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 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 and complete symptomatic recovery from his own doctor.

An inquiry in the Leeds University department of surgery, where treatment is given to 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.,

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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 squint. We consider that close cooperation with those who are 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 compromised and we feel that 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,
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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, Mycoplastma 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 bronchitis, 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 PEV, and FVC may not disclose the aggravating effect of infection, but longitudinal 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 of the prevention of chronic bronchitis and anything less is to be condemned. I am, etc.,

PAUL CROSBY
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Disability and Coal Workers' Pneumocisiosis

SIR,—I am grateful to Dr. J. S. McIntintock and his colleagues for their report (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, because it is nonspecific and upsets the commonest symptoms in respiratory disorders. In the same way Dr. J. W. Todd (17 August, p. 471) protests against conscious pathology while saying it is in diabolic connotation. 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 write down the degree of impairment they expect to find in their patients (not those interested in occupational medicine). 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 malingering 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 we, 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 chronic bronchitis 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.3 are the mistake instead of trying to discount 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 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 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.,

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Tumastic Hindquarter Amputation

Sir,—Your leading article (5 October, p. 4) states that "there has . . . been one case of tumastic 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 tumastic hindquarter amputation in which the patient has survived. McLean4 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 had his amputation performed by Mr. Bruce Mc Culloch in Bishop Auckland. Neither of these cases had previously been recorded. Two members of the Holdsworth Club stated that they had seen similar injuries, McPherson5 reported one case in 1960, Wade and Mackwood6 reported two cases in 1965, and a single case was reported from Budapest in 1969 by Lasso.7 The most recent case reported is that of Ganapathy8 in 1973.

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

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Middlesbrough, Cleveland

4 Lasso, P., Oracis Healog, 1969, 17, 970.

Cold and the Heart

Sir,—Your leading article (17 August, p. 430) gives inadequate advice, I believe. True, the hypertensive stress reaction to cold does make the normal heart impossibly demanding 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 avoid cold exposure and perhaps they should indeed increase their daily measure of beta-blocking medication during the cold months. But such advice is stop-gap, medical, 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, regardless of their degree of coronary artery disease. 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 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 cold shower after a warm bath the circulatory stress response itself will become attenuated 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 stress. But the real problem is one of adjusting to 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 temperature changes and training the adaptation process deserve, I believe, our major attention. —I am, etc.,

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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. Someone, somewhere must carry the can for him." (28 September, p. 789.) I find this denigration of colleagues who serve for high turnover in order to run their service without a waiting list regrettable.

The high turnover strategy does not make the long-stay problem go away, but it can give a more efficient service based on one's limited resources.1 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, his relatives, the general practitioner, and the community services would otherwise have to bear. Someone 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.,

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Experts and Child Abuse

Sir,—Dr. Selwyn Smith and Mrs. Ruth Hanson are I feel breaking new ground with their paper (14 September, p. 666) which draws together the psychological, community paediatrician and psychiatric fields into the joint study of battered children. Professor S. D. M. Court and his colleagues (27 September, p. 686) argue that the doctor does not have to intervene at all, but that the doctor cannot intervene. 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 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 of the children 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