If that is so, why not free the doctor to consider these questions really dispassionately, instead of permitting policemen to breathe down the necks of the medical profession?—I am, etc.,

EVELYN FISHER.

London S.W.13.

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- ² Ministry of Health, personal communication, March 1966.
- Baird, D., *Brit. med. j.*, 1965, 2, 1141.
- ³ Ekblad, M., *Acta psychiat. (Kbh.)*, 1955, Suppl. No. 99.
- ⁴ Diggory, P. L. C., in *Abortion in Britain*, 1966, p. 88. London.
- ⁵ N.S.P.C.C., *Annual Report*, 1965-6.

SIR,—The main and governing clause of this Bill (31 December 1966, p. 1650)—Clause 1 (1)—is in my view inadequately expressed. I believe that the subclauses (c) and (d) about which there is so much controversy derive much of their suspect nature from this inadequacy.

1 (1) "... terminated by a registered medical practitioner if that practitioner and another registered medical practitioner ..."

In connexion with this repetitive phrase, the B.M.A. and the R.C.O.G. agree and recommend that "... it be made obligatory for the termination to be carried out by or under the supervision of a consultant [gynaecological] in the National Health Service. ..."

Thus with this amendment alone any medical practitioner may ask (demand) a gynaecological consultant to carry out the operation of pregnancy termination. This construction, or indeed Clause 1 (1) as it stands, would in my view leave the door open to what one might call the front-street abortionist—either in the accepted sense of a medically unscrupulous but qualified medical man, or that of a medical practitioner whose attitude is lax in this regard. I believe that if such qualified men do not exist today this Bill in its present form will assuredly produce them.

I suggest, therefore, that the gynaecological consultant who carries out the treatment or operation for pregnancy termination must be a responsible partner in deciding its necessity.

"... formed in good faith ..."

If this phrase means anything legally it can surely be whittled down to mean little or nothing by two qualified medical practitioners if similarly they are either unscrupulous or lax in their attitude. I submit, therefore, that legislation should contain no latitude in this respect.

As it stands, this wording might convey either a subtle compliment to the integrity of the practitioners concerned or even a suggestion of hope that the opinion will be so formed. It appears to be a word sequence of weakness in a legal document. In this decision of such grave concern to both doctor and patient ambiguity such as is here suggested should be avoided.

I submit, therefore, that Clause 1 (1) should be amended as follows:

"... when a pregnancy is terminated by a qualified gynaecological consultant if that consultant and another qualified medical practitioner are of the opinion formed on scientific grounds."

Medical, psychiatric, and sociological opinion are equally regarded as scientific.

This construction could obviate the necessity for subclauses (c) and (d).—I am, etc.,

Manchester.

K. VERNON BAILEY.

Infectious Diseases as a Specialty

SIR,—Your leading article (7 January, p. 2) makes the valid point that, despite the changing pattern of the infectious diseases, this important specialty must be preserved. In the larger areas of population consultants devoting all their time to the infectious diseases are required, whereas in other hospital centres there is need for an adequately experienced consultant-general physician and/or paediatrician to have additional responsibility for patients in the infectious diseases beds. It follows that there must be a sufficient number of suitably trained senior registrars to take the place of retiring consultants.

So far there has been no agreement about what constitutes adequate training for this specialty. It was therefore particularly pleasing that the recent report of the Scottish Standing Joint Committee on Training for Consultant Physicians¹ recommended that senior-registrar training should include two years in a major infectious diseases department. There has been a recent tendency to regard good experience in general medicine as the only training necessary for a consultant

post in infectious diseases. Such experience is of course essential, but as with all other branches of medicine there is equal need to gain adequate experience of the specialty itself.

The Scottish report wisely recommends that trainee infectious diseases physicians should also have some experience of microbiology and epidemiology. A period of clinical experience abroad is advised, and this might most usefully be spent in India or Pakistan, where, in particular, smallpox could be seen and studied. The Scottish report further recommends a period of training in such special units as cardiology, neurology, and paediatrics. The latter is particularly important, but the list could justifiably be extended to include experience in chest diseases, dermatology, gastroenterology, geriatrics, otolaryngology, etc. Quite clearly, such extensive training is impracticable.

However, stating the advantages of the widest possible experience serves to underline the fact that the knowledge and skills of any and every specialty are required from time to time to cope with the wide variety of illness admitted to infectious diseases beds. Because of this and the consequential need for consultation with many colleagues, infectious diseases departments should be sited at general hospitals.—I am, etc.,

United Oxford Hospitals, JOHN F. WARIN.
Oxford.

REFERENCE

- ¹ Report of Standing Joint Committee on Training for Consultant Physicians, 1966. Edinburgh.

Photographing Jejunal Biopsy Specimens

SIR,—The use of jejunal biopsy both in diagnosis and for following up the result of treatment of malabsorption states is now well established. The changes which occur in the jejunal mucosa may be assessed by the examination of the fresh specimen or of histological sections. Examination of the fresh specimen is a simple procedure requiring no complex apparatus or techniques. No staining is required, and, provided reasonable care is taken in handling the biopsy, its value to the histologist is not impaired.

Two main systems of grading the severity of mucosal change have been put forward.¹ One of these systems gives high numbers to the most severely affected grades, while in the other the numbering is in the reverse direction. This may lead to confusion unless the system being used is clearly specified. Even when a single system is used the grading given by different observers for the same specimen may not be in agreement. These difficulties may be overcome by having a permanent photographic record of the biopsy.

Such a record is easily made, using simple, readily available equipment.

Biopsies were taken using a Cooke, Crosby, or Carey capsule. Immediately the capsule was retrieved the biopsy was removed from it and spread out on a black "slide." It was then covered with a few drops of isotonic saline to prevent it from drying. The slide was mounted on the microscope stage and illuminated from above with a small spot of light from the Nikon lamp. The biopsy was brought into focus and the lighting adjusted so that a reading of LV 2 was given by the exposure meter when applied to the

FIG. 1 shows how the apparatus was set up.

FIG. 2 shows a black-and-white reproduction of a colour photograph taken using this method. The biopsy is flat with a mosaic pattern, there being no villi of any sort present. The mouths of the intestinal glands can be seen. This biopsy was taken from a 16-year-old child with coeliac disease.

viewfinder of the camera. Care was taken to exclude all light other than that emerging from the viewfinder. The image magnifier was then inserted and fine adjustments of focus were made. The exposure meter reading was rechecked after removal of the image magnifier. Photographs were taken at exposures of 1/8 and 1/15 of a second using an Agfacolour ASA 50 film.

Illumination of the specimen from above is essential. Illumination from below using an ordinary glass slide and the normal microscope lighting system gives poor results. Careful focusing is necessary, as the depth of focus is shallow with this system. Magnification may be increased by using higher-power objectives or a tube extension on the camera. Illumination must then be suitably increased or the exposure lengthened. The apparatus required is:

- (1) Labrolux microscope, the binocular barrel being replaced by a monocular barrel.
- (2) Eyepiece $\times 10$.
- (3) Objectives (a) $\times 2.5$ objective.
(b) $\times 10$ objective.
- (4) Minolta SR 1 reflex camera with microscope adapter in place of lens system.
- (5) Image magnifier for fine focusing.
- (6) Sekonic Microlite exposure meter. (Model L-88.)
- (7) Nikon 9011 focusing lamp.
- (8) Black plastic "slides" of the same dimensions as an ordinary microscope slide. These were cut from surgical dressing boxes.

I should like to thank Mrs. M. P. McDermott, B.A., A.I.M.F.W., Professor P. B. B. Gatenby, Dr. M. G. T. Webb, of the Department of Clinical Medicine, Trinity College, Dublin, for their advice and assistance. I was in receipt of a Research Fellowship from the Medical Research Council of Ireland while this work was in progress.

—I am, etc.,

MERVYN TAYLOR.

Royal Northern Hospital,
London N.7.

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- ² Creamer, B., *Brit. med. J.*, 1964, 2, 1371.

Tractor Accidents

SIR,—Tractor cabs (9 July, p. 112) and angle indicators (1 October, p. 830) may prevent deaths by overturning, but less serious injuries can result from simply driving a tractor. An unusual lesion, submitted to the pathology department of this hospital as a surgical specimen, if not caused by driving a tractor was at least exacerbated by this occupation.

For several weeks in the autumn of 1966 a farmer aged 43 years was working land recently broken up. He was on his tractor for about eight hours each day. It was very rough ground and he remembers that he half sat and half stood, trying to steady himself with his arms. His left testis began to be painful about 21 September 1966, and later he noticed a swelling above this testis. It became more swollen and uncomfortable when riding on the tractor, but he does not remember any specific injury. On examination the lump was freely mobile, hard, and irregular.

The surgical specimen received here on 17 November 1966 consisted of epididymis, tunica vaginalis, and a length of spermatic cord measuring altogether 6 by 3 by 2.5 cm. On section a

hard, yellowish, poorly circumscribed mass in the upper pole of the epididymis extended upwards for 2 cm. beside the ductus deferens. It had a whorled appearance and encompassed the spermatic vessels. Microscopy showed reactive fibrosis surrounding the spermatic cord. The internal spermatic artery was completely occluded by an organizing thrombus with some recanalization. The epididymis was partially fibrosed.

Recanalized thrombus in the left internal spermatic artery. ($\times 10$.)

Nesbit and Hodgson¹ reported two cases of thromboangiitis obliterans of the spermatic cord and reviewed seven more from the literature. Abercrombie² has since described one case. All these occurred in the left spermatic cord. Thrombosis of the pampiniform plexus of veins with signs and symptoms resembling subacute or acute endemic funiculitis has been described by McGavin.³ Thrombosis of vessels in the spermatic cord may follow torsion, but a review of the literature suggests that spermatic artery thrombosis is uncommon even after trauma. This case had no histological features suggestive of Buerger's disease, the patient is physically fit, and he has had no other thrombotic episodes. Presumably the left spermatic artery thrombosis resulted from unnoticed repeated minor trauma from tractor-driving.

I wish to thank Dr. J. C. Menzies, of Morden, Manitoba, for the clinical details and for permission to report this case.

—I am, etc.,

Winnipeg General Hospital,
Manitoba.

J. V. CLARK.

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- ³ McGavin, D., *Lancet*, 1935, 2, 368.

Pink Disease

SIR,—I was very interested in Dr. C. D. Granger's letter (31 December, p. 1656) recording that in 40% of 52 cases of pink disease mercury was not implicated.

In 1963¹ you published a letter from me stating that in 21 children with this disease treated by me only 9 had ever had teething powders, and one of these had a powder

containing no mercury. In a personal communication Dr. C. K. J. Hamilton tells me that he has notes of 200 children treated by him at a syphilitic clinic at St. Thomas's Hospital with hydrarg. cum cret. None of them showed symptoms that might have been pink disease.

In 1920 I was the first paediatric house-physician at Guy's Hospital and saw all the young children brought to the casualty department. I must have seen at least 200 babies a week. In those days nearly every sick baby was given grey powders whatever the illness, and all eye infections and children with impetigo were treated with ung. hydrarg. oxid. flav.

I am sure that none of these children presented symptoms of this illness. I cannot believe that the paediatricians of those days who were such astute clinicians would have missed such a dramatic syndrome. Moreover, in all the descriptions of chronic mercury-poisoning that I have been able to read, sweating, photophobia, and tachycardia are not mentioned, and these are the most striking signs of pink disease.

Children suffering from this illness may well be hypersensitive to mercury, but I cannot believe that it is the only cause of the condition which suddenly appeared (patchily) in this country in the early 1920s.—I am, etc.,

Leicester.

J. VERNON BRAITHWAITE.

REFERENCE

- ¹ Braithwaite, J. V., *Brit. med. J.*, 1963, 1, 1230.

Obstetrics in Africa

SIR,—Dr. D. A. M. Gebbie's timely and relevant study from Kampala (17 December, p. 1490) made interesting reading. After two years of midwifery practice in much less sophisticated surroundings in Nigeria and Malawi I have the same strong impressions—namely, the grave consequences of indiscriminate sectioning and the puzzling inconsistencies in criteria for predicting disproportion.

I have learned and practised the homely principle of surgical induction of labour as a solution to this problem. The main snag to this is the suspicion of uninformed people—not confined by the way to that continent—strengthened by many prophecies about the dire tragedies, physical and spiritual, that must follow such an unnatural practice. This is overcome only by making the plan a part of the community health service, of which disciplined antenatal care and baby care are the most important parts. A healthy baby weighing 6 lb. (2.7 kg.) proves an excellent advertisement, and the mothers we knew were glad to be relieved of the last fortnight or so of excess weight-bearing.

The cost was the price of four Drew-Smythe catheters. Assessment was on the usual grounds, and we successfully induced a few patients who had had previous caesarean sections. The results were excellent. No survey of the value of Dr. Gebbie's could be made, of course, and figures for section rates vary with the many variables that force individual obstetricians to this course anyway. However, we did list a series of 44 consecutive women subjected to induction, of whom possibly half would have come to section and certainly most to forceps delivery. Induction at between 37 and 39 weeks gave 44 live babies, one of whom had to be born by