management of tissue viability disorders such as pressure sores. It would be unwise in principle for one group to concentrate research on a universal seating system because, firstly, the system of care of which it is an important part is inefficient and poorly organised; secondly, there is unlikely to be a crock of gold at the end of the technological rainbow—that is, patients and diseases are so diverse that a variety of cushions and seats is desirable; and, thirdly, proving the device would be a multicentre exercise. For beds and mattresses the case for variety has been argued in detail, and the conclusion reached that present technology is adequate if available and properly used. In other words, the system of care requires more attention.^{1 2}

(3) We entirely agree that skills such as those of the biomedical engineer are available to solve the problems that can be formulated.³ We believe that the DHSS demonstration centres and Scottish aids centres already play major parts and may have solved the problems of the team approach. The concept of multicentre, multidisciplinary special interest groups has been described^{4 5} and a national group to deal with tissue viability disorders meets three times a year. This tissue viability group has a cushion and seating section,⁶ which meets for the third time on 17 September, when six papers will be read.

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¹ Kenedi RM. *Bed sore biomechanics*. London: Macmillan, 1976.

² Robertson J C. *Nursing Mirror*, supplement; May 1979.

³ Ferguson-Pell M W, Wilkie I C, Reswick J B, Barbenel J C. *Paraplegia* 1980;18:42-51.

⁴ Wessex Rehabilitation Association. *Annual Report*. Salisbury, Wessex Rehabilitation Association, 1979.

⁵ Robertson J C. *Salisbury Medical Bulletin* 1979; 368-70.

⁶ Spinal Injuries Association. *Newsletter* 1980;15:4.

Respiratory infections in the older infant

SIR,—In his article on respiratory infections in the older infant (14 June, p 1442) Dr H B Valman discussed the examination of a child's throat, always an unpopular task for any physician. An adult armed with a light and a piece of wood (spatula) approaching a child from the front must often appear threatening, particularly when the child is feeling unwell. Having experienced the resultant lack of co-operation, and because I had done anaesthetics just before starting general practice, I adopted a different method. It has stood me in good stead over the last 15 years, and may be of some interest to others who have struggled for a view of a young child's throat.

With the child sitting on the parent's lap and facing away from you, ask if they can be laid down backwards. Draw your chair up so that the child's head is resting on your knees.

By this time they are generally reduced to an astonished silence. As you look over the child's forehead, with the aid of the spatula the mouth opens readily to give an excellent view. Children over the age of about 3 have generally done it all before, and open their mouths like hungry thrush fledglings.

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Brachial plexus injuries in motorcyclists

SIR,—I was interested to read Mr C B Wynn Parry's letter (12 July, p 149) and would support his view that amputation of the paralysed arm is no longer the treatment of choice in patients with preganglionic lesions. They seldom wear an artificial limb for functional or cosmetic reasons and the psychological effect of amputation should not be underestimated. The flail arm splint described by Dr Wynn Parry¹ may be helpful and some patients seem to manage well without any appliance.

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¹ Wynn Parry CB. *Injury* 1979;11:265-85.

Care of the unconscious

SIR,—Dr Jean M Horton describes a simple systematic approach to the management of the long-term unconscious patient (5 July, p 38). While such an approach is essential if some important aspect of care is not to be missed, inevitably the patient becomes dehumanised. Therefore, I believe that three further aspects of care should be added to Dr Horton's list.

Firstly, there is a need for care of the psyche as the conscious level rises. Sensory deprivation, pain, fear, etc, can all prolong recovery to full consciousness. Secondly, there is a need for spiritual care. The priest or equivalent should be a common and accepted visitor to the patient, and not seen as merely a harbinger of doom or administrator of last rites. Thirdly, the patient's relatives need care and attention.

These aspects are as important as physiological and pharmacological management in the total care of the unconscious patient.

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Trial of synthetic steroid for preventing postmenopausal osteoporosis

SIR,—The reported trial of the synthetic steroid Org OD14 in the prevention of postmenopausal osteoporosis by Dr Robert Lindsay and others (17 May, p 1207) does not mention changes in the height and weight of the trial patients. As the authors show that

Org OD 14 is significantly better than placebo in preventing osteoporosis perhaps one may presume that the patients taking steroids maintained their initial height. During the course of therapy with an anabolic steroid did they also gain weight?

Cochrane *et al*¹ have demonstrated a strong positive association between the Quetelet Index (weight/height²) and total mortality in women aged 55-64 years. Increase in weight at the menopause is not desirable on medical or aesthetic grounds. If long-term treatment with an anabolic steroid such as Org OD 14 is accompanied by a significant increase in weight many women would feel that this was too high a price to pay for the prevention of bone loss.

The authors describe the initial mean values of height and weight for the trial patients: could they possibly provide similar data for the groups after two years' treatment?

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¹ Cochrane AL, Moore F, Baker IA, Haley TJL. *Br Med J* 1980;280:1131-3.

*. We sent this letter to the authors, whose reply is printed below.—Ed, *BMJ*.

SIR,—We thank Dr Coope for her interest in our publication (17 May, p 1207) and for her comments. The point she makes is an important one. Final height and weight measurements were omitted from our publication simply because no significant changes occurred during the two years of the study (see accompanying table).

In our larger, long-term study of oophorectomised women we have shown previously that hysterectomy with bilateral oophorectomy is associated with subsequent weight gain, which does not occur after hysterectomy alone.¹ Almost all weight gain occurred in patients who were already overweight at the time of the operation and was not apparent in women of normal weight. The provision of postmenopausal oestrogen therapy prevented weight gain in these obese women.

In our current study, as Dr Coope correctly points out, we have used a steroid with an unusual endocrine profile. Only nine patients treated with Org OD 14 for two years were overweight (>20% in relation to height) at the start of the study and two gained weight during the study. In the placebo group ten were overweight at the start and four of those patients gained weight. Mean weights and heights for the two groups did not change during the study.

Despite the general hypothesis that there is a direct positive relationship between weight and mortality, this is in fact not totally suggested by the Framingham study.² This study shows minimum mortality around the average weight, with increasing mortality with both increasing or decreasing weight. In fact age-adjusted six-year mortalities among women in the Framingham study are almost as high (3.7%) in the leanest group as they are in the

Heights and weights (means $\pm$ SD) of women in trial

Group	Height (cm)		Weight (kg)	
	Initial	Final	Initial	Final
Org OD 14	159.0 $\pm$ 1.2	158.9 $\pm$ 1.1	60.4 $\pm$ 1.4	61.1 $\pm$ 1.7
Placebo	160.5 $\pm$ 1.1	160.2 $\pm$ 1.0	63.3 $\pm$ 1.4	62.4 $\pm$ 1.8