paper by strongly supporting Jackson's excellent paper² in its plea that the family doctor in training should be involved in the care of paediatric abdominal emergencies in hospital. This suggestion still needs practical support.

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¹ Winsey, H S, and Jones, P F, *British Medical Journal*, 1967, **1**, 653.

² Jackson, R H, *British Medical Journal*, 1963, **2**, 277.

Prognostic value of early features in rheumatoid disease

SIR,—I shall be grateful if you will kindly allow me on behalf of my colleagues to apologise to Professor J Wawrzyńska-Pagowska and colleagues (9 October, p 876) for misquoting their article.¹ In fact they studied exactly the same number of patients as we did although their patients were pre-erosive. We are pleased that our own results² are in broad agreement with theirs and look forward to reading the report on their 10-year follow-up.

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¹ Wawrzyńska-Pagowska, J, et al, *Acta Rheumatologica Scandinavica*, 1970, **16**, 99.

² Fleming, A, et al, *British Medical Journal*, 1976, **1**, 1243.

Syphilis presenting as hair loss

SIR,—I was most interested to read of the two cases reported by Dr C Kennedy (9 October, p 854). I saw a similar case about 25 years ago and do not believe that I have seen another since. My patient was a young man with patchy baldness who brought a letter from his doctor asking if there was any effective treatment for alopecia areata. He was, it stated, otherwise healthy but had visited the surgery twice in the previous few months, once for a "labial herpes" and the second time for a mild pyrexia. This was treated with sulphonamides but they were stopped when he broke out in a rash. It all fitted very nicely.

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Oxytocin and neonatal jaundice

SIR,—A recent short report on the role of oxytocin in producing neonatal jaundice (4 September, p 564) concluded that jaundice associated with its use was the result of the lower gestational age of babies produced rather than a toxic effect of oxytocin itself. When considering "lower gestational age" as the cause of neonatal jaundice in these circumstan-

ces the tendency is to think of a gestational age of less than 37 weeks.

In a recent retrospective but controlled study babies who became markedly jaundiced (bilirubin ≥ 15 mg/100 ml (256 μ mol/l) were matched for gestational age with babies who were not jaundiced.¹ Significantly more of the jaundiced babies had been born after oxytocin was used to induce labour, while the percentage who had had oxytocin commenced during labour was almost the same in both jaundiced and non-jaundiced groups.

As the mean gestational ages of both groups were not significantly different and most were at term, that is, 37-42 weeks (see table), it seems likely that the spontaneous onset of labour was being anticipated by perhaps just a few days and that this led to an increase in the incidence of severe neonatal jaundice. The findings support the idea that there is a failure to "prime" fetal enzyme systems if labour is induced early.²

D G SIMS

¹ Sims, D G, and Neligan, G A, *British Journal of Obstetrics and Gynaecology*, 1975, **82**, 863.

² Davies, D P, et al, *British Medical Journal*, 1973, **3**, 476.

Thyrotoxicosis induced by iodine in food

SIR,—I thank Drs J C Stewart and G I Vidor for their kind comment (18 September, p 701) on my letter about thyrotoxicosis induced by iodine in food (24 April, p 1016). I agree with them on all the general principles.

There must, of course, be some difference between those goitre patients who become thyrotoxic after iodine repletion and those who do not. The latter may obviously have an increase in thyroid hormone production within so-called normal limits, whereas the former proceed to clinical thyrotoxicosis. If the thyroid-pituitary axis were always to respond in the way Drs Stewart and Vidor suggest, then few if any of these patients would become thyrotoxic at all.

Thyroid nodules may, as Drs Stewart and Vidor so clearly point out, often be the result of iodine depletion, such as has been seen also in this country.

Patients with large iodine-deficient goitres have athyroid hormone production reserve so large that adjustment to low TSH stimulation must certainly take some time after iodine repletion and thus make thyrotoxicosis more probable than in patients with small goitres. The same may be true when iodine depletion has prevailed for a long time, which may explain the higher incidence with age of thyrotoxicosis after iodine repletion which was observed by Drs Stewart and Vidor.

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Postoperative pain

SIR,—The painful necessity of trying unaided to sit up from lying down in the first few days after abdominal surgery was dreaded by myself like most patients. I found that this could be overcome as follows. Intelligent patients can be taught to concentrate on the use of an alternative muscle group instead of the abdominal muscles. The patient draws up one knee far enough to clasp both hands together behind the knee with the arms straight, while relaxed and leaning back to allow the body weight to be lifted at the next phase. The other foot remaining under the weight of the bed-clothes, etc, is sufficient to balance the body weight as the bent knee is quietly straightened with only one thought in mind—to bring the other foot down alongside its opposite number.

The pull of the hamstrings on to the clasped hands easily raises the relaxed trunk into the upright position, painlessly, provided the patient makes no attempt to tighten the abdominal muscles and concentrates on putting the raised foot down to the bottom of the bed. (For the mechanically minded, the iliopsoas group takes the place of the abdominal muscles in lifting the trunk in this manoeuvre in opposition to the hamstrings.)

JOHN B TRACEY

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A medical saga

SIR,—The history sympathetically outlined by Sir Harold Himsworth (2 October, p 792) made compelling reading to those who knew of a less lucky saga. Brief details of a more poignant story may therefore be of interest.

A Scotsman who had spent his childhood in South Africa went up to Cambridge in 1913. He had a car accident while still an undergraduate, and this left him with an arthrodesed left hip. After graduating he went to the United States for a year on a travelling scholarship. While there he married an American, whose mother was one of the earlier women doctors. He then joined the RAMC as a medical entomologist, and worked in this country and in East Africa. After the 1914-8 war he was appointed to the Burroughs Wellcome Research Bureau and visited Mauritius in 1922. He wrote articles about the life cycle of mosquitoes and published his malarial surveys. He became a DSc and invented an electronic rectifier. A firm making accumulators purloined his invention, and after a law-suit he received only nominal damages. He had hoped to obtain an FRS, but instead he developed Addison's disease in 1932 at the age of 43. He became weaker, more pigmented, and began vomiting, despite treatment with sodium chloride. He died in January 1933, just before DOCA therapy was available. His wife died, seven years later, from lung fibrosis caused by postoperative x-ray treatment for a mammary carcinoma. His father, sister, and one brother died from alimentary neoplasms, and his remaining brother developed insulin-diabetes six years ago. His older son had typhoid fever in transit to Mauritius and later pneumonia before Prontosil was introduced. He has also had coeliac disease for the last 55 years.¹

Some questions are decided by either hereditary or environmental factors. Tuberculosis and sarcoidosis occur together in some families. The father of the first reported case of sarcoid Addison's disease had, for instance, died of pulmonary tuberculosis,² and three cases of this syndrome have since been recorded.³⁻⁵ This Scotsman's accident possibly reactivated a tuberculous focus in his hip joint. He had no evidence later of tuberculosis,

	Overall matching		Oxytocin induction		Oxytocin to expedite	
	Case numbers	Mean age (weeks) $\pm$ SD Range (weeks)	Case numbers	Mean age (weeks) $\pm$ SD Range (weeks)	Case numbers	Mean age (weeks) $\pm$ SD Range (weeks)
Jaundice	46	38.8 $\pm$ 1.6 34-41	24	39.4 $\pm$ 1.6 35-41	7	38.4 $\pm$ 1.3 37-40
Control	92	39.1 $\pm$ 1.5 34-41	26	39.9 $\pm$ 1.2 36-41	12	38.8 $\pm$ 1.9 36-41
Significance		P < 0.5 NS		P < 0.3 NS		P < 0.7 NS

and his Addison's disease might have been induced therefore by sarcoidosis rather than by "idiopathic" adrenal failure. If so, his wife could have contracted one or other of these diseases herself subclinically. The prolonged cellular immunity generated by sarcoidosis might have even triggered off her mammary carcinoma.⁶ Was raised immunity then responsible for the other malignancies in this family? A few tuberculous parents have had children who later developed sarcoidosis. The son in this family was found much later to have the coeliac syndrome. Was this also caused by the sarcoid agent?⁷ The answers to these questions are still unknown because not enough facts are yet available. But it is unlikely in the meantime that natural selection will eliminate the sarcoid agent.

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¹ Personal paper, *Lancet*, 1969, 1, 725.

² Karlish, A J, and MacGregor, G A, *Lancet*, 1970, 2, 330.

³ Kopelman, H, Case presented at Brompton Hospital, 1971.

⁴ Burns-Cox, C J, and Pearson, J E G, *Postgraduate Medical Journal*, 1972, 48, 115.

⁵ Irving, W, Personal communication.

⁶ MacGregor, G A, *Lancet*, 1973, 1, 1185.

⁷ MacGregor, G A, *British Medical Journal*, 1976, 2, 106.

Names of Asian women and babies

SIR,—The names of Asian women and their babies in maternity hospitals are giving rise to difficulties. The previous practice in our maternity hospital at Luton was to use the mother's name only. The surname used was part of the mother's name, so the surname was either Begum, in Moslem names, or Kaur, in Punjabi or Sikh names. We then found large numbers of Mrs Begums or Mrs Kaur, both names in their native language meaning "Mrs." The babies were then called Baby Begum or Baby Kaur. This created various hazards, as follows: (1) The wrong baby could have been given to the wrong mother. (2) When discharged, the baby was given another name; he was no longer Baby Begum or Baby Kaur; thus there was no continuity of records for the child. (3) There were no means of relating the name of the baby to the mother's or father's name, as there was no way of relating the mother as the wife of her husband, who would have a separate name. (4) It was impossible to keep accurate notifications of infectious diseases, records of BCGs given, and other public health records.

As surnames do not exist in the Asian sub-continent they have another system of keeping track of their teeming millions. The method used is: person's name, followed by the father's name, and then the caste name. This applies mainly to the Hindus. The Moslems can use the same system, using the father's name as a surname, except a few families that have adopted a family name related to a trade, a place, or a title.

I propose that we adopt a system not only in hospitals but in the community health service and in general practice that is similar to the Asian system, but modified so as to be acceptable both to the immigrant and to us.

We find the majority of these mothers are illiterate in their own mother tongue and need help from interpreters. The interpreter who first helps to register the new patients at the maternity hospital asks (1) the patient's name,

(2) the husband's name, (3) the family name, if one exists. If no family name is used the husband's name is entered as the surname, hyphenated if necessary. For example, Mrs Akhtar Mohammed-Hussain is Akhtar, the wife of Mr Mohammed-Hussain. Their child would be Baby (male or female) Mohammed-Hussain. Similarly, for the Sikhs, the mother would be known by her first name—for example, Amrit, wife of Pratap-Singh, as Mrs Amrit Pratap-Singh. This system identifies the family under the name of the head of the family—the husband. For the records the name would be recorded under the first part of the hyphenated name. The whole family would use that as the surname. We found the old system intolerable and this new system much more workable. I am sure that other hospitals in cities with large Asian immigrant populations must have similar problems and suggest that our system is tried.

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Diagnosis of Down's syndrome at birth

SIR,—For those who have the unenviable task of "breaking the news" your leading article (9 October, p 835) is very informative and demonstrates clearly the clinical difficulties that may be met. But the brief mention of "early supportive management" hardly does justice to the enormity of the task. There is no blue-print, and each doctor has to work out for himself how best to manage this crisis situation. A working party¹ on the subject pointed out the problems involved and emphasised the far-reaching implications of the initial way in which parents learned of their child's condition. It is never a task to be undertaken lightly or by the inexperienced, and it is because it is a time of such importance that I feel the need to point out the omission.

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¹ Carr, E F, *et al*, *Lancet*, 1971, 2, 1075.

Community health councils and the public

SIR,—Your correspondent Dr S L Sacks complained (18 September, p 701) that he was not allowed to take part in the debate at the September meeting of the Peterborough Community Health Council and that he was not given a copy of the agenda.

Certainly one way of discovering the views of members of the public would be to encourage people to join in discussions at our monthly meetings. But unfortunately this would just not be practicable. We have barely adequate time to allow all the Community Health Council members to make their contributions. However, we do from time to time hold additional public meetings for the sole purpose of listening to what people have to say about their health services. Our office is open every weekday, and our members are available to anyone who wishes to discuss health matters with the Community Health Council.

These are just some of the ways in which we encourage the public's involvement in our activities and in their health services. We do also welcome people to attend our monthly

business meetings, to listen to our debates, and talk to us afterwards. May I assure Dr Sacks that in future members of the public will be provided with the relevant papers. We have tried not to let our secretary's many months' absence due to sickness affect our service to the public. On this occasion it did, and I apologise.

I am sorry that Dr Sacks reached his conclusions after attending just one part of one meeting. I have the feeling that if the Community Health Council reached such a conclusion after such a cursory inquiry and then made it public we would be labelled as irresponsible.

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CMV retinitis

SIR,—Having recently reviewed the subject of cytomegalovirus (CMV) retinitis in adults¹ I read with interest the report of Mr Chawla and others (31 July, p 281) which presented an otherwise healthy woman with this infrequent manifestation of CMV infection. Although the authors state that there have been only six reports of CMV retinitis in adults, we found a total of 19 cases in the English literature.²⁻¹⁴ We reported two additional patients as well. Thus, despite CMV infection being reasonably common in the general population, retinitis still remains an unusual complication.

CMV retinitis has occurred almost exclusively in immunologically compromised patients (18 of the 21 were renal transplant recipients, one had breast carcinoma, one had Hodgkin's disease). However, the first description of adult CMV retinitis² was in a woman who, like the patient of Chawla *et al*, was also apparently healthy. Although a minor point, the authors should amend the statement about theirs being the first reported case of this association.

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¹ Murray, H W, *et al*, *American Journal of Medicine*, in press.

² Foerster, H W, *Survey in Ophthalmology*, 1959, 4, 296.

³ Smith, M E, *Archives of Ophthalmology*, 1964, 72, 44.

⁴ Maler, G H, and Kisker, W A, *American Journal of Surgery*, 1970, 119, 334.

⁵ de Venecia, G, *et al*, *Archives of Ophthalmology*, 1971, 86, 44.

⁶ Aaberg, T M, Cesarz, T J, and Rytel, M W, *American Journal of Ophthalmology*, 1972, 74, 407.

⁷ Madge, G E, *Medical College of Virginia Quarterly*, 1972, 8, 251.

⁸ Porter, R, *et al*, *British Medical Journal*, 1972, 3, 133.

⁹ Porter, R, *British Journal of Ophthalmology*, 1972, 56, 555.

¹⁰ Wyhinny, G J, *et al*, *American Journal of Ophthalmology*, 1973, 76, 773.

¹¹ Coulson, A S, *et al*, *Western Journal of Medicine*, 1974, 120, 1.

¹² Astle, J N, and Ellis, P P, *Annals of Ophthalmology*, 1974, 6, 1269.

¹³ Fiala, M, *et al*, *Journal of Infectious Disease*, 1975, 132, 421.

¹⁴ Oberman, A E, and Chatterjee, S N, *Western Journal of Medicine*, 1975, 123, 184.

Postinfluenza depression

SIR,—Dr T H Flewett's letter (2 October, p 815) notes a lack of correlation between hospital admissions for depression and the occurrence of influenza outbreaks. This may be due to the fact that depression following influenza is usually mild, usually goes un-