“specialists” who treated sciatica with iontophoresis of the leg, unaware (as I found out in speaking to them, for I speak Russian) of the rudiments of pathophysiology. The same applies to amyotrophic lateral sclerosis, to diabetic nephropathy, and a host of other maladies (including coronary disease) about which their level of knowledge is unbelievably poor. While the peaks of Russian medicine are very high there is doubt in my mind (and in that of several of my colleagues quite “inclined” to the communist regime for political reasons) that Soviet medicine is at least two decades behind our Western level.

To sum up, while the delivery of public health is good behind the iron curtain I still am firmly convinced that should anyone need medical care he will be better off to cope with the inherent deficiencies of the American or British systems than to receive the generous, magnanimous, etc. (I am looking for adjectives to extol it) Soviet medical care.—I am, etc.,

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Endovenous Diathermy Destruction of Internal Saphenous

Sir,—More than two years ago, believing the conventional stripping operation for varicose veins to be a rather imprecise procedure with certain hazards, we began a technique for destroying the internal saphenous vein throughout its length from within the calf by diathermy coagulation of the intima. This eliminated the difficulties and dangers produced by the blind process when the vein was pulled off the tributaries. We are about to begin a long-term survey of the value of this treatment, but the encouraging results so far prompt me to make an initial report in the hope that others may try the method. The technical details are somewhat similar to that for an ordinary stripping operation. The internal saphenous is ligated in the groin and all tributaries below it to the internal saphenous and directly into the common femoral vein at this site are carefully ligated and divided. A specially designed electrode is then inserted into the internal saphenous vein, which is exposed by a small vertical incision over the internal malleolus. The “stripper” is passed the full length of the vein and brought out through the top of the divided saphenous in the groin. A ligature held around each end prevents leakage of blood. A bare area on the upper end of the insulated stripper is then connected to the diathermy machine. The stripper is then pulled up until the distal end is about half an inch (1.2 cm) where the vein and the lowest most catgut suture is tied fully. The leg is then raised to above the heart level so that blood is drained out of the veins as completely as possible. The electrode is now withdrawn upwards and the diathermy operated. We have found a steady rate of about one inch per second best, using the diathermy current employed for coagulation of vessels in other surgical operations. This much slower current causes a more uniform treatment. No symptoms of nervousness and muscles are unnecessary. After the stripper has been finally withdrawn in the groin the upper leg is also tied and the wounds closed. Bandaging is unnecessary, and the patient may walk around on the day after the operation. We prefer to keep the patients in hospital for two to three days but, since there is no bruising and little discomfort in the legs, this is not absolutely necessary. Probably the operation could be done as an outpatient procedure.

At first we did a conventional stripping operation on one side and the diathermy procedure on the other. Follow-up has shown no significant difference in the results, except that diathermy is much less distressing and is a much more precise procedure. Any small residual tributaries after two months are dealt with by sclerosant injections in the usual fashion. Pressure pads and bandages are not needed for this.

The strippers we have used are made of Fluon-coated wire of a multi-strand type. There is a bare segment near the upper end, which is introduced first, and this is also rounded with a metal tip. At the lower end there are multiple small points from the bare ends of the wire. The use of Fluon makes passage of these instruments much easier than that of conventional metal or plastic strippers, and intermediate incisions to enable the stripper to negotiate the full length of the vein are rarely necessary. We hope it will soon be possible for the electrodese to be purchased cheaply in a disposable form.—I am, etc.,

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URINARY TRACT INFECTION IN THE NEWBORN

Sir,—It was interesting to read your leading article on urinary tract infection in the newborn (2 September, p. 542), and I agree with the importance of culturing the urine in any neonate that is unwell.

I should like to raise the point of suprapubic puncture of the bladder, since many people regard this as a reliable method of establishing whether a true urinary infection is present. In this unit cystometry is performed on most neonates with spina bifida, and this entails inserting a suprapubic cannula over a central stilette. On removing the stilette there is occasionally faceal leakage of urine, which does not appear to be the case if a blunt needle was flowed freely. Evidently the tip of the needle had entered the rectum before returning to the bladder. This is more liable to occur if the needle is inserted just above the pubis, especially if directed downwards, as the bladder of a neonate is truly abdominal, the pelvis containing only the bladder neck and urethra.

In such circumstances an infected urine might reflect the rectal flora rather than infection within the bladder. I hasten to add that none of the babies in whom this occurred suffered any untoward effects. As a precaution against introducing infection neurolysis (2-3 cm) of the bladder at the bladder at the end of the procedure.—I am, etc.,

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Clinical Assessment Scheme

Sir,—I would like to reply to Mr. R. S. Murley’s comments on the clinical assessment scheme (2 September, p. 592) and to refute his suggestion that the scheme is unworkable.

Firstly, assessment is not designed to be more than a rough measure of competence or incompetence. After a month it should not be difficult for a doctor to judge if a doctor is fit to practise. Secondly, the difficulty of uniform standards is common to all examinations, but if the procedure is successful it is hoped to wean out the incompetent a sophisticated system is unnecessary. Thirdly, the accommodation issue is a subsidiary one (and not a proper criticism of the scheme). Doctors on long-term sick leave do not need to be housed in Y.M.C.A. hostels and even hotels where no hospital accommodation was free. Fourthly, the consultant’s admittedly arduous clinical duties (added to by the responsibility of assessments) would be still more arduous if there were fewer junior staff—the logical result if the scheme failed. Fifthly, and lastly, hospitals employing doctors failed under the scheme are obviously on dangerous ground, and those employing unregistered doctors are, of course, breaking the law. But this is evidence of authorities refusing to co-operate with the scheme rather than criticisms of its workability.

The value of the scheme to the Health Service is that it provides a practical measure of spoken English and practical competence. An E.C.P.M.G.-type examination is of little practical use in most parts of the country, and those who do not talk fluently in written English and theoretical medicine but their working experience is inadequate. Hospitals find the scheme valueless because those successfully assessed are available for locum and regular posts (often those not easy to fill). The benefits to the doctor assessed are obvious. In fact the scheme is worthwhile to everyone, but some