

made whereby ophthalmologists will delegate to opticians wherever practicable the bulk of refraction work, in the knowledge that such work will be carried out to the entire satisfaction of both professions." In 1948 the introduction of the supplementary ophthalmic service effectively prevented any collaboration between ophthalmologists and ophthalmic opticians, took from the ophthalmologist his right to diagnose and treat his patients, and created a demand for outpatient treatment which the hospital eye service has never been able to satisfy.

The time is again opportune to try to improve the eye service of the nation along the lines suggested by Scouler and Professor Russell. There would be a shift of emphasis from the hospital to a community-based service³ in which diagnosis and treatment would be provided as well as refraction, and ophthalmologists and opticians would work together as a team. At the apex of the pyramid would be the ophthalmic consultant surgeon in hospital; in the next tier would be four ophthalmic specialists (at present graded S.H.M.O., Medical Assistant, O.M.P., or Para 94 appointment) working mainly in the community but also in the hospital outpatient service; in the third tier would be some 16 ophthalmic opticians, and in the fourth dispensing opticians supported by frame stylists and receptionists.

Team effort and a pyramid plan would achieve the best results with the amount of national income available, would increase the sense of commitment of staff to the local population, and exercise the intellect of ophthalmologists and opticians to better advantage.—I am, etc.,

P. RICHARD DAY

Tonbridge, Kent

- 1 Scouler, L. G., *British Medical Journal, Supplement*, 1944, 2, 10.
- 2 Giles, G. H., *The Ophthalmic Services under the N.H.S. Acts 1946-52*. Appendix X. London, Hammond, 1953.
- 3 Office of Health Economics, *Building for Health*. London, O.H.E., 1970.

Prevention of Deep Vein Thrombosis

SIR,—I have followed the correspondence on this subject with interest, particularly on the question of intermittent pneumatic compression of the legs in the prevention of deep vein thrombosis. I would, however, like to put the record straight with regard to the statement made by Dr. N. H. Hills and others in their letter (1 April, p. 49) when they say that their series reported at the Surgical Research Society in July 1971 was the first report. On 21 November 1964 I reported a series of cases treated by intermittent pneumatic compression at the Surgical Research Society and subsequently demonstrated the same method at a symposium at the Liverpool Medical Institute in January 1965, and subsequently reported in the journal of that institute.—I am, etc.,

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Coalminers' Pneumoconiosis

SIR,—Dr. J. P. Lyons and his colleagues (18 March, p. 713) reach a conclusion which is in conflict with the evidence they present. This is that "the excess emphysema in the pneumoconiosis cases, shown in our earlier

paper... is an integral and significant part of the disease." Yet the impairment of ventilatory function which they attribute to emphysema was greater in men without than in those with simple pneumoconiosis. Since there is now good evidence that the radiological category of pneumoconiosis is well related to the dust content of the lungs,¹ the evidence in this paper supports the conclusion that there is no relationship between disability and amount of dust in the lungs which has previously been established in epidemiological studies, and it counters their own conclusion that simple pneumoconiosis is a cause of emphysema.—I am, etc.,

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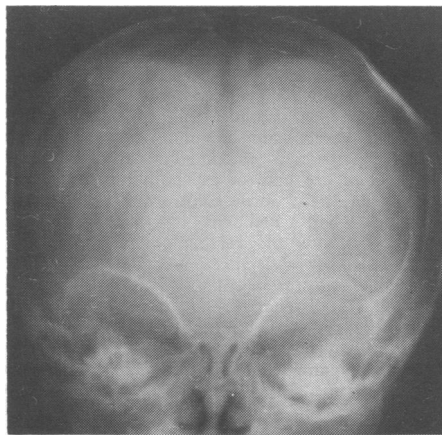
- 1 Rossiter, C. E., *British Journal of Industrial Medicine*, 1972, 29, 31.

Reduction of Pond Fracture

SIR,—An easy method of reducing pond depressed fractures in infants is described.

A boy aged 5½ months was brought to our paediatric outpatient department with a depressed pond fracture of the left parietal bone. The evening before he had been carried around on the back of a house maid, as is usual in African countries. In the morning the mother noticed a depression in the head. Although at first strongly denied, it was later admitted by the girl that the baby had fallen from her back.

The depression was about 4½ cm in diameter. Physical examination did not reveal any other abnormality; notably no neurological disorder was found. It was decided to use the vacuum extractor to reduce the fracture (Fig.). A suction-cup of 50 mm



diameter was applied over the depression. No anaesthetic was given. Negative pressure was quickly increased to 0.8 kg with the Malström-vacuum hand pump. Suction was kept on for four minutes, after which the cup was removed. No traction was exerted. As soon as the caput succedaneum had decreased, palpation revealed the fracture to be reduced and this was confirmed by one x-ray. After some hours the child was sent home. On subsequent visits the child was found to be perfectly well.

Pond depressed fractures are not rare in Africa because children tend to fall down from the backs of their mothers or nannies. In the last 18 months we have dealt with three cases, of which the first one, in a child of four months, was reduced according to the method described in Hamilton Bailey's

Emergency Surgery.¹ In the second case, an infant of seven months, the vacuum extractor was successfully used. Within the same period the vacuum extractor was used on three occasions to reduce pond depressed fractures sustained in labour. On each occasion a period of 24 hours was allowed to lapse before reducing the fracture. No complications were encountered. In the last of these cases two minutes' suction at 0.8 kg was sufficient.

Although the perforation traction method of reducing pond fractures is quite easy and satisfactory, it is considered that the method here described is even easier and safer, especially in circumstances prevailing in underdeveloped countries. Inadequate surgical asepsis and limited surgical experience of the attending doctor in tropical up-country hospitals could make perforation of the skull hazardous.

The dangers inherent to the use of the vacuum extractor are minimal because the time of suction is short and traction is not exerted.

I wish to thank Mr. C. B. Sedzimir for his encouragement to report the method.

—I am, etc.,

A. VAN ENK

Agogo Hospital,
Agogo (A.A.), Ghana

- 1 Bailey, Hamilton, *Emergency Surgery*, 8th edn., ed. T. J. McNair. Bristol, John Wright, 1967.

Suction Retractor

SIR,—It is difficult to cover the literature thoroughly. The suction retractor described by Mr. Michael Burke (8 April, p. 112) is similar to the one I described in the *Lancet* in 1964.¹ Its use was to retract friable tissue as mentioned in the letter.—I am, etc.,

JOHN SHIPMAN

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Hitchin, Herts

- 1 Shipman, J. J., *Lancet*, 1964, 1, 1424.

Recurrent Urinary Infections

SIR,—We think that for the sake of the record we should point out to Dr. H. G. Jones (8 April, p. 113) that Hugh and Andy did not advocate routine tomography at the time of an intravenous pyelogram. It was a chap called Henry (11 March, p. 688).—We are, etc.,

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ANDREW SMITH

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Newcastle upon Tyne

The Doctor in Conflict

SIR,—Your leading article (25 March, p. 761) deserves comment. In it you state "Moreover, there is no reason to suppose, and no shred of evidence, that any doctor in the recent troubles has departed from the ethical traditions that guide the profession." Yet you do not quote the source of this information. Are we to use traditions as guidelines? If so what role do the Declaration of Geneva and of Helsinki, and the International Code of Medical Ethics, play? I and other doctors in Ireland signed a letter addressed to the General Medical Council requesting an investigation into the behaviour of doctors during the interrogation of detainees. In its reply it said it was not within the province