

## CORRESPONDENCE

Correspondents are asked to be brief

<b>Nurses for Nursing</b> Rachel Worsley, S.R.N. ....	727	<b>Gentamicin Dosage</b> R. Wise, M.B., and D. S. Reeves, M.R.C.PATH.; H. R. Ingham, M.R.C.PATH., and J. A. N. Emslie, M.D. ....	732	<b>Some Problems of Acute Osteomyelitis</b> D. A. Reynolds, F.R.C.S. ....	734
<b>Infantile Overnutrition</b> R. D. G. Creery, F.R.C.P.; I. G. Wickes, F.R.C.P. ....	727	<b>Australia Antigen and Pulmonary Tuberculosis</b> H. T. C. Hitchcock, M.D. ....	733	<b>Conscientious Objection to Abortion</b> P. S. Hughes, D.C.H. ....	734
<b>Clintest Tablet Stricture of the Oesophagus</b> R. J. Payten, F.R.C.S. ....	728	<b>How Infectious is Gonorrhoea?</b> S. M. Laird, F.R.C.P.GLASG., and R. B. Roy, F.R.C.S.; R. N. R. Grant, M.D. ....	733	<b>Scene on T.V.</b> A. E. Nicholls, M.R.C.S. ....	735
<b>Side Effects of the Pill</b> D. A. Varvel, M.B. ....	729	<b>Diagnosis of Arterial Embolism</b> J. W. Ardagh, F.R.C.S., and T. S. Weston, F.F.R. ....	733	<b>Geriatric Accommodation in Acute Illness</b> R. Tepper, M.R.C.P.; W. Fine, F.R.C.P. ....	735
<b>Coxsackie B Virus and Diabetes</b> D. R. Hadden, F.R.C.P.ED., and others. ....	729	<b>Oxygen Therapy</b> J. M. Leigh, F.F.A. R.C.S. ....	733	<b>Torsion of the Testicle Again</b> R. T. Burkitt, F.R.C.S. ....	735
<b>Making Hospital Geriatrics Work</b> B. Isaacs, F.R.C.P.GLASG.; S. Szanto, M.D.; M. F. Green, M.R.C.P.; P. W. Hutton, F.R.C.P.; A. E. K. Salvi, M.R.C.S. ....	729	<b>Dysuria</b> A. B. L. Peake, F.R.C.O.G. ....	733	<b>Removing Obstructed Balloon Catheter</b> S. C. Sood, F.R.C.S., and H. Sahota, D.T.M. & H. ....	735
<b>Pulmonary Function Laboratories</b> P. Lockwood, M.Sc. ....	731	<b>Scarred Heroes</b> L. M. Shirlaw, L.R.C.P. ....	733	<b>Forms for Hospital Investigations</b> R. Law, M.R.C.G.P. ....	735
<b>Active Management of Labour</b> L. B. D. Courtney, M.R.C.O.G.; P. E. N. Suter, M.R.C.O.G.; K. D. Salzmann, M.D. ....	731	<b>Cerebrovascular Accident</b> F. M. M. Eytton-Jones, M.D. ....	734	<b>Diagnostic Radiologists in Distress</b> J. G. L. Cole, D.M.R.D., and others. ....	735
<b>Middle Class Syndrome</b> D. G. Williams, M.R.C.P. ....	731	<b>A Kidney Sling</b> L. F. Tinckler, F.R.C.S. ....	734	<b>Clinical Assistants in Anaesthetics</b> M. M. Burrows, F.F.A. R.C.S. ....	736
<b>Detecting Sickie Haemoglobin</b> R. E. Bernstein, M.B. ....	732	<b>Eosinophils in the Blood Film</b> W. T. Menke, M.D. ....	734	<b>The Ten-session Contract</b> A. A. Vickers, F.F.R. ....	736
				<b>Occupational Health Services</b> T. H. Harrison, D.P.H. ....	736

## Nurses for Nursing

SIR,—Before the saga on "Salmon"<sup>1</sup> is concluded, may I try to set the record straight on several issues.

Ciphers used in the context of people are certainly deplorable and since nurses are firstly individuals, with "given" names and surnames, this personal form of address is surely to be preferred above all. The titles in the senior nursing staff structure are suggestions and in paragraphs 3-37 and 5-33 reference is made to the use of the original and traditional word "matron." Application of this title to male nurses is clearly unsuitable and the Salmon Committee's proposals (they were no stronger) tried to legislate for this. I doubt that there was a real desire within the profession to "do away" with matrons, in fact or in designation.

Your Coventry correspondent (18 November, p. 429) makes valid criticisms of an organization in which "it is difficult to find anyone really responsible for anything." However, this is not the fault of the staff structure per se, rather of ill-defined job descriptions and a failure of staff to appreciate their proper function and role within the organization. Additionally, there has been a failure on the part of hospital authorities to publicize the proposed changes in nursing management and to emphasize the expected benefits.

Few people in the hospital service would disagree that "the ward sister is the key person in the nursing care of patients." I can find no reference to integrating "the nursing managerial role of a nursing officer . . . with the work of a ward sister" as suggested by your correspondent. Their roles and functions are quite separate and clearly defined in paragraphs 4-1(2), 4-47, 5-1, 5-33, *et seq.*

The terms of reference of the Salmon Committee specifically excluded pay and conditions of service, so the oft-repeated comment that long-serving ward sisters should be able to command salaries and status commensurate with their experience and seniority is not relevant to a discussion on the merits and disadvantages of the new nursing management structure. Incidentally, most nurses would agree, and it is to be hoped that the nurses' and midwives' Whitley Council is addressing itself urgently to this matter.

The Salmon Committee had no magic wand with which to cure the many ills afflicting the nursing profession. Their report sets out proposals which have been implemented by the profession with far-reaching effects on other disciplines in the Health Service. By all means let us admit the imperfections of the system (was the old one better?) but in fairness let us be sure the faults are really due to the Salmon Committee's recommendations and not separate issues outside their purview, or attributable to other factors easily fitting into the "blame it on Salmon" category.

The Department of Health and Social Security's excellent booklet *Progress on Salmon*<sup>2</sup>, recently published, is recommended reading for those interested in pursuing their studies of this controversial subject.—I am, etc.,

RACHEL WORSLEY  
Chief Nursing Officer

Portsmouth Group H.M.C. Offices,  
St. Mary's General Hospital,  
Portsmouth

<sup>1</sup> Ministry of Health, *Report of the Committee on Senior Nursing Staff Structure*, London, H.M.S.O., 1965.  
<sup>2</sup> Department of Health and Social Security, *Progress on Salmon*, London, H.M.S.O. 1972.

## Infantile Overnutrition

SIR,—Dr. Annapurna Shukla and her colleagues (2 December, p. 507) have highlighted one of the most prevalent and probably most ignored paediatric problems of today—that of early unphysiological overfeeding and consequent overweight which many deplore but few do anything about. That this is not just another English disease was forcibly brought home to me last September while carrying out a survey, under the auspices of the International Grenfell Association, of the child population of a remote coastal settlement in Northern Labrador. Here I was astonished to find that more than 70% of the infants under one year were either overweight or obese. This seemed directly related to over-liberal and often concentrated evaporated milk feeds and seemed to be associated with a virtual abandonment of breast-feeding. On the other hand early introduction of non-milk solids was less common than in the U.K. but the excess calorie intake was undoubtedly there. Of the over-10-year-olds 49% were overweight or obese and it seems likely that in some at least of these children their overweight problem had started in infancy. There seemed to be an almost complete apathy on the part of the (admittedly few) medical and nursing staff in the promotion of breast-feeding in this part of North America, and it is interesting that the same lack of positive approach was found in Dudley, where 81% of the mothers appeared to get no appropriate advice on the merits of breast milk, nor, I suspect, on the demerits of cow's milk, which must surely be well known to trained staff. One might now hope for an emphatic demand for a return to feeding sanity following the clear evidence in this paper of the detriment

to infant health which may follow improper feeding of young infants. If some of the current preoccupation with child development could be transferred to the field of child nutrition, overnutrition and obesity might become things of the past and a slimmer and probably healthier child population might soon result.

In their discussion the authors state that "whether excessive dietary protein is harmful to babies is uncertain at present." To my knowledge there is no evidence that it is beneficial—why take chances? If there is the least doubt that it may be harmful (considerable elevations of blood urea and amino-acid levels can occur in cow's-milk-fed babies), then it would seem sensible that non-human-milk-fed infants (the majority) should take only substitute milks containing near-physiological amounts of protein (in the range 1.5-1.8% against 3.5% for unmodified cow's milk and 1.2% for human milk). The use of such modified and less unphysiological milks would have other advantages for the young infants; their lowered phosphorus content mitigates against disturbed calcium:phosphorus homeostasis and in the case of one at least of these adapted milks there is evidence of improved fat digestion and absorption. Such milks are more expensive, but not prohibitively so, and it is now to be our policy in the main maternity units of this area to recommend their use where natural feeding has failed or been declined for whatever reason. Every reasonable effort is still being made to promote breast-feeding ("breast-milk not beast-milk") and to ensure that parents know of the possibility of over-feeding, its recognition, its consequences, and its dangers. Particular stress is presently being laid on the avoidance of early non-milk solids and on the importance of reducing milk intake as solids increase in amount in the diet.

I can only hope that this clear and timely paper by Dr. Shukla and her co-authors will stimulate some equally clear thinking in high places on the necessity for rescuing medical and nursing interest in infant feeding from the deplorably low state to which it has fallen in recent years. I am quite certain that most parents, however misguided and badly advised they may seem to be in some cases at present, are only waiting for a lead and are anxious to do what is best for the nutrition of their infants. Let us hope that professional health workers are equally ready to play their part in imparting proper advice.—I am, etc.,

R. D. G. CREEERY

Cheltenham

**STR.**—Infant feeding has been subject to the dictates of fashion for centuries so we cannot expect to be exempt today. Overfeeding has been a bogey for as long. Before bacteria were discovered it was held to be the cause of gastroenteritis, the scourge of infancy. However, even in this century Truby King was able to get away with the ridiculous comment that "in the breast-fed baby over-feeding is more common and more dangerous than underfeeding" and this attitude persisted until after the second world war. In 1952<sup>1</sup> I reported an investigation of a series of 503 babies, 26% of whom had been diagnosed as overfed before they were two months old. Subsequent appraisal showed that in the vast majority unsatisfied hunger had been the cause of the symptoms and a

reduction of the feeds had usually aggravated the condition. This confusion is less surprising when one remembers that standard textbooks enumerate the same symptoms for over- and under-feeding—namely, vomiting, the passage of loose stools, and loss of weight. Since then, until recently, babies have enjoyed far more liberal feeding regimens with the advent of self-demand schedules and the ever-earlier introduction of solids, but there are now signs that the pendulum is beginning to swing back towards the Truby King approach with increased enthusiasm, since almost all our babies are now bottle-fed.

In their article Dr. Annapurna Shukla and her colleagues (2 December, p. 507) showed that 44.4% of their series of babies were "overweight" as compared with standards laid down by the Department of Health and Social Security. Their findings could, more convincingly I believe, be used to claim that the Department's standards are set too low because they are based upon a series of babies which included a significant proportion whose progress had been impeded by neonatal difficulties and or subsequent orthodox feeding restrictions. In another paper<sup>2</sup> I drew attention to the "stoking-up period," a self-limited spell of rapid gain in weight in the first three months of life during which healthy babies on unrestricted feeds gain weight faster than is commonly appreciated. Only 214 out of 503 infants qualified for the unimpeded progress group, though no doubt it could have been further whittled down had more information been available. In other words, the majority of infants in this series of "normal" babies had sustained setbacks in the first two months of life, and any standards based upon their average rate of gain would be bound to be sub-optimal. Incidentally, of the eight babies who averaged a gain of 2 oz (56 g) or more daily, five were wholly breast-fed and only one was wholly bottle-fed.

Orthodox feeding regimens have bowed to the principle that small babies have weak digestions and cannot tolerate strong feeds. The instructions on packets of dried milk have prescribed diluted milk for small infants, who are only permitted to graduate to a full-strength formula by the age of about six months (though they will probably have been taking solids long before this). Most small babies have a high potentiality for growth and a small-capacity stomach which can only fulfil that potentiality if super-strength milk, solids, or continuous drip feeds are given. The prevalence of the early introduction of solids in Dr. Shukla's series explains why her babies put the standards to shame. It is highly significant that there was a marked disparity between the standard figures and her group with regard to the caloric intake of babies under three months, whereas there was virtually no difference for older babies, indicating that her group had the opportunity of taking the advantage of the stoking-up period. Thereafter the intake and the rate of gain fall dramatically and there is no proof that these babies swell the ranks of obese adults, though it has been shown that babies who are fat in the second six months of life may do so. It has not been proved that extra food creates the extra complement of fat cells obese babies possess, and the familial tendency suggests that they are endowed with extra cells which "cry out" for extra food to fill them; alternatively it must be

admitted that extra food might create extra brain cells, in which case the choice would seem to lie between becoming slim and dim or fat and bright.

The onus is on those who advocate curtailing infant's feeds to prove these highly speculative points before the clinician puts them into practice. In the clinic, what are we to say to a mother who is repeatedly awakened by her hungry baby in the middle of the night? If she feeds him she may be made to feel guilty and if she gives gripe water instead he will obtain no lasting relief—either way she will enjoy her baby less and he will be discontented from the start. Perhaps, to conform with present views, we shall have to prescribe anorectic drugs routinely for 44.4% of all young babies.—I am, etc.,

IAN G. WICKES

Stock,  
Essex

- 1 Wickes, I. G., *British Medical Journal*, 1952, 2, 1178.
- 2 Wickes, I. G., *Archives of Disease in Childhood*, 1952, 27, 449.

### Clinitest Tablet Stricture of the Oesophagus

**STR.**—Clinitest tablets, used to detect glycosuria, are not generally considered to be dangerous and are sometimes kept in the same cupboard as medications. However, they contain 38% sodium hydroxide, which is very caustic to the oesophageal mucosa. Accidental ingestion, more common in children and the elderly, can lead to corrosive oesophagitis and stricture formation as the following case illustrates.



An 82-year-old diabetic woman with failing vision swallowed a Clinitest tablet, believing it to be aspirin, and immediately experienced a retrosternal burning pain. Three weeks later she was admitted to hospital with dysphagia for solids and liquids. A barium-swallow examination showed a narrow localized stricture at the level of the carina (see Fig.), which was confirmed at oesophagoscopy and dilated with bougies. Two further dilations were necessary in the next month and periodic bouginage may be necessary in the future.

Fortunately, swallowed Clinitest tablets are more often than not washed down