boys (and girls) choose the jobs they want to do (they will anyway) and then use medical techniques to help them keep at it, remembering that at most only one in five will get ankylosing spondylitis and, of those who do get it, probably not more than one in 10 will be so severely affected that a physically demanding job becomes impossible. In most cases this will be because of hip involvement, and orthopaedic surgery can offer considerable help here.

Indeed, spondylitic patients often suffer more from their doctors advising them to take up sedentary "undemanding jobs." We recently had the experience of treating a young woman with ankylosing spondylitis and showing that she was able to do her chosen job of nursing the elderly, only to find that she was refused the job on health grounds by the medical adviser elsewhere. A farmer's son, keen to take over his family farm, was advised by his family doctor on no account to do this, when assessment in hospital under careful conditions showed that he was perfectly able to cope with the physical activities (and they are not so many as they used to be) that a modern farm might require. It is surely no part of the doctor's job to keep people away from work which they want to do and of which they are capable.

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Atopic dermatitis and the forefoot

SIR,—There has been renewed interest in various countries recently in a characteristic dermatosis of infancy and childhood localised to the distal soles, including the toes and particularly the big toe but sparing the toe spaces. I have certainly seen children with the condition since the 'sixties, but it has become much more common over the past few years. Since 1973 I have personally seen 46 children (24 boys, 22 girls) with the condition, all between the ages of 2 and 14 years when seen, and 20 of these had a personal or family history of atopy.

Atopic dermatitis may involve the feet as part of a widespread involvement, but it may also occur in a localised form and one site of localisation is the toes and feet.¹⁻³ However, is this dermatosis localised to the forefoot really atopic dermatitis? It seems most likely that juvenile plantar dermatosis⁴⁻⁷ and its synonyms peridigital dermatitis,⁸ atopic winter feet,⁹ shoe dermatosis in children,¹⁰ and atopic eczema localised to the forefoot^{2,3} describe not only true localised atopic dermatitis but also a frictional irritant contact dermatitis to which atopics are prone¹¹ but which may also occur in susceptible non-atopics.^{4,7,10} The diagnosis of the condition should provoke questions relating to a personal or family history of atopy. Why does the condition seemingly occur only in infancy and childhood? Presumably it is in infancy and childhood that the forefoot skin is most susceptible to irritant dermatitis, but why not young adults also? If shoes and socks made of synthetic materials and oversweating within them are relevant as causes of irritant dermatitis, as most reports suggest, how can the dermatosis be explained when it presents in babies who do not wear occlusive footwear and in persons who wear pure leather (less occlusive) footwear, open-toed footwear, and

cotton socks? Perhaps both babies and these individuals have true localised atopic dermatitis.

More studies are clearly needed to sort out this increasingly common and interesting skin condition.

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Immunisation of adults against diphtheria

SIR,—The report by Dr F W Sheffield and others (22 July, p 249) suggests that there is still uncertainty about the best procedure for immunising adults against diphtheria.

The occupational health service here has been using diphtheria vaccine adsorbed BP for about 10 years, for both microbiology staff and nurses in training. If there is no history of immunisation in childhood, then a full course of two doses of 0.2 ml is given. If previously immunised then one dose of 0.5 ml is given. We have not carried out Schick testing and, according to our records, we have had no serious reactions.

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Early arrhythmias and prognosis in myocardial infarction

SIR,—Ventricular extrasystoles in the early hospital phase following myocardial infarction were previously classified in a manner believed to be of prognostic value in terms of subsequent serious arrhythmias.¹ Subsequent work has thrown doubt on this concept, for "warning arrhythmias" occur equally in those who do and those who do not develop ventricular fibrillation.²

Cardiac rhythm is not usually monitored before hospital admission, although this has been done in some studies.³ Little information is available on the significance of arrhythmias during this period. In the Brighton system of resuscitation ambulances trained attendants monitor patients en route to hospital. The information is stored on magnetic tape for subsequent analysis. During the period May 1977 to January 1978 we studied all available tapes (77) on patients admitted by resuscitation ambulance with a firm diagnosis of myocardial infarction and related arrhythmias on the tapes to subsequent hospital prognosis.

The overall mortality was 29%. This reflects the high risk in a group of which more than half were carried in response to 999 calls. The patients with disturbances of heart rhythm on the ambulance tape (48) had a four-fold higher mortality than those without (29). The mortalities of the groups were 40% and 10%

respectively. Rhythm disorders included apparently minor abnormalities such as sinus bradycardia, sinus tachycardia, and ventricular and supraventricular extrasystoles as well as the more sinister arrhythmias, including ventricular tachycardia and higher degrees of heart block. The patients with ambulance arrhythmias also had a higher incidence of significant arrhythmias in hospital (81% v 50%).

These findings suggest one method of identifying a "low-risk" group of coronary patients at a very early stage—those who show normal heart rhythm while being moved to hospital soon after the onset of major symptoms. We are now carrying out a more detailed analysis of the relationship of ambulance arrhythmias to subsequent hospital prognosis.

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Regulating blood glucose concentration in diabetes during labour

SIR,—Dr M Nattrass and his colleagues (26 August, p 599) describe a glucose-controlled infusion system for maintaining stable blood glucose concentration during labour in diabetic women.

Although it may be more physiological for insulin dosage to be regulated on the basis of blood glucose values, equally satisfactory results can be obtained using a standard insulin infusion pump. Insulin dosage can be dictated by hourly blood glucose estimations and in our experience it has been simple to maintain stable blood glucose levels below 6 mmol/l (108 mg/100 ml) without hypoglycaemia at an average infusion rate of 1.2 units of insulin an hour. This does not present the technical complexities or involve the expense of an "artificial pancreas."

Close attention to detail is vital at all stages of pregnancy and labour in the diabetic, but it need not be complicated.

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Medical care in inner cities

SIR,—As one of those elderly general practitioners who should be retiring in the next 10 years, if not sooner, I feel that I ought to comment on Dr J Robson's letter (9 September, p 766) in which he proposes "structure planning" and organisation for primary care in the inner city areas. I quite agree that rational planning of primary care facilities and future staffing, nurses, health visitors, and social service personnel, together with the skills of the full-time clinical medical officers, are very desirable and very necessary. I also agree that the problems presented by inner cities are the most demanding and complex.

But why does Dr Robson not mention even once the word "patient"? Is it not desirable