Conference Report

Roses not for pruning

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While cuts were one of the central themes of the main meeting, growth was the subject of the scientific part of the Annual Representative Meeting in Manchester. This irony was not lost on one of the speakers, Dr G P Maguire, a senior lecturer in the department of psychiatry in Manchester, who observed that he was talking about growth points in "the age of the great pruner." He clearly hoped that his particular scientific rose would not be the next into the bucket.

Specialist advances

Most of the growth points discussed have financial implications, not least the oxygen concentrators described by Dr T B Stretton, a chest physician from Manchester Royal Infirmary. He believes that the case has been made that domiciliary oxygen given to patients with advanced respiratory failure for at least 15 hours a day will prolong survival. The crucial questions that remain are who should be treated and at what stage, and who should decide whom is to be treated. The particular question that most concerns Dr Stretton at the moment is how these patients should be given their oxygen. He, and the other chest physicians in Manchester, have conducted a feasibility study of using oxygen concentrators and shown to their own satisfaction that these machines, which cost about £1250 and last for five years, will provide domiciliary oxygen much more cheaply than cylinders if the patient is using oxygen for more than three hours a day. The study was commissioned by the Department of Health and Social Security, and the results were submitted to it last year, but a decision on whether the concentrators will be made available is still awaited.

There are also considerable cost implications in the dramatic surgery undertaken by Mr J S Watson, a plastic surgeon from Withington Hospital. He described operations to sew back on amputated forearms, hands, and fingers. Generally, the more distal the injury the more difficult is the surgery, and it takes a highly skilled team 18 hours to put back four fingers. After most of these operations function is a long way from normal, and it is the restoration of nerve function that is most crucial and most difficult. A big step forward is needed with nerve repair, but Mr Watson could not see a way forward. In the meantime, there is still a gap between what can be done and what is done because a good many Mancunian fingers and thumbs are thrown into the bucket without anybody thinking of restorative surgery. The final message from Mr Watson was that if you find yourself holding a finger, thumb, or arm then pop it into a plastic bag with some ice and dispatch it off with the patient to the nearest specialist centre.

Mr Watson emphasised repeatedly that such highly specialised

and technical surgery is a team effort, and the same goes, Dr Pat Morris Jones, a Manchester paediatrician, explained, for the management of cancer in children. Bringing all the children together has improved treatment, follow up, and research.

FIG 1—Dr Pat Morris Jones, a Manchester paediatrician, addressing the scientific session at the ARM.

More and more children are being cured of their cancers, but they need long term follow up (for 30 years or more) because of the complications that may result from chemotherapy or radiotherapy. A tumour registry, which was set up in Manchester in the 1950s, has helped with follow up and has also allowed enough cases to be collected for insights to be gained into aetiology—for instance, an association has been found between germ cell tumours and congenital abnormalities.

In contrast to Dr Morris Jones, Dr Phillip H N Wood, director of the Arthritis and Rheumatism Council epidemiology research unit, is concerned with a very common condition—arthritis. Trends in rheumatological conditions are hard to comment on, he said, because apparent increases in prevalence probably reflect better diagnosis, but he was confident that rheumatic fever is disappearing and gout increasing. He was also confident that rheumatological services are inadequate in Britain—one in five districts does not have a specialist service.

FIG 2—Professor David Metcalfe, professor of general practice in Manchester, who organised the scientific session at the ARM.

General practitioner problems

Even fewer districts have specialist nurses for working with patients who have had cancer. Yet Dr Maguire showed convincingly that such nurses could lead to a considerable reduction in the substantial psychiatric morbidity associated with mastectomy. Before he started the Manchester specialist nurse scheme, Dr Maguire had found that a third of women who had had mastectomies had clinically important anxiety, depression, or sex problems, and yet in only a few of these women had general practitioners picked up the problems. But, Dr Maguire emphasised, these problems are severe and not self limiting: they are not "the normal reaction to mastectomy." One reason why general practitioners do not

pick up these problems is because they are reluctant to become too involved; they sense that the emotional strain might be too much.

This sort of work is indeed a great strain, and the nurses who do it need considerable support and training. Training in interview techniques, Dr Maguire has shown, increases dramatically the ability of nurses to pick up the patients' problems. Indeed, one of the main functions of the specialist nurses (recently renamed resource nurses) now is to train other nurses—both those on the wards and those in the community. The resource nurse is thus, by working through others, able to cope with a great many patients who have had mastectomies, and, Dr Maguire argues, the whole scheme is highly cost effective because psychiatric problems that might become disabling (and so expensive to manage) are nipped in the bud.

Professor David Metcalfe, professor of general practice in Manchester, brought a new twist to the debate over resources in his final paper on inner city general practice: he argued that we know too little about the problems of inner city general practice to be able to spend to full effect the £9m that the government has set aside for the problem. He illustrated the studies of his group, which have shown that there are not great differences between the inner city and the suburbs in Manchester in either the structure or the process of general practice: similar sorts of general practitioners in similar sorts of surgeries and partnerships work in much the same way in all the various districts of Manchester. What his group has shown, however, is that there are enormous differences within districts and between individual doctors. Some doctors, for instance, refer 20% of their patients to hospital while others refer under 2%. Some doctors do less than one investigation a week while others do dozens.

Professor Metcalfe's group has begun to study these differences to try to identify the factors that cause doctors to behave so differently. So far they have come up with nothing, and it certainly is not that the doctors see different types of patients. Yet identifying these factors will, Professor Metcalfe believes, be crucial for the future of general practice: the "outlying" doctors will need to be identified as a start in hauling up the average standard of British general practice. Throwing money indiscriminately into inner city general practice will not be the answer.

When opening a tin of food with a conventional tin opener small fragments of the can often fall into the food. Ingestion of small metal shavings must be common, so is there any evidence that this is harmful?

There is no evidence that shavings of tin cans in food are likely to be harmful to man. The metal fragments produced when a food can is opened are usually between 0.1 and 1 mg, occasionally up to 2 mg. When mixed with gastric juice only about 20% dissolves, producing an iron solution; tin is found only in trace amounts, and tiny amounts of lead may be discovered if the seams of the can are included. In studies in animals in which much larger amounts were administered abnormal amounts of iron were not discovered, though it was clear that fragments of the cans seemed to adhere to the mucosa for lengthy periods. Nor was there any evidence that the fragments produced significant trauma to the gut.—JOHN BENNETT, consultant physician, Kingston upon Hull.

When was acrylic cement first used in hip prostheses and what was the reason for using it?

When Charnley wrote his paper in 1960 about the anchorage of a femoral head prosthesis to the femoral shaft using cold curing acrylic cement,¹ he acknowledged the work of Block, who used an amine cured oxyline resin for bonding fractures. Obviously at the time Charnley

thought that he was the first to use cold curing methyl methacrylate. This was not the case, however, for Wiltse had previously reported an experimental study discussing the possible use of the material in orthopaedics.² He thought that there were problems with the material, the main one being the heat of polymerisation. His conclusion was therefore that the cement had no unequivocal indication in orthopaedic surgery. Even earlier than Wiltse, however, Haboush had discussed a new operation for arthroplasty of the hip based on biomechanics, photoelasticity, and fast setting dental acrylic, and other considerations.³ The paragraph on the "dental acrylic" was extremely short, and no follow up cases were ever presented. Although there is documented evidence that Charnley was not the first to use methyl methacrylate cement, undoubtedly it was he who pioneered its use. His careful work and documentation helped immeasurably in the management of diseased joints and their replacement, but it is interesting, albeit sad, to note that so soon after his death the use of uncemented prostheses is well advanced.—C D R LIGHTOWLER, consultant orthopaedic surgeon, London.

¹ Charnley J. Anchorage of the femoral head prosthesis to the shaft of the femur. *J Bone Joint Surg* 1960;42B:28-30.

² Wiltse LL, Hall RH, Stenehjem JC. Experimental studies regarding the possible use of self-curing acrylic in orthopaedic surgery. *J Bone Joint Surg* 1957;39A:961-72.

³ Haboush E. A new operation for arthroplasty of the hip based on biomechanics, photoelasticity, fast-setting dental acrylic, and other considerations. *Bull Hosp Joint Dis* 1953;14:242-77.