and other central teaching units, but is not always possible in the average district general hospital with which our article was mainly concerned.

The great majority of children in hospital in Britain are not admitted to specialized teaching units but to district general hospitals, where shortage of nurses with specialist children's training is common, particularly at night. To state that it is "retrogressive" for children to be admitted to an all-age intensive therapy unit in these circumstances is, I think, misleading, and shows a lack of appreciation of the difficulties under which many paediatric units in this country are working.

Surely it is for each hospital to provide the best service possible for critically ill children in this category, depending upon availability of staff and facilities? The solution to the problem basically depends upon the training of a greater number of nursing staff with specialist paediatric skills and their wide deployment throughout the country. Until this situation comes about, the trend towards the management of these children in a single all-age intensive therapy unit is likely to continue, and under these circumstances, it is of course, most important that the intensive therapy unit should be equipped and staffed with the care of child patients in mind.—I am, etc.,

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Vacuum Aspiration in Abortion

SIR,—I read with interest the article by Mr. A. E. R. Buckle and others on vacuum aspiration (23 May, p. 456).

Since I introduced this method into Britain, I am naturally keen that there should be no denigration of the principles which could make the method unpopular. Mr. Buckle and his colleagues advocate the use of metal suction curettes, and I think this is a mistake. Certainly they are not impracticable, but the advantages of a transparent curette are obvious. The tissue can be seen as soon as it is withdrawn from the uterus and pressure released if there is anything untoward.

The authors talk about catching the anterior lip of the cervix with a vulsellum. I strongly advocate the use of paracervical block and the use of two vulsella, one either side of the cervix. A teaching film of my method is available from the B.M.A. Library or the library of the Royal College of Obstetricians and Gynaecologists.

Finally, I would advocate the use of a spoon curette in every case at the end of the operation for the removal of shreds of membrane.—I am, etc.,

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Fibrinolysis and Menstrual Bleeding

SIR,—Mrs. Nafisa Horrobin in her letter (18 April, p. 177) regarding your leader on fibrinolysis and menstrual bleeding (10 January, p. 61) hypothesized that regular blood donations might protect men against coronary thrombosis as compared with non-donors. To confirm or disprove her

hypothesis she suggested that an investigation of her suggestion might have some merit.

Mrs. Horrobin will probably be interested in knowing that a number of studies have already been carried out on this and related areas. Langsjoen on his own and with Inmon has described viscosity and haematocrit changes in patients with acute myocardial infarction.^{1,2} Stables and colleagues³ have also demonstrated the presence of an elevated haematocrit in myocardial infarction, and have suggested that an aetiological relationship might be involved. Burch and DePasquale have made similar observations,⁴ and have demonstrated clinical improvement in ischaemic heart disease following reduction of haematocrit by phlebotomy.^{5,6}—I am, etc.,

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Is it Angina?

SIR,—Dr. M. E. Gill (4 October, p. 52) undoubtedly knows his patient much better than could be conveyed in a brief letter, and his assessment of him may well be correct. It is known that T-wave and to a lesser extent ST segments are unstable, easily upset by a variety of major and minor provocations, and that an "abnormal" tracing does not necessarily mean an abnormal heart.¹ However, I would like to suggest that severe chest pain radiating down the left arm unrelieved by trinitrate glycerine is not to be dismissed lightly. Despite the negative clinical examination, the E.C.G. showed evidence of ischaemia, inverted and flat T-waves in V3-6, although unchanged since a month previously. It is not stated whether there were any enzyme changes, electrolyte disturbances, etc.

I would like to recommend an investigation which may be helpful in the further management of this patient—for example, coronary angiography and ventriculography. When done carefully, it carries a very low risk as to morbidity and mortality.² It may confirm Dr. Gill's impression of this patient; or show stenotic coronary arteries, a perfusion deficit, or myocardial impairment. If the former, the patient may be helped by a clear cut presentation of the facts; if the latter, a myocardial revascularization procedure may be rewarding.³—I am, etc.,

SOL SHAZ.

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- 3 Vineberg, A., and Walker, J., *Diseases of the Chest*, 1964, 45, 190.

Screening for Developmental Defects

SIR,—We have been doing developmental screening in our practice for the past six years, and it has proved well worth while. This is done in our well baby clinic where we also carry out immunization, and where health visitors weigh the infants, and deal with various minor problems. One side-effect of this policy is that we have 100% immunization coverage.

It seems to me that what is now required is a national conference of those in all branches of the Health Service who are interested to develop a national policy on screening babies for defects in development, and to produce a proforma which would be useful to everyone concerned. I would suggest the form should fulfil the following requirements: it should be usable in local health authority clinics, general practitioners' surgeries, hospitals, etc.; it must, therefore, be of such a size as to fit into the E.C.5 envelope; the layout must be clear and concise; and the specific tests to be used must be indicated in order to give comparable results anywhere in the country.

The timing of the tests would have to be agreed, and these should be co-ordinated with the immunization programme.

Those attending such a conference might have to consider a series of related issues such as the details of the immunization programme and the whole future pattern of infant and pre-school care within the community in the light of the Sheldon report¹ and the Green paper.²

How is this knowledge to be disseminated as widely as possible?

What is required immediately is some co-ordination of those already doing developmental paediatrics and a stimulus for its wider application. Is anyone willing to give a lead in this? Perhaps it should be the Royal College of General Practitioners.—I am, etc.,

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Children in Hospital

SIR,—Your leading article "Children in Hospital" (9 May, p. 309) states "The golden age of paediatrics is not yet here. General and special hospitals with children's departments tend to lag behind children's hospitals . . ." Yet the report of the Central Health Services Council on the functions of the district general hospital¹ indicates "We therefore do not favour any further development of separate children's, women's, accident, orthopaedic or any other single specialty hospitals." But the term "single specialty hospital" is incorrect when applied to a children's hospital, which in fact is a general hospital for small patients in which all specialties are actively represented.

In this conurbation of Manchester and Salford the future need for paediatric beds is calculated to be about 600. If present discussions are a guide these will be scattered in children's units within general hospitals. We agree with your statement that general