workers spread the belief that lassitude and irritability presage a heart attack the suffering will be of a different order. The flood of patients already needing reassurance about their hearts will become an unmanageable torrent. The sight of a patient arriving by taxi and carrying his suitcase to the intensive care ward (presumably having "lost more than 80% of his usual capacity for physical effort") might cause sardonic amusement to those of us who have always believed that the usefulness of these wards has been exaggerated. One views with less equanimity the pathetic friend or colleague who has developed a neurosis believing that his irritability and lassitude may be the harbinger of death.

If doctors and especially cardiologists believe that these symptoms are due to anxiety and not coronary artery disease it is their duty to state this quite clearly, since silence may be assumed to be tacit approval for the concept that lassitude, deteriorating business efficiency, rising tensions, and an 80% loss of the usual capacity for physical effort but without angina are valuable predictive evidence of coronary artery disease.—I am, etc.,

P. B. S. FOWLER

Charing Cross Hospital,
London W.C.2

Breast-fed Infants and Gastroenteritis

SIR,—I read with great interest Mrs. Catherine L. Bullen and Dr. A. T. Willis's paper (7 August, p. 338). It recalls previous attempts by nutritionists, pathologists, and not least paediatricians to find a formula which would produce and maintain in the artificially fed infant who develops a predominance of *E. coli* in the stools the lactobacilliary bifid flora of the breast-fed baby, which has been regarded as the safeguard against Gram-negative enteric infections. The authors rightly assume that the shift from the physiological to the *E. coli* flora is mainly attributable to the nature of the food.

In the search for a feeding formula producing a predominantly lactobacilliary intestinal flora various modifications of cow's milk were not effective unless the carbohydrate content was increased by the addition of a mixture of two or three carbohydrates to bring it to the level of breast milk or above.¹⁻³ The present fashion to feed the newborn and premature baby on full milk formulas without the addition of sugar is bound to increase their liability to Gram-negative infection. Therefore the bacteriological control of the faeces should be part of their care.

It has been found that in the absence of breast milk this danger can be minimized by feeding on diluted cow's milk with 5-10% carbohydrates.

The results of the experiments by Mrs. Bullen and Dr. Willis are of considerable clinical value. They underline once more the superiority of breast milk and support the argument that the prophylaxis against enteric infection in the young infant can be achieved by alimentary means. Their endeavour to find the key to a breast-fed type of pH and flora in bottle-fed babies will be welcomed by paediatricians and babies alike.—I am, etc.,

MARTHA DYNISKI-KLEIN

London W.1

- ¹ Bessau, G., *Monatsschrift für Kinderheilkunde*, 1937, 68, 297.
- ² Finkelstein, H., *Säuglingskrankheiten*, Amsterdam, Elsevier, 4th edn., 1938.
- ³ Stone, E. L., *The Newborn Infant*. Washington, Lea and Febiger, 3rd edn., 1945.

Vasectomy

SIR,—Further to the letters of Mr. N. A. Regan (23 October, p. 233) and Mr. J. A. Williams (13 November, p. 426) I should like to add a technical point in the operation which has not been emphasized—namely, that only one skin incision is required. This serves to simplify the procedure yet further when carried out under local anaesthesia. Furthermore, it is my impression that this lessens the chance of postoperative haematoma formation on the assumption that a certain amount of bleeding will occur from the cut edges of the underlying dartos muscle, and therefore one incision is safer than two. Of course care must also be taken with the vascular bundle which immediately surrounds each vas.

A single 1 cm skin incision is placed anteriorly in the midline raphe of the scrotum. Each vas in turn can then be drawn through this incision with dissecting forceps as a cleanly isolated loop. Thereafter the operation proceeds in much the same manner as described by Mr. Williams. One vertical mattress catgut suture, which includes the underlying dartos, is used to close the wound with the knot placed deeply. Finally, the patient is given a suspensory bandage to wear postoperatively for a few days. Many are able to go back to their jobs that same day. In a fairly large series of cases haematoma formation has only been a mild complication in three patients (1.2%).—I am, etc.,

J. MCKENZIE BUCHANAN

Newcastle,
Staffs

Payment for Surgical Footwear

SIR,—Before 1 February 1965 patients who were prescribed surgical footwear paid £3 towards the cost. Patients on social security and old age pensioners were exempted. This charge was removed completely after this date.

Since everyone living in Britain must by the dictates of civilization wear shoes, it does seem reasonable that those who are wearing surgical footwear should pay at least a proportion of the cost because they would normally spend perhaps up to £10 a year on buying shoes for themselves. It is worth mentioning some statistics to show the cost of this service to the taxpayer. A pair of women's surgical shoes cost £17.30, and the cost of a pair of men's surgical shoes is £18.5. In addition, almost all surgical shoes have certain modifications and insoles, so that the cost works out at £21.50 approximately for a woman's pair of shoes, and approximately £22.50 for a man's pair of shoes. It may come as a surprise to most of your readers that all repairs and alterations are done at the State's expense, and this works out for a woman at £2.90 for soles and heels and for a man at £3.20. The total cost for surgical footwear at one of the hospitals where I work during the period of April 1970 to July 1971 reached the total of £1,574.18. The Department of Health some time ago gave the estimate of cost for surgical shoes

for England and Wales for one year as £1.2m.

I would like to see more effort made to look at the N.H.S. critically for common-sense saving.—I am, etc.,

NIGEL H. HARRIS

London W.1

Handicapped Children in Preschool Playgroups

SIR,—Dr. Elizabeth Grantham (6 November, p. 346) draws attention to the possibilities of useful co-operation between playgroups and paediatric and local authority services in the care of young handicapped children. Her diagram suggests a possible pattern for this, based on experience in the Peterborough area. The P.P.A. branch there is unusually fortunate in having its own medical adviser who understands the significance of parent involvement. By no means all areas have playgroup advisers (suggested in the diagram as a necessary link in placement and follow-up), though a trend to appoint such a person is now developing, particularly in educational priority areas.

It needs emphasizing that P.P.A. playgroups are intended primarily for 3- and 4-year olds, since we believe that most children are not ready before 3 to spend a whole morning away from mother. Handicapped children need the stimulus of play as early as possible, and for this reason the idea of the opportunity class or playgroup for the under-3 stage (irrespective of age) has gained ground, and can often be a bridge to an ordinary playgroup.

In my own experience an opportunity playgroup has furthered interdisciplinary co-operation in assessing the future educational needs of handicapped or developmentally impaired children. It has also shown how eager the supervisors, helpers, and mothers are to promote a child's development, and how necessary it is to devise a simple system of observation and recording so that individual play programmes of positive value can be planned and their results assessed. Ideally, before entry to the group each child should have an accurate appraisal of his stage together with an indication of his specific needs for helping progress to the next stage, but the latter is an area in which there appear to be very few guide-lines at present.—I am, etc.,

JANE GRUBB

Medical Adviser, Opportunity Playgroup,
Stoke Mandeville Stadium, and
P.P.A. Area Organizer, Oxford City

Oxford

Normal Range for Serum Transaminases

SIR,—Using optimized test packs from Boehringer Mannheim, Professor D. N. Baron and others stated (4 September, p. 583) that they found normal values for serum transaminases lower than those given in our information sheet. We are pleased that a discussion on these normal values and their determination has thus been stimulated. We would like to make the following remarks.

The normal values given in our instruction sheets were taken from a publication by Laudahn *et al.*¹ These authors examined 11,000 persons in Berlin in an attempt to identify unrecognized liver diseases. Serum transaminase levels were determined in 4,600 people using the optimized test packs,