ment. We do not agree. Surely it is better to recognise the importance of obstetric anaesthetic services and improve the services where they are inadequate. Currently the recruitment of doctors into anaesthesia is excellent and the opportunity exists. Unfortunately, medical administrators seeking to save money might misuse the views of Professor Hibbard and his colleagues and block the improvements that are necessary. This is the true importance of the argument.

D J BOWEN
A T LETCHWORTH
A D NOBLE

Department of Obstetrics and Gynaecology,
Royal Hampshire County Hospital, Winchester

- ¹ Noble, A D, et al, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1971, 78, 559.
² Weeks, A R L, Cheridjian, V E, and Mwanje, D K, *British Medical Journal*, 1977, 2, 730.
³ Willocks, J, and Moir, D D, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1968, 75, 225.

Airport hygiene

SIR,—Dr T D V Swinscow's letter (20 October, p 999) raises the whole issue of standards of cleanliness and hygiene in public facilities. Among the most striking things to confront the British traveller to Canada are the almost complete absence of litter (for example, in the Toronto subway system) and the uniformly smart and clean appearance of the people who work in the catering trade. It is a rarity in restaurants not to find clean facilities and adequate soap and paper towels. Such things seem the exception rather than the rule in England. Last time I went into the buffet at Victoria Station for a cup of coffee I felt as if I was in a garbage hole. An improvement in these facilities would do far more for the British tourist trade than many other promotional gimmicks currently employed.

D J HARRIS

University Department of Psychiatry,
Ottawa, Ontario K1N 7H5,
Canada

Treatment of chronic paronychia

SIR,—I read with interest the comments of Dr K A V Cartwright and others (17 November, p 1294) on your expert's reply to the questions about the treatment of chronic paronychia. Having been a consultant dermatologist for over 40 years, I have seen a great many of these disabled patients, many of whom have undergone heroic and often very painful therapy without avail. Surely the underlying basic cause is damage to the cuticle, which normally effectively seals the potential space between the nail and the overlying nailfold. This can be damaged by many things—cold in Raynaud's syndrome, as mentioned in the article; heavy manicure; accidental trauma; over-exposure to alkaline cleansing agents; constant immersion in syrup (as in the fruit canning industry); and even the application of adhesive plaster over a period of days, as shown years ago by Dr Howard Whittle; and so on. Cure therefore depends on restoring the normal cuticle. Immersion in water prevents this, but it is quite unrealistic to expect a busy woman to avoid all contact with water for the six to eight weeks required for the cuticle to regrow. I have treated this condition very successfully by explaining the problem to the patient and

then prescribing a nystatin-containing ointment with the instructions that this should be worked into the affected nailfold using the thumb of the other hand every time she is going to get her hands wet. This may be 20-30 times daily, but the time taken to do it is negligible. This is continued until the cuticle has regrown—a period of about six weeks, but longer in patients with the "chilblain" type of circulation.

The cure depends, in my opinion, very largely on having a water barrier in the nailfold rather than on the fungicidal or antibacterial action of the application. Years ago my sceptical friends would not believe that such a simple remedy worked, so before I held my next national dermatological meeting in Oxford I wrote to six patients chosen at random from our diagnostic index, and let my colleagues see the grateful patients—who all turned up cured by this simple method.

H R VICKERS

Hammersmith Hospital,
London W12 0HS

Subsidy of social functions by drug companies

SIR,—At a recent meeting of trainees from the Exeter GP vocational training scheme it was agreed by a majority decision that subsidies from pharmaceutical companies would not be sought in future for trainee-organised social functions.

General practitioners are probably the most vulnerable group of the medical profession so far as the promotional efforts of the drug companies are concerned. In many cases they do not have the facilities for critical discussions with colleagues of the information put forward by representatives and advertisements. Patterns of prescribing change following visits by drug company representatives, and were this form of promotion not cost effective in terms of increased use of the product in question the companies would have to stop investing large sums of money by advertising in this way.

In view of the above points I feel that it is commendable that the move to reject such methods of advertising by drug company representatives should come from a group of GP trainees and that they are leading general practitioners and the medical profession as a whole in this way. This represents an important advance in awareness of the potential problems inherent in accepting pharmaceutical companies' subsidisation of social functions and, to my knowledge, this is the first time that a group of doctors have made such a decision.

D HILTON

Royal Devon and Exeter Hospital (Wonford),
Exeter EX2 5DW

"A Touch of Sensitivity"

SIR,—The *Horizon* programme *A Touch of Sensitivity* not only confirmed our knowledge of the necessity for intimate contact between mother and baby but—a point not mentioned by your reviewer (17 November, p 287)—it also drew our attention to the importance of non-genital touching for a happy marriage.

The marriage counsellor interviewed showed how a couple could reawaken their mutual love by such simple acts as stroking the partner's arm, provided that a point was

reached where the one doing the stroking desired not so much his own pleasure as to give happiness to the other. This brings to mind the constant teaching of Dr John Billings and his co-workers in Melbourne—that love can be fostered between a couple even when genital contact is temporarily ruled out. Since 1964 they have developed and extensively researched the form of natural family planning known as the ovulation method. This relies entirely on the presence or absence at the vulva of cervical mucus, with observations of the changing or unchanging characteristics of the mucus. By these "observations" (some of its users are blind) the days of probable fertility can be discerned. One of the most important "rules" of the method is that on fertile days there must be no genital contact whatsoever between the couple if pregnancy is to be avoided (the use of barrier methods alters the secretions at the vulva). During the past year the World Health Organisation has conducted a survey of the method in five countries.

An *Atlas of the Ovulation Method* and other literature, including reprints of articles published in professional journals, can be obtained from the Ovulation Method Research and Reference Centre of Australia, 86 Wellington Parade, East Melbourne, Victoria 3002.

CHRISTINE M FITZGERALD

Stockport SK6 6AH

Bronchodilator effect of sodium cromoglycate

SIR,—I read with interest the paper by Drs J T N Chung and R S Jones (27 October, p 1033) on the bronchodilator effect of sodium cromoglycate (SCG) in children. Since this phenomenon has not been reported in adults they raise the possibility that children and adults have different physiological responses to SCG.

As an atopic asthmatic I can report a good subjective and objective (as measured by peak expiratory flow rate) bronchodilator response to SCG in doses of 20 mg taken via the "Spinhaler." I thought that I was unique in this way until I recently treated a 19-year-old atopic asthmatic girl who reported that she used her SCG only when she felt wheezy—and was relieved of her wheeze in a short time.

PHILIP HELLIWELL

Bingley, W Yorks BD16 4AB

Rubella vaccination and unnecessary abortions

SIR,—We question the recent advice given by the DHSS that women who have been vaccinated with a live attenuated rubella vaccine within three months of a pregnancy should be considered to have put the fetus at risk of congenital rubella. This ruling undoubtedly leads to a number of unnecessary abortions at a time when indications for abortion are becoming increasingly strict.

We understand that the ruling arises from an American report that live rubella virus was recovered from a fetus when the mother had been vaccinated seven weeks before conception. There is now, however, some evidence to show that the vaccines used in America are not teratogenic. We would like to suggest that the

British vaccines should be subjected to a similar investigation without delay, to avoid terminations as a legally defensive measure on the part of the gynaecologist.

Furthermore, no women of childbearing age should ever be vaccinated without clear laboratory evidence that they are non-immune. Only a very small proportion (possibly 15%) of the population requires vaccination and in these cases a long-acting, injectable contraceptive might be indicated.

JOHN W PETERS
E G DOWSETT

Basildon Hospital,
Basildon, Essex SS16 5NL

Coal-mining and mortality

SIR,—Your well-balanced review of coal-mining mortality (10 November, p 1168) encourages me to complete the picture with some unpublished data.

The 20-year follow-up of a random sample of the male population of Staveley has been successfully completed. The mortality of the 149 "pure" miners (categories 0, 1, 2, and 3) was 66%, as compared with a mortality of 71% amongst the 80 "non-dusty" workers. It is therefore becoming likely that the standardised mortality ratio of working miners in general is about 80 and that of miners and ex-miners about 100. This would make the Rhondda Fach the odd man out.

The only hypothesis put forward to explain the difference between Staveley and the Rhondda Fach was that of differential migration,¹ but recent work at the MRC Epidemiological Unit has rendered this very unlikely. We are now working on an alternative hypothesis.

A L COCHRANE

Rhose, S Glam CF6 9EP

¹ Cochrane, A L, and Higgins, I T T, *British Journal of Preventive and Social Medicine*, 1961, 15, 1.

Audiological consultantship—a sinecure?

SIR,—It is very sad that the only way doctors can apparently be attracted into the specialty of audiological medicine is by cynically suggesting that it is a quick way to a consultantship (10 November, p 1231). The welfare and rehabilitation of the deaf in this country have long been neglected, mainly because those who should have given the lead—the ENT surgeons—have generally not been interested. This is hardly surprising since someone who is interested in surgery or in medically treatable problems is unlikely to be also interested in social work with the deaf or in hearing aids. Once hearing therapists are appointed in the NHS they will not be happy working with an audiological physician who is primarily interested in an easy way to a consultantship.

Dealing with the geriatric deaf requires a lot of commitment and is very demanding. Schemes where voluntary workers visit the housebound deaf and service their hearing aids are badly needed; who is going to organise these and refer patients to these schemes? The team leader has to create new work and break new ground, and not be looking for the easy way out and simply discharging patients with intractable deafness or prescribing hearing aids without follow-up, as tends to happen at present. In any hierarchical set-up enthusiasm

has to percolate from the top downwards: it is here that the basic standard of care is necessarily set.

A G GORDON

London SE5 8AD

Inhalation of formaldehyde vapour

SIR,—You state in a reply to a question (29 September, p 778) regarding inhalation of formaldehyde vapour, "Assisted exhaust ventilation may be needed if susceptible individuals must work in a formaldehyde-contaminated atmosphere."

I would hope that no individual works in an atmosphere containing formaldehyde. The threshold limit value (ceiling) of formaldehyde in air is 2 ppm (3 mg m⁻³) at 25°C, 760 mm Hg.¹ This is a concentration that should not be exceeded even for an instant. It is not a time-weighted average or the short-term exposure limit. I am quite sure that Health and Safety Executive officials would take a very dim view of staff working in conditions where they inhale formaldehyde.

A R LYNE

Ministry of Agriculture, Fisheries,
and Food,
Bristol BS10 6NJ

¹ Health and Safety Executive, *Threshold Limit Values for 1977*, EH-15-77. London, HMSO, 1978.

*Our expert writes: "The question was about the harmful effects of formaldehyde (and xylene) and was answered on that basis. It was not a question about the views of the Health and Safety Executive officials, whose interpretation of health does not necessarily accord with demonstration of a pathological process. In a perfect world there would be no formaldehyde in the atmosphere, but in practice intermittent contamination is likely during certain manoeuvres. No harm will come except to susceptible individuals, who would be wiser to seek alternative employment. A balance must be kept between proper caring for staff and wasteful expenditure on measures to protect staff against non-existent or negligible risks. The money would be better spent on the sick, whose needs are established and not yet fully met."

Guar crispbread in the diabetic diet

SIR,—Drs M Cohen and F I R Martin (3 March, p 616) reported failure to confirm the utility of guar as an adjunct to diabetic treatment. While they indicated that this could be explicable on the basis of a difference in type of patient from those in which Dr D J A Jenkins and associates (23-30 December 1978, p 1744) had demonstrated a beneficial effect, Drs Cohen and Martin suggested the need for confirmation by careful long-term studies. The Jenkins group (Dr T D R Hockaday and others, 19 May, p 1353) replied by suggesting that if guar was not added properly to the diet it would not be fully effective—the gel-forming fibre had to be in the food, not just on it.

Yet I found some disturbing aspects about the original reports by the Jenkins group. There were several numerical discrepancies in the data. In large part the reduction in mean urinary glucose output, from 583 ± 150 mmol (105 ± 27 g)/24 h to 322 ± 61 mmol (58 ± 11 g)/24 h, was due to a single patient, who showed a decrease from an unusually

high value of 1681 mmol (303 g)/24 h to 477 mmol (86 g)/24 h. Further, that patient had been below average in terms of urinary glucose concentration before taking guar, with a concentration of 27.7 mmol (0.49 g/100 ml) compared with the average of 61.0 mmol/l (1.10 g/100 ml) for six patients. In fact, at a concentration of 27.7 mmol/l the patient would have had to void 61 litres of urine in 24 hours to achieve a total urinary glucose output of 1681 mmol.

If it is the long-term effects of guar administration which are of principal value, the results of Dr Jenkins and his colleagues were unsatisfactory, being based only on final determinations. The six patients on long-term administration had durations ranging from five to 11 weeks. No report was made of their progress during the course of guar administration or at comparable times during that course. No objective rule was stated about when treatment was to cease and final measurements were to be taken. One could readily bias the results of a study of this nature simply by declaring treatment to cease for a patient whenever that patient showed a desirable response, even if only by chance. To guard against such a doubt, we should be told the entire course of the results for each patient and also the rule for saying when the study was ended for each patient.

NATHAN MANTEL

Biostatistics Center,
George Washington University,
Bethesda, Maryland 20014,
USA

If I was forced to cut

SIR,—During the past few months the *BMJ* has published several articles by a special correspondent called "If I was forced to cut," which have all more or less been themes on the same melody. In my opinion this basic melody is written in a false key and, although I am not qualified in national economics, may I be allowed to express a few reflections?

Shortening the length of hospital admission will certainly result in a higher turnover, which may reduce and perhaps even eliminate the departmental waiting list. As empty beds cost approximately the same as full beds, an economic saving can result only if departments are closed down or restructured and staff dismissed or transferred. I find it hard to imagine how consultants can be encouraged to carry out such reforms, especially as any financial saving may be more apparent than real when other departments are obliged to take staff they neither need nor want or the ranks of the unemployed are increased.

Although early discharge may be imagined to reduce hospital costs, it ought not to be forgotten that at the same time it may increase costs outside the hospital service. District nurses, home helps, and general practitioners all cost money, as do the few days' absence from work which the patient's husband, wife, relative, or friend might consider advisable.

Reduction in administrative personnel both at a local and at a central level seems to be a commonly played theme but the consequence of reduction has hardly been discussed. Redundant staff can be transferred, in which case other departments will become over-staffed and exceed their budget. They can be slowly reduced by not replacing staff who retire. This will mean fewer jobs in the service, which in turn will increase un-