cortical thinning being the only radiological sign of osteomalacia. Thus true osteoporosis was responsible for the cortical thinning in only the cases of steroid therapy and Cushing's syndrome—three out of 18 cases. The other 15 were due to hyperparathyroidism and osteomalacia.

Cortical thinning cannot therefore be regarded as synonymous with osteoporosis.

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¹ Anton, H C, *British Medical Journal*, 1969, 1, 409.

Antacid and sodium content of Gaviscon

SIR,—We were interested to read the paper by Dr R E Barry and Mr J Ford (18 February, p 413) referring to the sodium content and neutralising capacity of some commonly used antacids.

We would like to correct an apparent misconception in the paper and point out that the action of Gaviscon in the management of dyspeptic symptoms depends on the formation of an alginate raft for the suppression of gastric reflux and not upon neutralisation of gastric acid. The antacid component in liquid Gaviscon is present to aid the formation of the alginate raft.

The sodium content of the Gaviscon range has been clearly stated in our literature and our data sheets since 1971 and cautionary warnings about the use of the products in conditions in which sodium intake needs to be controlled have also been made.

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Hot foot syndrome

SIR,—I was most interested to read the report of a case of unilateral lumbar sympathectomy due to retroperitoneal tumour by Dr R C Brown and others (18 February, p 410). The combination of a hot foot, ankle oedema, and pain associated with recurrent retroperitoneal tumour has become known as the "hot foot syndrome," first described at a clinical meeting by Dr R J Evans, head of the Eleanor Smythe Pain Clinic, Toronto General Hospital, who has since collected many cases. An article from him is currently in press detailing the findings of his cases. Since I first learnt of this syndrome from him I have collected six cases and have found the hot foot sign to be a very valuable indicator which may precede all other evidence of tumour recurrence. One of these patients underwent a laminectomy on the basis of a diagnosis of disc protrusion before the recurrence of her ovarian carcinoma became obvious.

Thermography is obviously a useful investigation in these cases and has shown that the main temperature difference occurs at the feet but a much smaller difference is detected along the lower leg. One very recent case was of an inoperable carcinoma of the rectum in which the temperature difference between the feet was very marked indeed, this being confirmed by several independent examiners. However, by the time the patient attended the

radiotherapy centre for treatment the difference could not be detected by either palpation or thermography and could not be elicited by making the legs dependent or by exercise. It is interesting to note also that this patient did not have any pain whatsoever, although pain does usually accompany this sign.

Hot foot sign should clearly be regarded as a very valuable physical finding for tumours which may recur in the retroperitoneal space and I would echo Dr Brown's comment that a deliberate search should be made for this sign in all suitable cases.

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Cost of outpatient chemotherapy

SIR,—I would like to add to the interesting article (25 February, p 493) by Professor K C Calman and others. Having been an outpatient myself for chemotherapy for over a year the largest saving of all was the continuing ability to stay at work throughout treatment. Being a teaching hospital representative with ICI and a district councillor means that I have plenty to do. I found eventually that even on the days I received intravenous therapy I would be fit enough to attend council meetings in the evening. My results at work remained above average, as did my income, this point being especially important to our children, now in final years at school and university.

The greatest impact of outpatient therapy has been on my friends and people in general. People are learning that it is possible to live with cancer for eight years, go as an outpatient and return to one's own family each day, and usually get to work the next day, and still be able to give to life.

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Snap-happy parents

SIR,—I was most interested to read the letter from Drs J A Sills and J E Handley (11 February, p 368) and thought your readers might be interested to know how I adopted the same practice of providing a clear photograph to all mothers who are separated from their babies in my special care baby unit. About 18 months ago a father asked me if he could take a Polaroid picture of his newly born premature baby who had been transferred 30 miles from another hospital where there were no facilities for coping with such babies. This was a new idea to me, and when I saw the resulting "instant" picture, which contained a minuscule baby surrounded by the paraphernalia of incubator, oxygen analyser, etc, I decided to ask our hospital photographer to provide a larger picture instead. As a routine now she takes a 10 × 6 in black and white picture of the nude baby only, so that the mother can see all the features of the baby clearly. This picture is then sent to any separated mother immediately to encourage "bonding" and because of the importance of this first critical 36-h period in this respect.

I have interviewed several of these mothers subsequently and all have been very enthusiastic in expressing how much that photo-

graph meant to them when they had to remain in another hospital surrounded by other mothers who had their own babies near them. I intend carrying out a survey of all the mothers who have received such photographs, to include developmental progress of their children and the occurrence of any subsequent disturbed behaviour or poor mother-child relationship as compared with a similar group of premature babies whose mothers did not receive photographs in past years.

Following that initial inspiration of seeing the father use his Polaroid camera I discovered that it was also standard practice in such hospitals as Mill Road, Cambridge, and Queen Charlotte's and King's College, London, so that any aspirations to originality rapidly vanished.

I might add finally that we always try to take the photograph before inserting umbilical and other catheters, nasal cannulae, ECG electrodes, etc, which might otherwise present a frightening appearance to the mother. I think the practice of introducing an explanatory leaflet about the special care unit, explaining the purpose of these items of equipment, is an admirable one and this was something else that I learnt was used in the Cambridge unit and will shortly be introduced here.

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Help for parents after stillbirth

SIR,—So far in the correspondence about stillbirth there has been no mention of any kind of planned management being carried out in hospitals. Although it is only in its initial stages and will need to be co-ordinated with what happens in the delivery room and on the wards following the delivery of a still-born baby, a deliberate approach has been adopted by the social work department at this hospital. We are automatically informed of all deliveries in the hospital and are almost always able to talk to mothers of stillborn babies before they are discharged—usually within 48 h of delivery. The greatest value of this first interview is not so much the opportunity it offers of giving these mothers the information they always request (in the main they require explanation and reassurance from doctors at this time); rather it lies in enabling us to follow up these mothers after they return home.

For many mothers the time spent in hospital is remembered as a prolonged nightmare. However, as long as they are in hospital they can continue to see themselves as mothers, albeit bereaved mothers. After discharge from the hospital they rapidly have to adjust and are often pushed by family and friends into denial of ever having been expectant mothers. It is during this time that feelings of depression, guilt, and resentment are strongest and also during this time that a continued link with the hospital can be of great value.

We maintain contact with these mothers by telephone after discharge and see them again at home after the district midwives have stopped going in. Whether or not follow-up continues depends on whether the parents are agreeable to it, on the reaction the mother has to stillbirth, and on the help she has received from family and friends.

Such follow-up takes a lot of time but its value is immense. Firstly, it gives immediate support to parents of stillborn babies. Mothers

are invariably relieved by talking to someone who has known of similar tragedies. Many often ask if there are other mothers of stillborn babies in the hospital at the time. Others ask us, some time after delivery, if they can be put in touch with more mothers of stillborn babies. Secondly, it enables us to offer much more help to these mothers when they become pregnant again. It is at this time that many complications, often due to repressed grief reactions, can occur. This can take the form of rejecting the new baby, of acute anxiety about labour, etc. One hopes that by working well with mothers after stillbirths some of these difficulties will be avoided.

In addition to our work with mothers who have just delivered stillborn babies we have recently started to screen women booked into the hospital antenatally who have had a difficult obstetric history. These mothers can be identified from the hospital booking cards. They are written to as early in pregnancy as possible and invited to see us when they attend the clinic. We are just beginning to get some results from this.

Our approach is only a beginning and we are very aware that we need to work much more closely with both doctors and nurses. It would be very interesting to hear of any other work being done with mothers of stillborn babies.

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Drawbacks of monocomponent insulins

SIR,—The introduction of the monocomponent insulins a few years ago appeared to offer important advantages. Insulin antibodies are not produced and this allows control of blood glucose levels with lower doses of exogenous insulin than would be necessary with the older, more impure insulins. This undoubtedly happens and when a patient on one of the older insulins is switched to the monocomponent insulins hypoglycaemic reactions often occur even when the dosage of the monocomponent insulins given is markedly lower than that of the older insulins. This advantage is very useful in patients who have hitherto been controlled only with very large doses of insulin. It has been postulated furthermore that high circulating insulin levels may play a part in the premature development of atherosclerosis and possibly other diabetic complications, and lowering these levels may help to prevent or delay the development of these complications.

Because of these theoretical advantages I have been anxious to manage all my "new" diabetic patients with the monocomponent insulins and to switch over all the unstable patients attending by diabetic clinic to these insulins. Often I have obtained a good response. However, in a few patients I have had problems. There is one group of patients in whom repeated attempts to control their blood glucose with these insulins have failed and where the old-fashioned insulins have worked with little problem. There is a second group who respond beautifully to these pure insulins, but only for a period of time. Control is then lost however hard one tries to achieve it; ketonuria develops, often with vomiting, and repeated admissions to hospital are necessary. Control is achieved only when the older insulins are substituted. I have recently met two such

patients in whom the combination of Actrapid and Monotard was effective for a year; control was then lost and achieved again only when the soluble-isophane combination was substituted.

It has been suggested that insulin antibodies may be helpful to some patients in allowing a gradual release of the insulin, but other factors may well play a part in explaining the better response obtained to the older insulins.

The views and comments of your readers would be of interest.

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Mumps and its complications in Stockholm

SIR,—The justification for large-scale vaccination programmes against mumps is at present being discussed in several Western countries.¹⁻³ In a leading article last year (11 June, p 1489) you stated that the cost and work of widespread mumps vaccination seem disproportionate to its benefit. However, surprisingly little hard data concerning the social and medical implications of mumps and its complications are available. From epidemiological observations over a 22-year period (1955-76) from the city of Stockholm we have accumulated some results that may have certain relevance for the future policy on mumps vaccination in this area.

Our data on uncomplicated mumps are drawn from the statistics of the Stockholm school health authorities covering the age groups 7-16 years (1965-76) and 17-20 years (1970-6). Information on mumps meningitis (MM) and mumps orchitis (MO) was obtained from Roslagstull Hospital, which is the only infectious disease hospital of the city and serves a region with a mean of 800 000 inhabitants, constituting about 10% of the Swedish population. For information on the selection and the representative nature of the material we refer to our dissertations.⁴⁻⁶

During the period 1970-6 the average annual incidence of mumps in the age group 7-16 years was 2.4% and in the 17-20-year group 0.4%. In Stockholm patients suspected of MM are mostly admitted to hospital. The incidence of MM, here defined as ≥ 5 leucocytes/mm³ ($\geq 5 \times 10^6/l$) in the cerebrospinal fluid in cases of mumps suspected of meningitis, showed considerable annual variation, although with a close correlation to the annual incidence of mumps in the population at large. For the whole period of observation the peak incidence by age of MM was seen among children at the age of 7 years, though 40% of the MM patients were aged 15 or more. The ratio of male to female MM patients varied with age of the patients. Thus for patients below 20 years this rate was found to be 3-4:1. In the age group 20-29 years males and females were represented in equal proportions, whereas for patients of 30 years or more the males regained dominance. Over the period 1965-74 the ratio of MM to clinical mumps in the age group 7-16 years averaged 2.4% (1.4-2.8%).

The peak incidences of MO were found in the age groups 15-19 and 25-29 years (1972-6). MO was rare before puberty and after the age of 50 years. The mean age in the MO group was 28 years. In the age group 17-20 years the ratio of cases of MO admitted to hospital to cases of clinical mumps was about 5%.

In patients suffering from MM the length

of hospital care usually varied between two and four weeks during the period analysed (1955-64) and the period of disability between one and two months. However, in about 10% of these cases, many of them being in adults, the disability periods were considerably longer. In MO the disability period rarely exceeded three weeks.

On the basis of the above data we estimate that about 1000 Swedes are treated in hospital or at home for MM and about 300 for MO each year. The implications of our investigation are that in Sweden the average annual number of days of hospitalisation due to MM could be 20 000, and correspondingly the number of days of disability in individuals aged 15 years or more is between 20 000 and 40 000. In addition, we have to count on considerably larger numbers of people on sick leave at home owing to mumps or complications of mumps.

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¹ Modlin, J F, Orenstein, W A, and Brandling-Bennet, A D. *Journal of Infectious Diseases*, 1975, **132**, 106.

² Lang, W. *Münchener medizinische Wochenschrift*, 1976, **118**, suppl (24 September), p 9.

³ Alestig, K, et al. *Läkartidningen*, 1977, **74**, 326.

⁴ Skoldenberg, B. *Scandinavian Journal of Infectious Diseases*, 1972, suppl 3.

⁵ Bjørvatn, B, and Wolontis, S. *Scandinavian Journal of Infectious Diseases*, 1973, **5**, 253.

⁶ Bjørvatn, B, and Wolontis, S. *Scandinavian Journal of Infectious Diseases*, 1974, **6**, 5.

GP obstetrics

SIR,—Several recent publications¹⁻³ question the present-day role of the general practitioner obstetrician and seem to imply that the GP maternity unit may soon be an anachronism. Our experiences in Oxford, in a GP obstetric unit very similar to that described by Mr B V Lewis and his colleagues (25 February, p 484), suggest that this need not necessarily be the case. For example, in 1977 of 705 patients booked, 38 cancelled and 183 (26.0%) were transferred for consultant care during pregnancy. Of 484 patients admitted in GP care, 61 (12.6%) were transferred in labour and some degree of specialist aid was required with a further 26 (3.7%). Altogether 88.6% of patients delivered spontaneously, the instrumental delivery rate was 10.4%, and a further five patients (1.0%) came to caesarean section. GP obstetricians attended 78% of their patients at some time during labour and 64% at the actual delivery. The perinatal mortality rate for admissions was nil and that for all original bookings 3 per 1000 (one stillbirth—anencephalic; one neonatal death—placental abruption at 28 weeks).

A paper in the course of preparation will review the results obtained by the Oxford unit over the past 10 years with particular reference to the performance of GP obstetricians and also the outcome for nulliparous patients booked in GP care. However, a number of factors can already be identified that have without doubt contributed to its success. Firstly, GPs operating in the unit should have an overriding commitment to the care of their patients and all new entrants are required to have approved postgraduate experience in obstetrics. Secondly, we have the dedicated support of a group of experienced community