for the clinical convictions of the rescue services, since the inability of the laboratory-based research worker to reproduce the clinical results found in the field may be due to a fault in the design of the laboratory experiment and not, as is presumed at present, to errors of observation by the rescuers.

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¹ Kehlet, H, *et al*, *British Journal of Anaesthesia*, 1974, 46, 73.

² Oyama, T, *Canadian Anaesthetists' Association Journal*, 1969, 16, 361.

Rugby injuries to the cervical cord

SIR,—The letters published (20 January, pp 192 and 193) can only increase the concern already felt by the Medical Officers of Schools Association. We urgently need to know the incidence of cervical cord injuries due to rugby football, and hope that the suggestions made by Dr J R Jenner and his colleagues (p 193) for a central reporting system will bear fruit. Meanwhile the association is (conducting its own retrospective survey of these injuries in schoolboys in order to report to a meeting which has been called for 22 March, and I have already written to many colleagues who may know of cases. May I, through the courtesy of your columns, ask any readers who have not already heard from me to get in touch without delay if they can provide information about any cervical spine injury due to rugby football in a schoolboy?

T W HOSKINS

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Medical Officers of
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Rugby injuries involving the hand

SIR,—With reference to the article (23-30 December, p 1759), written by Drs J E Davies and T Gibson about injuries in Rugby Union football, we noted with interest the absence of any significant injuries to the hand reported in their studies of 185 players.

During our six months in a busy accident department in Newcastle upon Tyne, attached to a hand injuries unit, and because of our specific interest in sports injuries, we have noted eight cases of significant injury to the hand as the result of playing rugby.

Seven out of eight injuries resulted from a dislocation of the proximal interphalangeal joint during the tackling of opponents. The eighth injury was a fracture of the second metacarpal, which was the result of a hyper-extension force applied to the fingers during the act of catching the ball. Four out of the initial seven injuries resulted in a boutonniere-type deformity of the fingers as a result of rupturing of the central slip of the extensor expansion as it crossed the proximal interphalangeal joint; all were treated by external splintage.

Of particular interest was the observation that the boutonniere type injuries occurred because of the fingers being caught in the clothing of the opponents during the tackle. In two of the cases it was the pockets of the shorts of the opposition that were the culprits.

It raises the question of the usefulness of pockets in rugby shorts, particularly as we have seen injuries directly attributable to their presence.

We must also make the point that any manual worker who suffers a boutonniere injury to any of his fingers is not able to pursue his normal employment because of the injury and the splintage used in treating the condition. This results in both loss of productivity by employers and, if he is privately employed (for example, as a dentist, like one of our patients), loss of income. Clearly rugby injuries of this sort represent a not insignificant proportion of the upper limb injuries sustained in the game of rugby, and the morbidity resulting from these injuries causes both loss of playing time and loss of income.

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"Trench foot" caused by the cold

SIR,—In this generally temperate climate localised cold injury is relatively uncommon. Because of this we think the following case of "trench foot," presenting at the end of the recent cold spell, to be of some interest.

The patient was an 18-year-old male student who lives in a comfortable, well-heated hall of residence. It was not until the sixth day after the initial exposure that he came for medical advice. The history was that six days previously, after a rather meagre breakfast, he went for a 20-mile cycle ride on a dry, clear day when the temperature was freezing or just below, wearing on his feet stretch-nylon socks and tightly laced training shoes, with a pair of tight bicycle clips round his ankles. He cycled quite slowly for about three hours, with the arches of the feet, not the toes, on the pedals, during which time he realised that his feet were very cold as after a short time he was unable to feel them. At home that evening his right foot began to be painful over the fourth and fifth toes. During the following two days the pain in the right foot increased and he noticed a macerated area between the fourth and fifth toes, but these discomforts did not prevent him walking several miles into university from his hall in the same footwear and in equally cold weather, the temperature averaging 2-4°C. The fourth day was again very cold (-3°C), and again he went cycling. His feet went cold and numb. When he was some four miles from hall his cycle broke down and he had to walk home. That evening, when sensation had returned, the right foot had become swollen and blue; indeed the area near his fourth and fifth toes was almost black, and he was unable to put his shoe or slipper on. Next morning, despite pain and great difficulty getting his right shoe on, he cycled three miles. By mid-day blisters had developed on his toes, and sufficient "sticky" fluid had oozed from his foot for him to be aware of a squelching noise as he walked. However, after this the shoe became easier on his foot and the pain was relieved.

Examination of the foot showed that the dorsum was moderately swollen and was a mottled bluish colour near the toes. There was blanching on pressure, but with poor capillary return. There were small blisters on the great and second toes. The thickly macerated area between the fourth and fifth toes was thought to represent a coincidental flare-up of tinea pedis. He was kept in sick bay and treated conservatively with bed rest, no specific "warming" being applied, and he made a slow and steady recovery. Interestingly, despite the absence of superimposed infection, the small blisters have taken over two weeks to heal.

In addition to the foot condition he developed an itching, macular rash, initially on the hands and

later involving the lower limbs and the umbilical area. Indeed, he primarily sought advice because of the rash. The rash faded without any specific therapy concurrently with the improvement of the foot. Unfortunately it was not possible to perform a cold agglutinins estimation until the eighth day, and the result was negative. We cannot be sure of the exact aetiology of the rash, but believe it on clinical grounds to be directly associated with the cold injury. A full blood count was normal; the erythrocyte sedimentation rate was 2 mm in the first hour.

This is a case of "trench foot" occurring in a cyclist. It demonstrates the necessity, even in our so-called temperate climate, of adequate protection of the extremities even in those who, by virtue of their physical activity, might otherwise expect to keep reasonably warm.

I C FRASER
JUDITH A LOFTUS

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Epidural analgesic for bronchitic patients with fractured ribs

SIR,—The review of epidural analgesia relating to labour and delivery (13 January, p 72) brings to mind two recent patients who obtained remarkable benefit from this technique.

Both patients were middle-aged bronchitics who had fallen during the previous few days and fractured several ribs. One had been treated at home with bed rest and inadequate oral analgesia; this led to inability to cough owing to severe pain and consequently stasis of secretions resulting in hypostatic pneumonia. The other also obtained little benefit from oral analgesia and opiates were contraindicated because of his history of bronchitis. Both obtained immediate and remarkable relief of pain, were able to breathe and cough properly, and were rescued from impending respiratory failure by the timely relief of pain without any danger of respiratory depression by the use of epidural anaesthesia. I feel that this form of analgesia for the treatment of fractured ribs in the bronchitic patient is not practised sufficiently often.

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Terminology of enuresis

SIR,—I support Mr John R Hindmarsh (16 December, p 1714) in his plea for more precision in the terminology of enuresis. But I would prefer more precision than he shows in his letter. Firstly, it is important to qualify the term enuresis with "night-time" (or nocturnal) or "day-time" (or diurnal). Too often the day-time wetting problems get overlooked and yet are a serious problem to a great many schoolchildren.

The term enuresis is usually reserved for persons who void urine inappropriately at an age when continence is to be expected. I agree that it is inappropriate to use it for persons who have an organic lesion, such as a neuropathic bladder, and are suffering from overflow incontinence. However, to suggest that nocturnal enuresis should be applied only to persons who have "persistently wet the bed all their lives" will cause confusion. It is exceedingly uncommon to find anybody over the age of 5 who has wet the bed every night.

Of 200 consecutive children or young adults with nocturnal enuresis I found only 2 who appeared not to have had a single dry night. In other words, true "primary" enuresis is exceedingly rare and the usual situation is one of "intermittent" nocturnal enuresis.

I agree with Mr Hindmarsh that the term "recent-onset enuresis" or "secondary" enuresis is not very helpful. Its incidence, association and management will depend on the period of dryness that is demanded before the person is labelled as having "onset" enuresis. For instance, if a period of 12 months' absolute dryness is demanded the number of persons with onset enuresis will be small. If a period of only three months is demanded, the number with such onset enuresis will be quite large.

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"Lecture Notes on Medical Statistics"

SIR,—The point that has got lost in this "wordy warfare" (23-30 December, p 1783; 13 January, p 123; and 27 January, p 263) is the nub of my criticism (9 December, p 1631), which was contained in the words "the statistics needed by the intending clinician or medical researcher [is] different from that required by the intending statistician." Incidentally, reviews are signed because they are only the *opinion* of their authors.

May I cite two examples of the increasing concern with what statistics doctors and other medical writers do know? Firstly, there was a meeting last year in Lexington, Kentucky, organised by the Biometric Society under the title "Should there be Statistical Guidelines for Medical Research Papers?"¹ Secondly, this coming April a meeting is to be organised by the Royal Society of Medicine's section of medical education, in conjunction with the Association for Medical Education, under the title "Teaching and Learning Statistics in Medicine," at which your associate editor is delivering the first paper.

My opinion is that rehashing first-year statistics courses and spreading a few medical examples around the text is not the right way to educate medical students statistically. But it is only my opinion.

IAN CLARKE

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¹ *Biometrics*, 1978, **34**, 538.

Phantom limb pain and propranolol

SIR,—Your excellent and comprehensive leading article (9 December, p 1588) has prompted me to share my observation with your worldwide readership.

Case 1—In August 1977, a 69-year-old man was admitted with diabetic ketoacidosis, diabetic angiopathy and neuropathy, coronary heart disease, and Gram-negative septicæmia. He underwent below knee amputation for gangrenous toes of the right foot. He was discharged home after a stormy and eventful stay in the hospital. He was then plagued with "phantom limb" pain. Analgesics prescribed by his family physician did not improve this condition. Propranolol 40 mg/day was added in his regimen to control his hypertension and angina. From that time not only did his cardiovascular status improve but the phantom limb pain also disappeared. After propranolol had been withdrawn because of cardiogenic shock and

heart blocks following recent myocardial infarction, he started having severe phantom limb pains.

Case 2—In October 1977 a 69-year-old man underwent below knee amputation because of gangrenous toes of the left foot. He had survived two myocardial infarctions (1957 and early 1977) and was diabetic and a heavy smoker. He developed attacks of stabbing and lightning pains in the stump lasting for hours and days. Analgesics offered no solace. Propranolol 40 mg daily was added in the regimen for angina pectoris. He never complained of this "wretched pain," as he called it, while on propranolol.

These two patients were incapacitated with pain but lived happily after taking propranolol. The second was very happy that he could manage to use his artificial leg. I feel it is worth reporting the usefulness of propranolol in these two "mentally and physically crippled" patients who managed to cope better with their lives.

Further investigation of this observation should be undertaken because anything which mitigates the lot of the patient with phantom limb pain is very much worth while.

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1918 influenza epidemic

SIR,—I remember as a house physician in Queen Alexandra Hospital, Cosham, during an influenza outbreak in, I think, 1957, seeing a middle-aged man, admitted in a moribund condition from his general practitioner's surgery, with a stench so fearful that I could only examine him for some seven minutes at a time. At the subsequent necropsy one lung was green and gangrenous with multiple small abscesses forming.

I do not know if similar pathology occurred in the 1918-8 outbreak, but if it did it might account for the stench referred to by Minerva (16 December, p 1722).

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"Helping with Health"

SIR,—Your reviewer TS in "Medicine and the Media" (13 January, p 118) appeared puzzled by the intended audience for "Helping with Health," yet he diagnosed it quite correctly. The series was intended for all professional health workers and this was clearly announced at the beginning.

It will be repeated in July (Sunday afternoons, Radio 4, VHF) and will be followed early next year by a related series on health education, on the prevention of illness, which, like the recent series, has been developed in consultation with the Health Education Council (and many others).

When professionals talk to professionals jargon sometimes crops up as a form of shorthand, though we don't encourage it.

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Abortion and the NHS

SIR,—The impression gained from the paper by Dr F G R Fowkes and his colleagues (27

January, p 217) is that the writers are in favour of abortion on demand. It suggests that the NHS figures show "discrimination" against applicants who are single; surely many of these are not covered by the terms of the Abortion Act?

One of the most emphasised recommendations of the Lane Report was the need for better facilities for counselling. No comment is made on this in the article.

Does not the low rate of sterilisation in the private sector suggest that there is no incentive to kill the goose that lays the golden eggs?

MARY BELTON

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Who does the surgery?

SIR,—I was delighted to read Professor Douglas Roy's "Who does the surgery?" (25 November, p 1474). The approach to the training, role, and career structure of the "specialist" district physician outlined is admirable, and could be adopted in my own country with great benefit to our various peoples.

However, I believe the programme errs in excluding anaesthesia (suggested as optional) as an essential component. Even if anaesthesia is given by specially trained assistants, I believe the knowledge and expertise gained during three to six months' intensive training in anaesthesia could be of great benefit to the district physician, not only in supervising his "anaesthetist" but also in providing valuable education and experience applicable to other fields—for example, the use of regional or conduction anaesthesia, neonatal resuscitation, management of acute cardiopulmonary failure, etc.

Also, would he not consider the role of the specially trained surgical assistant in dealing with routine surgical procedures (for example, herniotomy, circumcision, setting of fractures), as employed with success in other African countries, such as Malawi?

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Clinical medical officers

SIR,—Those who have been concerned about the status, role, and training of those clinical medical officers who carry out so much of the work involved in preventive child care and developmental surveillance will welcome the letter from Drs Gwynne Lewis and others (13 January, p 128) suggesting that they might in future work within general practice without necessarily being trained as principals. This was the solution that many of us hoped that the Court Report would recommend and it would have avoided the disagreements that have resulted in the report's being shelved rather than implemented.

Community physicians have the information and resources to identify those children needing immunisation or assessment, but this need not mean that the clinicians who do the field work should come under their jurisdiction: instead they should tender the work to general practices by contract, using only those practices which can deploy principals or assistants (who will often be married women