Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Diagnostic Terms in Chest Diseases

SIR,—Professor J. G. Scadding's article (December 7, p. 1425) on the meaning of diagnostic terms in bronchopulmonary disease should stimulate chest physicians to think more precisely about definitions, diagnosis, and diagnostic criteria. But it is most important to carry this clear thinking beyond the confines of the clinic, and when this is done "a human being with disturbed structural function" can no longer be equated with "a patient." The epidemiologist knows that there are many such human beings who are not patients. I suggest that the definition of disease should be extended beyond the practice of physicians to include "the sum of those abnormal phenomena which are observed in any group of people with disturbed structure or function, the group being defined in a stated way."

The definition of emphysema which Professor Scadding gives requires not only definition of "the normal," as he points out, it also requires a statement as to the condition under which the size of the respiratory air spaces is to be measured. If these are measured indirectly during life, as by the residual volume, then emphysema is indeed present transiently during an acute attack of asthma, and Professor Scadding could not justifiably quarrel with the case report about the patient who was stated to have "suffered from several attacks of emphysema." If such temporary over-inflation of the lungs is to be excluded from the ambit of "emphysema" there must be some statement either about the permanence of the changes or about the conditions under which they are to be measured. I think there is much to be said for insisting that whenever the word "emphysema" is used it should be preceded by an appropriate adjective, such as "distensive" or "destructive," to show whether the increase in size of air spaces is due to temporary distension or to irreversible destructive changes.—I am, etc.,

C. M. FLETCHER.

Postgraduate Medical School,
London W.12.

Grants for Surgery Premises

SIR,—The most important step towards modernizing general practice is to provide modern, well-designed surgery premises. Without these the doctor cannot employ ancillary staff. How is the money for this to be found? Neither interest-free loans nor group practice is an adequate answer. In the country many doctors are of necessity single-handed and have to find £5,000 or more to build the sort of premises that country practice demands.

Consultants do not pay for the hospitals they work in, nor should general practitioners be expected to bear the whole cost of their surgeries. Our representatives in their forthcoming negotiations with the Ministry must ask for more than interest-free loans if an adequate stimulus to building is to be found. Direct grants for whole or part of the cost and tax relief on the money the doctor himself spends are the sort of measures we should be thinking about. These are the incentives towards improvement that the farming industry has long enjoyed, and it is time that we had a little of the same feather-bed treatment. One-tenth of the capital to be spent on new hospitals or one-half of that for new local authority health buildings would provide a new surgery for every general practitioner in the country.—I am, etc.,

R. P. C. HANDFIELD-JONES.

Haddenham, Bucks.

Tetanus Prophylaxis

SIR,—I am sure there is a mistake in the excellent article on tetanus prophylaxis by Dr. Colleen A. Cox and her co-workers (November 30, p. 1360), but just in case some enthusiastic house-surgeon reads the article and thinks that the correct dose of adrenaline in a case of threatened anaphylactic shock is 1 ml. of the 1 in 1,000 solution intravenously it should be pointed out that this would be a lethal dose. A maximum dose in such a case would be 0.5 ml. of a 1 in 10,000 solution subcutaneously.—We are, etc.,

Royal Hospital,
Chesterfield, Derby.

J. M. GRAHAM.

H. E. POOLER.

* * We showed this letter to the authors of the article in question, who replied as follows:

"Space did not allow a full description of this patient's management.

"The anaphylaxis was not threatened but had actually occurred, and the patient had been pulseless for one minute before injection of intravenous adrenaline was commenced. Divided doses of 0.25 ml. 1/1,000 adrenaline were given at minute intervals with external cardiac massage until the heart restarted. Cardiac action and rhythm then proceeded normally for 20 minutes. It stopped again and further resuscitative measures, including open cardiac massage, were given. We agree that *threatened* anaphylaxis requires a very much smaller subcutaneous dose."—Ed., *B.M.J.*

F.R.C.S. in the Specialties

SIR,—Surely it is only the anatomy section of the primary Fellowship examination which is really objectionable to

men intending to specialize in ophthalmology or E.N.T. This is largely a feat of memory and most of the facts are forgotten in six months. It must be remembered that these same facts have previously been "mugged up" for the second M.B. examination, and to go through this unnecessary process for a second time seems to be the height of folly. One would think that special anatomy papers could be set, and it would be open for a man who wished to turn to general surgery to take a paper in general anatomy, possibly at a later date.

The present anatomy hurdle does nothing to improve the calibre of men entering the specialties and must be the equivalent of about four wasted months. One would think that this time could be put to better use. The fact that the great London schools of ophthalmology have a plethora of candidates with the primary Fellowship merely proves how many men have to waste so much time to acquire so much useless knowledge.—I am, etc.,

Coventry.

J. S. GROVES.

Fish Against Mosquito

SIR,—Dr. P. G. Shute's letter states (December 7, p. 1468) that sticklebacks would play no useful part in controlling mosquitoes breeding in brackish waters in our low-lying coastal areas. Three-spined sticklebacks (*Gasterosteus aculeatus*) do seem to thrive in some brackish waters, at least on the west coast of Scotland.

One point to remember in attempting biological control with fish is that if the fish are too successful, and if they do not have an adequate alternative food supply, they may, by wiping out their food supply, drastically reduce their own numbers through starvation so that the mosquitoes can breed successfully again. The end-result is likely to be a balance between fish and mosquito, with substantial numbers of mosquitoes remaining, though less than if there were no predatory fish.

This is not to decry the usefulness of fish in reducing mosquito numbers, particularly if an alternative food supply can maintain fish numbers in the absence of larvae.—I am, etc.,

Bearsden, Glasgow.

DAVID STEVENSON.

SIR,—I was very surprised to see the opinion expressed by Mr. P. G. Shute (December 7, p. 1468) that sticklebacks might be expected to play no useful part in controlling mosquitoes which breed in brackish water. I should have thought they would be a most promising family for trial. I have the clearest possible recollection of capturing as a small boy both three- and four-spined varieties in the broad shallow ditches which lie behind the seawalls all round the Essex coast. These stretches of water often dry out in summer and also are frequently flooded by sea-water at spring tides, but sticklebacks thrive under these conditions.