guide as to where the general-practitioner obstetrician is to practise in the future; if he is to practise in general-practitioner units, where are they to be situated, and what will be their purpose; and make comment on his obstetric education both in the primary training and the continuing education fields.—I am, etc.,

DAVID BROWN.

Postgraduate Institute of
Obstetrics and Gynaecology,
St. Johns Hospital,
Chelmsford, Essex.

Immunization Schedules

SIR,—Many general practitioners will endorse the remarks of Professor R. S. Illingworth (12 October, p. 118) on immunization schedules. There is another aspect of the question which is by no means unimportant, and that is the traumatic experience which all these injections involve. This is bound to be greater after one year than before and readily sets up in the infant's mind painful associations with the doctor which may take years to eradicate.

I feel sure many will continue the well-established practice of giving the first "triple" synchronously with the mother's postnatal examination at six weeks, followed a month later by the second "triple" and first "polio," and so on until all, including smallpox vaccination, have been completed by six months. Theoretical objections are more than compensated by the almost 100% immunization rate achievable by this method and the gratitude of the parents that all, save boosters, have been given before the infant is fully aware of what is happening.—I am, etc.,

S. L. HENDERSON SMITH.

Lindley,
Huddersfield.

SIR,—The comment on the recent vaccination and immunization schedules (28 September, p. 807) is most timely.

This can be illustrated by the experience in this small town (population about 1,000) during last year. As far as possible all babies start immunization with triple antigen at 12 weeks. During the spring it was obvious that a respiratory infection was prevalent among the younger children in the town, and, though none was severely ill, many had spasmodic cough and sickness, which suggested a modified pertussis infection. It was therefore unfortunate that, for various reasons, one infant had reached the age of 5 months without immunization when an older child in the same family developed this mild infection. In spite of courses of ampicillin and tetracycline, as both prophylactic and treatment (one wonders if chloramphenicol might have been helpful), this infant became severely ill with typical whooping-cough, and eventually required several weeks in hospital. Though apparently fully recovered at the time, some recent symptoms have suggested the possibility of residual neurological damage.

One can speculate about the spread of this illness in the town if protection had been deferred till six months. As it was, no other child had symptoms to give rise to concern. I propose to continue beginning immunization with triple antigen at 12 weeks.

With regard to measles vaccination, it seems ill advised to vaccinate infants without the provision of a second dose at a later age. It has been a common observation that infants aged 9–18 months who contract measles often show an altered clinical course, which may not confer permanent immunity. It is reasonable to suppose that live vaccine would behave in the same way, when there is presumably some persisting maternal resistance.—I am, etc.,

M. F. BREWSTER.

Wigtown,
Wigtownshire.

SIR,—The revised list of fees for vaccinations and immunizations contained in E.C.N. 682 amazes me. Surely two years' experience of the previous list should have suggested some need for simplification of the system of payment. Why are two rates of fee retained? The administrative cost of recalling a patient for a third or reinforcing dose could justify a higher fee, but one could use the same argument to justify the same fee for a first dose if the patient was notified that it was due. Would not a single fee of 6s. for all procedures have been a reasonable compromise?

Why must we continue this mad business of classification into paragraphs, sub-paragraphs, and sub-sub-paragraphs? The clinical details included on the form should be sufficient evidence of the probity and honesty of the doctor's action. A simple statement that immunization has been given in accordance with the latest recommendations should suffice—the maternity services claim form provides a precedent.

Whatever one thinks about these matters, the drafting of the appendices is awful. In paragraph 3, tetanus, no reference is made to children under 15 who require tetanus immunization only; the subparagraphs are unlettered, and, even if they were, the differentiation in the 15–19 age group between those at school and those having left school seems unnecessary. In paragraph 4, poliomyelitis, there are certain to be differences of opinion on classification in the 16–19 age group.

Although international certificates of vaccination have been obtainable from executive councils for the last four years, the "Notice to Travellers" is still not amended. In the interest of preventing forgery, these certificates should not be supplied to the public.—I am, etc.,

M. A. C. HEAVENS.

Chigwell, Essex.

Types of Ehlers-Danlos Syndrome

SIR,—I am delighted that Dr. P. Beighton (14 September, p. 656) confirmed in his series of 100 cases of Ehlers-Danlos syndrome most of my findings in a series of 39 cases.¹ We both found that the syndrome comprises several subgroups and that a minority of patients with a clinically distinct form of the syndrome are especially liable to lethal complications. Dr. Beighton calls this important form the "ecchymotic" type, while I termed it the "arterial" type of the Ehlers-Danlos syndrome.

In 1936 Sack² probably described the same disorder and called it "status dysvascularis." He noted the extreme tendency to bruising, the transparent skin, the hypermobility of

fingers, and the frightening tendency to major arterial ruptures. I propose therefore that until the basic defect is discovered this condition should be given the name of the person who first described it. The Sack's syndrome, instead of the "arterial," "ecchymotic," or "dysvascular" type of the Ehlers-Danlos syndrome, would emphasize the enormous difference in prognosis between this disorder and other types of the Ehlers-Danlos syndrome. Indeed, despite some overlap in the clinical features (which is not unusual in inherited connective tissue syndromes), the Sack's syndrome is clearly distinct from the Ehlers-Danlos syndrome and should not be grouped with it any longer.—I am, etc.,

A. P. BARABAS.

Norfolk and Norwich Hospital,
Norfolk.

REFERENCES

- ¹ Barabas, A. P., *Brit. med. J.*, 1967, 2, 612.
- ² Sack, G., *Dtsch. Arch. klin. Med.*, 1936, 178, 663.

"Myringotomy"

SIR,—I have read with interest Mr. S. R. Mawson's paper on myringotomy (31 August, p. 539). He has shown that an operation which was performed so frequently for acute otitis media before the introduction of antibiotics has tended to be forgotten, yet there are many instances where a patient will benefit considerably by myringotomy.

I must, however, disagree on a number of important aspects of the pathology of the lesions treated by myringotomy. Acute suppurative otitis media is a very common illness among children, especially during the winter season in industrial areas, where overcrowding, bad housing conditions, and malnutrition still contribute towards its occurrence. The infection involves the nose, post-nasal space, Eustachian tubes, middle ear, and mastoid process because these structures are in continuity. Very frequently these children have infected noses with mucopus trickling into the postnasal space, their middle ears are lined with congested mucous membrane which bleeds after myringotomy, and the mastoid air-cells are lined with inflamed mucous membrane. In the pre-antibiotic era a child suffering from acute otitis media frequently underwent a cortical mastoid operation, but the surgeon found the cells were lined with inflamed mucous membrane and no pus was found. Such a patient requires treatment with an intensive course of a broad spectrum antibiotic such as ampicillin, and given in adequate dosage every six hours for at least 10 days. This will resolve the infection throughout the upper respiratory tract, and help to re-establish natural aeration and drainage of the middle-ear through the Eustachian tube.

A myringotomy will drain the middle-ear contents only and will not prevent infection invading the lateral sinus wall with consequent thrombotic complications seen so rarely nowadays. Middle-ear infections fail to resolve completely or relapse because the child has not received an adequate course of antibiotic. The child improves rapidly once treatment has begun, but the mother uses her own judgement when to discontinue treatment, especially if she keeps a supply of antibiotic in the bathroom cabinet. Frequently she is