use oral clindamycin or, as a preoperative injection, intramuscular lincomycin as our antibiotic of choice.

The department treats approximately 75,000 new patients a year, of whom some 5,500 now receive lincomycin or clindamycin, making a total of 22,000 patients treated with these antibiotics during the past four years. Owing to the drug's rapid absorption and high tissue penetration the clinical results have been excellent and bacteriological monitoring shows that the staphylococci remain completely sensitive. The rapid resolution of acute soft-tissue infections has greatly reduced the number of patients' return visits, with consequent benefit to the cost and efficiency of running the department. Adverse reactions have been remarkably few. Three patients have had a transient generalized skin rash. A small percentage complain of dyspepsia and occasionally a patient who has had a few loose stools will remark, with an air of satisfaction, "that was good opening medicine, doctor." Only one patient has had incapacitating diarrhoea. He had about 15 motions a day for three days but then made a rapid recovery on symptomatic treatment from his own doctor.

An inquiry in the Leeds University department of surgery, where treatment is given for colitis patients from a very wide area, reveals that no patient has come under their care for colitis secondary to lincomycin or clindamycin therapy.

These observations suggest that lincomycin and clindamycin if used in isolation in the recommended dosage (600 mg of intramuscular lincomycin followed by 150 mg oral clindamycin 6-hourly for four days for the adult patient) are extremely effective and almost completely safe as the antibiotic of choice in the treatment of acute staphylococcal infections.—I am, etc.,

D. H. WILSON

Accident and Emergency Department,
General Infirmary,
Leeds

SIR,—We are impressed with the incidence of intestinal abnormalities in patients taking clindamycin. We see many patients with severe acne vulgaris since we are interested in the investigation of such patients. We have found clindamycin effective in patients with severe acne. However, 12% of 70 patients developed mild diarrhoea within two to three weeks of starting clindamycin; the diarrhoea, which was never troublesome stopped on withdrawing treatment. This figure of 12% contrasts with a complete absence of diarrhoea in 72 matched patients taking tetracycline. No patient had frank pseudomembranous colitis.

We prescribe clindamycin (150 mg twice daily for three to six months) only for severe acne and only after tetracycline and other treatments have failed. One reason for failure of tetracycline is poor absorption; tetracycline should be taken half an hour before food and not with milk. We warn the patients about diarrhoea and keep them under review.—We are, etc.,

W. J. CUNLIFFE
S. G. TAN

Department of Dermatology,
Leeds General Infirmary,
Leeds

Squint

SIR,—On reading the discussion that has followed your leading article (17 August, p. 430) we feel that there is one point in particular that should be clarified. This is the desirability for early surgery in acquired childhood squints if a functional result is to be hoped for. Of the last 200 patients with squints having surgery at this hospital, excluding congenital cases and those without the possibility of a functional result, the most frequent age at initial operation was 3 years.

If surgery is delayed until the age of 5 years the prognosis for a functional result is considerably reduced, and this was one of the points raised by Mr. G. V. Catford, Mr. K. C. Wybar and Mr. T. K. Lyle (5 October, p. 42) in their correspondence.—We are, etc.,

DAVID TAYLOR
M. D. P. CRICK

Moorfields Eye Hospital,
London W.C.1

** This correspondence is now closed.
—ED., B.M.J.

Role of Infection in Chronic Bronchitis

SIR,—I am amazed at the statement in your leading article, "Smoking and the Common Cold" (7 September, p. 594) that "there is now good evidence to conclude that the progress of airways obstruction associated with chronic bronchitis is unaffected by recurrent chest infections."

Those of us who have spent a lifetime looking after chronic bronchitics have witnessed a different scenario. Though the role of infection in the pathogenesis and natural history of chronic bronchitis is uncertain, there is little doubt that the respiratory viruses, *Mycoplasma pneumoniae*, and *Haemophilus influenzae* (1) cause acute exacerbations of chronic bronchitis; (2) increase purulent sputum and produce inflammation, ulceration, and eventually fibrosis of smaller airways, thereby increasing airways obstruction; (3) usher in cor pulmonale, particularly in the "blue bloater" type of chronic bronchitic, by increasing hypoxia which further elevates pulmonary hypertension; and (4) may even complicate intrinsic asthma with pulmonary eosinophilia and allergic alveolitis. There appears to exist a synergistic and reciprocal relationship between infection on the one hand and irritants and lung damage on the other. The latter predisposes to infection and infection aggravates bronchial damage and obstruction.

Then there is the evidence from the role of IgA, which may be decreased not only in chronic bronchitis but also in bronchial asthma. Even in cases of hereditary deficiency of α -antitrypsin infection may further contribute to parenchymal damage by release of elastolytic proteases from the increased number of phagocytes. Because the smaller airways, which are narrowed in chronic bronchitis, do not significantly contribute to airways resistance the measurement of FEV₁ and FVC may not disclose the aggravating effect of infection, but long-term studies may show that recurrent infections have insidiously brought on scarring and narrowing of terminal bronchioles.

The prompt and energetic treatment of every respiratory illness and the protection of the bronchitic from such irritants as smoking, atmospheric pollution, and fog are the fundamental basis in the management of chronic bronchitis and anything less is to be condemned.—I am, etc.,

PAUL CROSBY

Marple, Cheshire

** We can sympathize with the views expressed in this letter as clinical experience suggests a role for infection promoting airways obstruction and indeed this is seen during the acute phase of the illness. However, it is usual for this functional decline to be restored upon recovery from acute bronchitis. Studies have been summarized by Fletcher¹ and have shown that it is difficult to support the notion that bronchial infection is an important cause for the progressive airways obstruction seen in some patients with chronic bronchitis. There does not appear to be a relationship between purulence of sputum, frequency of chest illnesses, or antibiotic treatment and the rate of decline of FEV₁ that is observed in these patients. Thus there is no doubt that acute bronchitis can temporarily worsen airways obstruction but there is considerable evidence giving reason to doubt the idea that episodes of acute infection influence the progress of airways obstruction in these patients.—ED., B.M.J.

¹ Fletcher, C. M., *Journal of the Royal College of Physicians of London*, 1968, 2, 183.

Disability and Coal Workers' Pneumoconiosis

SIR,—I am grateful to Dr. J. S. McLintock and his colleagues for their response (3 August, p. 343) to my paper (22 June, p. 652). But I beg of them to abandon the use of "bronchitis," which indicates a disease, for the presence of cough and sputum, the commonest symptoms in respiratory disorders. In the same way Dr. J. W. Todd (17 August, p. 471) protests about conscious patients being said to be in diabetic coma.

Professor W. K. C. Morgan (3 August, p. 343) emphasizes the difference between pulmonary impairment and disability. I hope, however, he does not expect us to adopt his dictum that "pulmonary disability is an inability to work because of pulmonary impairment" (my italics). How right he is to say that impairment affects people in different ways! Yet he seems to be able to decide when impairment produces disability. People who think they can do this should write down the degree of impairment they expect to find in their patients (not those interested in compensation). Whichever tests they use they will find patients with relatively small impairment who will have disability as far as can be judged by careful clinical assessment and others with much worse readings who can do a fairly heavy job. Are we then to regard the former as malingerers or lacking in moral fibre? This may sometimes be true, but should we not also say that these tests do not reflect disability as closely as our scientific minds would like to believe?

I can assure Professor Morgan and Dr. R. M. McGowan and his colleagues (24 August, p. 521) that I do understand that

when groups of people with pneumoconiosis are compared with others the differences in symptoms, function tests, and expectation of life are small. What I object to is the assumption that all patients with simple pneumoconiosis respond to dust in their lungs in the same way. Can the statisticians tell us how many may, for example, develop secondary emphysema and disability without upsetting the statistical conclusions that, as a group, they are no worse off than non-pneumoconiotics? It is time we accepted that the post-mortem studies of Lyons *et al.*¹ are the best available instead of trying to discredit them, mainly, it seems, because they do not support current dogma. Does Professor Morgan really believe that they are more biased than some of his studies in which ex-miners and retired miners are not included?

Most of the letter from Dr. McGowan and his colleagues deals with the aetiology of chronic bronchitis in miners and is a distraction from my main theme. As they seem to feel that my criticisms of panels are unjust I would like to offer four helpful suggestions which they have the power to implement.

(1) That when recording the results of ventilatory tests the expected readings should be added. This should reduce the frequency with which abnormal readings are reported to be normal. Dr. T. J. G. Phillips may recall a recent case in which readings of 70% of the expected were repeatedly claimed to be normal.

(2) That the frequent practice of writing statements such as "disability slight" under the readings should be abandoned—that is, disability should not be determined solely by these.

(3) That chronic bronchitis of various degrees of severity should not be diagnosed on naked-eye examination of post-mortem material unless criteria for making such a diagnosis and distinctions can be given.

(4) That when rejecting pneumoconiosis as a factor in disability or death panels should not use as the main argument such statements as "this degree of pneumoconiosis should not prevent him from carrying out his regular occupation" and "insufficient pneumoconiosis was present to have caused or accelerated death." The present philosophy is that pneumoconiosis does not matter until x cm of progressive massive fibrosis are present; x is bad, x-1 is harmless. In the latter case there may be a lot of scratching around for alternative explanations and practice (see (3)) is then often invoked.—I am, etc.,

D. DAVIES

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Rainworth,
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¹ Lyons, J. P., *et al*, *British Medical Journal*, 1972, 1, 713.

Traumatic Hindquarter Amputation

SIR,—Your leading article (5 October, p. 4) states that "there has . . . been one case of traumatic hindquarter amputation, and the patient survived." This presumably refers to Gordon-Taylor's series, but it could be interpreted as indicating that you know of only one case of traumatic hindquarter amputation in which the patient has survived. McLean¹ was under a similar impression when he reported his case in 1962.

Recently at a meeting of the Holdsworth Club I showed a patient of my own who had survived a traumatic hindquarter amputation and mentioned another case treated by Mr. Bruce McCulloch in Bishop Auckland. Neither of these cases had previously been recorded. Two members of the Holdsworth Club stated that they had seen similar injuries. McPherson² reported one case in 1960, Wade and Macksood³ reported two cases in 1965, and a single case was reported from Budapest in 1969 by Lasslo.⁴ The most recent case reported is that of Ganapathy⁵ in 1973.

This injury is perhaps not so common as we had previously thought.—I am, etc.,

GILBERT PARKER

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Middlesbrough, Cleveland

¹ McLean, E. M., *Journal of Bone Joint and Surgery*, 1962, 44B, 384.

² McPherson, J. H. T., jun., *Journal of the Medical Association of Georgia*, 1960, 49, 494.

³ Wade, F. W., and Macksood, W., *Journal of Trauma*, 1965, 5, 554.

⁴ Lasslo, P., *Orvosi Hetilap*, 1969, 17, 970.

⁵ Ganapathy, D. H., *Injury*, 1973, 5, 51.

Cold and the Heart

SIR,—Your leading article (17 August, p. 430) gives inadequate advice, I believe. True, the hypertensive stress reaction to sudden cold may cause myocardial hypoxia in a person with ischaemic heart disease, and avoidance of sudden exposure to cold will, of course, prevent such occurrence. Also I agree that those who use nitrates would do well to take an extra dose before exposure and perhaps they should indeed increase their daily measure of beta-blocking medication during the cold months. But such advice is stop-gap, remedial, and fails to make any attempt at correcting the heart's ability to cope with the increased work cold stress evidently demands.

Anginal patients will experience myocardial hypoxia during exertion. But do we advise them to stay in bed and take extra medicine when they must walk? On the contrary we urge them to strengthen the heart muscle and to improve coronary oxygen supply by gradually increasing exercise. The same applies with regard to temperature changes and needs attention when one must face winter each year, as in the U.K. By routinely taking a cool to cold shower after a warm bath the circulatory stress response itself will become attuned or numbed to the sudden cold stimulus and the heart will be trained to cope with the response. In contrast the use of beta-blockers suppresses the heart's compensatory action and will thereby tend to weaken the heart. I believe that adaptation through training is a therapeutic principle of prime importance for the long haul, while avoidance and medication must be considered temporary, short-term necessities.

A second point: stepping out into the cold is one way of looking at this cold stimulus. But the other way is emerging from the heat. We are dealing here not so much with exposure to cold or winter as with the impact of a sudden change. I advise my patients to bring their indoor temperature in better harmony with the outdoors, both in summer and in winter, and to dress indoors accordingly. For the winter that means an indoor temperature in the low

60s and being warmly dressed. This greatly reduces the "insult" of stepping out into the crisp cold.

While there are yet other points to consider (did exposure to cold happen after a hearty meal or on an empty stomach; did the patient drink coffee or tea or whiskey; is he obese or lean; did he argue with his wife?), adapting oneself to the seasonal temperatures and training the adaptation process deserve, I believe, our major attention.—I am, etc.,

WM. F. KREMER

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Maryland, U.S.A.

Geriatric Policies

SIR,—Professor G. F. Adams says that "the geriatric physician with a high turnover and no longstay problem is . . . suspect as a gerontological spiv. Somebody, somewhere must carry the can for him" (28 September, p. 789). I find this denigration of colleagues who strive for high turnover in order to run their service without a waiting list regrettable.

The high turnover strategy does not make the longstay problem disappear, but it can give a more efficient service based on one's limited resources.^{1,2} Those of us who use this approach feel that the tougher discharge policy is a good exchange for abolition of the wait for admission which the patient, the relatives, the general practitioner, and the community services would otherwise have to bear. Somebody has to "carry the can" either way; what needs to be properly examined and discussed is which of the alternatives imposes the lighter burdens. Should we not argue the relative merits of the high turnover strategy and of the conventional system without unnecessary emotionalism or insults or implying that those of one's own persuasion have the monopoly of "warmth, feeling, compassion, humour, patience, integrity and understanding"?—I am, etc.,

H. M. HODKINSON

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Harrow, Middlesex

¹ Hodgkinson, H. M., and Jeffreys, P. M., *British Medical Journal*, 1972, 4, 536.

² O'Brien, T. D., Joshi, D. M., and Warren, E. W., *British Medical Journal*, 1973, 4, 277.

Experts and Child Abuse

SIR,—Dr. Selwyn M. Smith and Mrs. Ruth Hanson are I feel breaking new ground with their paper (14 September, p. 666) which draws together the psychological, community paediatric and psychiatric fields into the joint study of battered children. Professor S. D. M. Court and his colleagues (28 September, p. 801) have pointed out that the doctor cannot intervene uninvited. Hence it is all the more important for him to become invited by meeting the parents-in-need half-way, through the context of the ordinary and routine child health service. Dr. Smith and Mrs. Hanson report that many (50) of the 134 children studied had no doctor as a general practitioner, yet many were already "at risk" since developmental quotients were significantly lower for battered children of low birth weight or with failure to thrive. There were then clear reasons for parental concern. The authors