20-month-old baby, who developed a roseolar rash at the same time. Among the types of virus isolated from throat or faecal specimens from my patients at the time of their roseolar reactions were adenovirus 2, 3, and 14, echovirus 9, 11, 27, and 30, Coxsackie A6 and 9, Coxsackie B2, 4, and 5, and parainfluenza type 1.

Most children who received the earlier, less attenuated, measles virus vaccines developed a roseolar reaction as their fever subsided. This rash differed from that of measles in two respects: it began on the trunk instead of the face and it appeared as the temperature dropped and not at the start of the secondary fever.

Children who undergo either the fast ("one-spike") or the slow (roseolar) febrile immunizing reaction are as a rule otherwise healthy and free from any localizing signs of infection in the ears, nose, throat, chest, abdomen, or urine. The younger the child, the higher is the temperature likely to be. Presumably the roseolar rash is due to virus particles being neutralized in the skin at the end of a period of viraemia. Perhaps viraemia does not occur in the "one-spike" fever and so no rash appears.

Please may sixth disease now disappear from the next edition of textbooks?—I am, etc.,

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¹ Watson, G. I., *Journal of the College of General Practitioners*, 1966, 11, Suppl. 1, p. 15.

² Watson, G. I., *Proceedings of the Royal Society of Medicine*, 1969, 62, 1135.

Hernias in Children

SIR,—Your leading article on this subject (31 August, p. 540) was moderately distressing to me since I described the transperitoneal probing technique 11 years ago.¹ Shortly after the article appeared I was informed by a colleague from New Jersey that he had published such a procedure in an earlier article in that state's medical journal. More recently a U.S. naval surgeon exhibited a film at a clinical congress of the American College of Surgeons without prior reference.

I suppose what this represents is an unfortunate tendency for good ideas to become buried under the tons of more current literature, so I would not be surprised to learn that some canny Scot had described the same technique in an obscure journal around the turn of the century. But, for the moment, the Colonials have it over the Danes three to one.—I am, etc.,

EDWARD O. GOODRICH JR

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¹ Goodrich, E. O., jun., *Surgery*, 1962, 54, 432.

In Arduis Fidelis

SIR,—As a medium-brass regular R.A.M.C. officer, may I express my admiration for Sir George McRobert's fine review of Lt. Gen. Sir Neil Cantlie's stirring *History of the Army Medical Department* (12 October, p. 111) and may I express my gratitude to you, Sir, for the generous allocation of space for the review.

I write, however, to take sharp exception to a sentiment expressed in the first para-

graph—"the modern view . . . that defence medical services should consist of a regular 'core' of doctors highly trained in logistics, administration, and military planning and that consultants and clinical doctors should be obtained on a temporary basis from civil sources seems to be gaining ground." I think this view may be losing a little ground. It is most important that doctors considering joining the R.A.M.C. be not misled. The great majority of R.A.M.C. officers are engaged in the clinical care of the wounds, diseases, and injuries of members of the Army, their wives and children, and a large number of other persons entitled to treatment who include such sufferers from exotic diseases as the Chinese, Nepalese, and Cypriots.

In my experience the very highest posts in the Army Medical Service are filled by the appointment of Army doctors of clinical skill and experience who also happen to possess skill in administration, logistics, etc., whether natural or acquired. That experience in military surgery and tropical medicine is still acquired by the Army's consultants is fortunate, for these are the injuries and diseases of disasters, famines, wars, and social collapse; knowledge and experience that it is important for all ranks of the Army Medical Service to possess.

I had better add that these represent my own views and are not to be construed as the views of the Service.—I am, etc.,

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Medicine and the Common Market

SIR,—Perhaps some of the least publicized features emerging from the E.E.C. regulations on social security are the reciprocal medical treatment arrangements. These regulations go some way along the road to dispelling public sensitivity over the hitherto unilateral United Kingdom N.H.S. "good Samaritan" service. In particular, they provide that worker nationals (and members of their family) of the U.K. and other community countries who are on holiday or otherwise staying temporarily in a community country will be entitled to medical treatment for sickness or accidents which require urgent attention, on the same basis as insured nationals of that country, subject to their being armed with appropriate documentation. A welcome reciprocal tit-bit. The experiences to date of U.K. hospitals and general practitioners on this front would doubtless be interesting—or perhaps the experiences of the British public in the other member states would prove more interesting. However, nestling in the related E.E.C. regulation is a more intriguing, thought-provoking provision which demands precise quotation.

"A worker, and any members of his family . . . who is authorized by the competent institution to go to the territory of another member state to receive there the treatment appropriate to his condition, shall be entitled . . . to benefits in kind provided on behalf of the competent institution by the institution of the place of stay (or residence) in accordance with the legislation which it administers . . . the length of the period during which benefits are provided shall be governed, however, by the legislation of the competent state . . ."

"The authorization required may not be refused where the treatment in question cannot be provided for the person concerned within the territory of the

member state in which he resides." (Article 22 of Regulation/E.E.C./No. 1408/71 of the Council of 14 June 1971).

Few could deny the laudable intentions of such philosophy but, in turn, few could fail to detect palpable fundamental attendant difficulties. Inherent in such a system is the need for prearranged admission to hospitals, exchange of medical histories, the related hazards of "queue-jumping," language difficulties, disclosure of patients' records, etc. Other questions spring readily to mind. Who decides whether the treatment is appropriate to the condition—indeed, what medical significance has the expression "appropriate"? Could, for example, a rejection by one member state that certain treatment was "appropriate," though successfully practised in another member state, perhaps sour European medical rapport to some degree? Doubtless few cases have surfaced since our entry into E.E.C., but such is the profundity of the doctrine of this feature of the regulation and its practical possibilities that it seems to me timely to inquire of hospitals, consultants, and general practitioners what their experience has been in terms of general difficulties, documentation, the overall mechanics of such exercises, how much awareness they had of the regulations, and the reaction from the patients. Perhaps these columns would be a convenient vehicle for such information.—I am, etc.,

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Ethylloestrenol

SIR,—With reference to your leading article on "Fibrinolysis and Venous Thrombosis" (16 November, p. 365) I would like to correct the error made in calling ethylloestrenol an oestrogen. Though I appreciate its name may falsely suggest it to be oestrogenic, it has been shown by Junkmann and Suchowsky¹ to possess primarily anabolic, some progestogenic, and slight anti-oestrogenic properties.—I am, etc.,

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¹ Junkmann, K., and Suchowsky, G., *Arzneimittel-Forschung*, 1962, 12, 214.

Agoraphobia

SIR,—Your leading article on this subject (26 October, p. 177) dismisses the use of tricyclic compounds in the treatment of this condition somewhat abruptly, yet these compounds are frequently effective in agoraphobic conditions and they are often the first line of therapy in both general practice and psychiatric clinics. Two preparations in particular are of value—namely, clomipramine and opipramol.

In the treatment of agoraphobic patients in a busy outpatient clinic Harding¹ reports favourably on the use of oral clomipramine, describing this drug as being useful in these circumstances. Marshall and Micev² have shown the effectiveness of intravenous infusions of clomipramine in phobic disorders. No controlled trial of the use of clomipramine in phobic states has, however, been reported.

Capstick and Rooke³ in a double-blind trial of opipramol in comparison with a