² to justify his group's statistics of infant deaths due to violence and to question those of the Registrar General. He believes that children are pushed through windows and that their deaths are recorded as accidental and that a child dying from pneumonia after physical injury would be certified as death due to pneumonia without mention of the injury inflicted. This is not possible. All deaths in which there has been any suggestion of violence, however remote, or of poison, neglect, or industrial disease are automatically referred to the coroner. The coroner is obliged to hold an inquest and to sit with a jury. He receives death notifications from many sources.

A coroner's court can return a verdict of death due to (1) natural causes, (2) accident, (3) misadventure, (4) suicide, (5) felonious killing, or (6) an open verdict. A verdict of felonious killing is rare because the police are usually already involved and somebody is charged. The coroner opens his inquest and adjourns his court. After the criminal trial the court administrator notifies the coroner of the judicial verdict. The coroner

reconvenes his inquest and a formal verdict is returned in accordance with that of the criminal court. It is this verdict that the Registrar General includes in his own statistics. Thus, those who dispute the Registrar General's statistics for death due to "homicide and injury purposely inflicted by other persons" quarrel with the judiciary.

Dr. Franklin states that his figure of 700 infant deaths due to "baby battering" is a projection based primarily on studies in Preston by Dr. M. H. Hall.³ Dr. Hall recorded five such deaths between 1970 and 1972. He has stated (personal communication): "To attempt to project my small series into national incidence would be the height of statistical folly."—I am, etc.,

KENNETH T. FARN

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¹ Cavenagh, W. E., *Justice of the Peace*, 1974.

² Franklin, A. W., *The Times*, 9 June 1975.

³ Hall, M. H., *Police Surgeon*, 1974, 6, 1974.

Reticulum Cell not a Haematopoietic Stem Cell

SIR,—In their article on myeloproliferative disorders in the series on blood and neoplastic diseases (16 November 1974, p. 399) Drs. S. M. Lewis and L. Szur state that the "reticulum cell is thought to be the haematopoietic precursor cell from which originate the erythrocyte, granulocytic leucocyte, and megakaryocyte." In a diagram they illustrate this view and suggest the relationship with myeloproliferative disorders. There is no experimental evidence, however, that the reticulum cell can be the haematopoietic stem cell. Ontogenetic studies showed that the haematopoietic stem cell originates in the yolk sac, is next present in the fetal liver,^{1,2} and finally in the bone marrow. To the best of present knowledge the pluripotent haematopoietic stem cell in post-natal life has the morphology of a small round cell like a small lymphocyte but quite distinct from that of the reticulum cell.³ The reticulum cell, on the other hand, is a large cell with specific morphological features and forms reticulin fibres.^{4,6}

In our view it is more appropriate to make a distinction between cells deriving from the

haematopoietic stem cell and those from mesenchymal origin (see fig.).⁷ Such a distinction based on morphological, cytochemical, functional, and kinetic characteristics offers ample opportunity for the classification of myeloproliferative and other neoplastic diseases.⁷—We are, etc.,

R. VAN FURTH

J. W. M. VAN DER MEER

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Leiden, Netherlands

¹ Moore, M. A. S., and Metcalf, D., *British Journal of Haematology*, 1970, 18, 279.

² Cline, M. J., and Moore, M. A. S., *Blood*, 1972, 39, 842.

³ Bekkum, van D. W., et al., *Blood*, 1971, 38, 547.

⁴ Stuart, A., in *Mononuclear Phagocytes in Immunity, Infection and Pathology*, p. 111. Oxford, Blackwell, 1975.

⁵ Carr, I., in *Mononuclear Phagocytes in Immunity, Infection and Pathology*, p. 117. Oxford, Blackwell, 1975.

⁶ Hoefsmit, E. Ch. M., in *Mononuclear Phagocytes in Immunity, Infection and Pathology*, p. 129. Oxford, Blackwell, 1975.

⁷ Furth, van R., Langevoort, H. L., and Schaberg, A., in *Mononuclear Phagocytes in Immunity, Infection and Pathology*, p. 1. Oxford, Blackwell, 1975.

Pemphigus Induced by D-Penicillamine

SIR,—We have observed six cases of bullous cutaneous eruptions with features of pemphigus in patients who were (or had been recently) receiving D-penicillamine (DP) for seropositive rheumatoid arthritis. The clinical aspect of the eruption was in one case typical mucocutaneous pemphigus vulgaris and in the remaining five cases a purely cutaneous bullous disease, which presented three times as pemphigus seborrheicus and once as dermatitis herpetiformis. The diagnosis of pemphigus was based in all cases on: (1) the Tzanck cell test; (2) histological demonstration of acantholysis; and (3) circulating antibodies to intercellular substance, the titre of which was rather low except in one case in which it reached 1/1600.

The bullous disease developed during DP treatment in five cases (in one on resuming treatment after an interval). In the sixth patient the pemphigus started after DP had been withdrawn for several months owing to a previous non-specific bullous rash. (Another case, seen in collaboration with Dr. C. Grupper, showed a similar delayed

onset.) The evolution of the disease followed two patterns: a benign one, rapidly stopped by moderate doses of corticosteroids, and a classical course, sometimes very difficult to control.

Before these six patients were seen at our clinic a previous case had been reported in a patient under treatment for Wilson's disease.¹ Since our first reports of this condition^{2,3} and our further observations we have received verbal communication of three more French cases, making a total of 10 known cases of DP-induced pemphigus.

Two kinds of DP produced by three pharmaceutical firms share the responsibility of inducing the 10 cases of pemphigus: French extractive DP (Hôpitaux de Paris); Knoll's extractive DP, and Bayer's synthesized DP.

The pathogenic implications of these data may afford a new approach to research on the aetiology of pemphigus.—We are, etc.,

J. HEWITT

M. BENVENISTE

M. LESSANA-LEIBOWITZ

Clinique Tarnier,
Paris

¹ Degos, R., et al., *Bulletin de la Société Française de Dermatologie et de Syphiligraphie*, 1969, 76, 751.

² Hewitt, J., et al., *Annales de Médecine Interne*, 1971, 122, 1003.

³ Benveniste, M., Thèse, Paris, 1972.

Sequelae of Delayed Spontaneous Respiration in Breech Infants

SIR,—The current controversy about vaginal versus caesarean delivery for breech infants¹ has led me to follow up infants from a series of 106 vaginal breech deliveries without death from tentorial tear to see whether infants who were kept alive by prompt intubation and prolonged positive pressure respiration (P.P.R.) developed gross long-term sequelae. The three who failed to breathe spontaneously within 20 min have all been traced and only one is grossly handicapped, being spastic and slightly mentally retarded at 3 years. This child was born at 40 weeks gestation (birth weight 3.7 kg) after concealed accidental haemorrhage, was shocked at birth, and was treated with P.P.R. for 30 min. The second was born at 37 weeks (birth weight 2.35 kg) with a true knot in the cord and without a palpable apex beat. He was treated with cardiac massage and P.P.R. for 60 min. At 12 years he is of average intelligence with no sign of spasticity. The third infant was born at 34 weeks (birth weight 2.3 kg) with a prolapsed cord and received P.P.R. for 40 min. He had numerous childhood illnesses and was slow in developing speech and learning to read, but at 12 years he has overcome these difficulties, is tall and well built, and is "coltish" in his movements without being too clumsy. In the first case forceps were applied to the after-coming head; in the other two the Mauriceau-Smellie-Weit technique was used for delivery.

All four infants who failed to breathe spontaneously within 20 min after toxic accidental haemorrhage in Neligan's series,² however delivered, developed cerebral palsy. (Our case, taken with his, leads us to the conclusion that one should desist from P.P.R. after 20 min in any infant after concealed accidental haemorrhage.)

DIFFERENTIATION AND LOCALIZATION OF CELLS DERIVED FROM THE HAEMOPOIETIC STEM CELL AND MESENCHYMAL CELLS