literature. The *American Journal of Mental Deficiency* of May, 1958, contains two major review articles: one uses mental retardation to describe the whole field of mental deficiency,¹ while the other restricts the term to cases in which "no pathology is . . . detectable and environmental deficits provide the causal explanations."²

We would make a plea that the term "mental retardation" be reserved for this non-organic category of patients, although with some further qualifications. Mental deficiency (or mental subnormality) has many causes. Only some of these fit the concept of a permanent intellectual deficit usually present at birth and persisting through growth and development to maturity. We believe, with others, that some causes can retard the development of minds normal at the outset; we have recently presented evidence which may help to define some of the characteristics of one such form of retardation.⁴ This retardation, which thus becomes apparent during development, is to some extent recoverable.

The syndrome of mental retardation would include most of those cases of mental subnormality designated by Lewis as "subcultural,"⁵ by Doll as "pseudo-defective,"⁶ and by Penrose as "residual,"⁷ as well as some of those designated by Tredgold as "primary amentia,"⁸ and by others as "garden variety."⁹—We are, etc.,

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Handicapped Children

SIR,—We read with interest your leading article on "Children at Risk of Handicap" (July 27, p. 193) and the comments of your correspondents (August 17, p. 443, and September 14, p. 685) on this subject.

In our opinion the value of knowing that the child is "at risk" is in alerting medical and public health personnel, so that the early diagnosis of the suspected physical or mental deficit allows for adequate medical, educational, and rehabilitative procedures to be instituted.

A Registry for Handicapped Children has been in operation in the Province of British Columbia for eleven years. Its chief function has been to ensure that the handicapped children of the Province do have full opportunity for proper medical,

educational, and rehabilitative care. It has also resulted in the accumulation of valuable incidence and prevalence statistics. In the light of your article, we have given some thought to how a "risk register" may supplement the Registry for the Handicapped now in existence and have the following points to make.

First, it is apparent in retrospect that a large number of the children now on the British Columbia Registry would have been on a "risk register" if one had been in existence. Second, a "risk register" or listing does seem worth while on a local health unit level by making the health officer and staff aware of those children or families (in the case of recurrent problems) which might merit special attention and to ensure prompt registration in the Registry for the Handicapped if the potential disability becomes manifest.

In our opinion it is most important that a register for the handicapped is based on a large population in order to provide a central reporting area which allows for the collection and compilation of accurate statistics on all handicapping or potentially handicapping conditions.—We are, etc.,

DONALD PATERSON.

JAMES R. MILLER.

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Central Sterilization

SIR,—Reading the description of the "Edinburgh Pre-set Tray System" (November 23, p. 1322), I was interested to compare this experiment with that carried out at this hospital at High Wycombe over the last three years. Here we have used packs in theatre supplied by the C.S.S.D. No sterilization of any sort is done in the theatre suite. Details of the system may be found in *The Hospital*¹ and the *Lancet*.²

Briefly all packs for theatre are packed in the C.S.S.D., which also serves the rest of the hospital. Before each list the packs are delivered to theatre, where they are stored in what used to be the sterilizing room. As at Edinburgh only when the patient is on the table are the packs opened.

While the Edinburgh system has the decided advantage that there is no laying up to be done in theatre there are several other points which we at High Wycombe would not feel altogether happy about:

1. The use of only three sizes of tray must result in considerable bulk. We use a system of a few comprehensive packs together with supplementaries, so that even though there are about 100 packs many of them are very small. With this system we feel that we have gained the advantage of standardization but without the disadvantage of forcing inflexible practice. We have also found that it is useful to be able to pack some items in transparent nylon film in order that size may be checked before opening.

2. At Edinburgh considerable ingenuity has been used to overcome drying difficulties occasioned by the use of trays. We have found that by using paper wrappers and purpose-designed cardboard boxes this difficulty does not arise.

3. We have also noticed an increased demand for the autoclave, but only to the extent that it is now used more consistently throughout the day.

4. The increase in instruments quoted by Edinburgh seems phenomenal. At High Wycombe we examined every procedure and as a result have been able to make savings in the number of instruments laid up. We found that in some cases custom, not practice, had stipulated the numbers of instruments laid up. For instance, we were able to cut down the number of Spencer Wells, as we are now using more diathermy. The result of this review was that very few extra instruments have had to be provided because of the new system.

5. In the new High Wycombe hospital the C.S.S.D. will operate two work streams, the inner one for the theatres sited above it and connected by "clean" and "dirty" hoists, and the outer one for the rest of the hospital. It is not contemplated that there will be any difficulty in adapting the present system, which only serves 150 beds, one theatre, and very busy accident and out-patient departments, to deal with three theatres and up to 1,000 beds.

Finally, it is encouraging to know that not everyone is being deterred by the often repeated cry that central sterilizing of theatre instruments will not work; both Edinburgh and High Wycombe have shown that it can work most successfully.—I am, etc.,

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Chronic Pneumonitis and Asbestosis

SIR,—In your issue of November 2, p. 1130, Dr. Paul Gross refers to a letter of mine of January 12, 1963, on exposure to asbestos dust and diffuse pleural mesotheliomas. He states that my diagnosis of basal asbestosis seems to depend upon the recognition of a limited slight chronic interstitial pneumonitis in conjunction with the finding of one or several isolated asbestos bodies in lung juice. He further credits me with the assumption that the very small amount of asbestos dust which may be found in urban air is sufficient to produce basal asbestosis. The bulk of his letter is a reasoned and reasonable evaluation of these two opinions, and his conclusion is that one should be cautious in accepting them.

These opinions, however, are not my opinions. In the paper referred to by Dr. Gross we clearly stated that it was only in those cases with abundant asbestos bodies in smears from the lung bases that

an asbestosis, basal or classical, is likely to be present, and that industrial, not urban, exposure was the mechanism.¹ We gave as our opinion that at the moment the amount of urban exposure to asbestos was not sufficient to produce pulmonary lesions or disability. In the summary at the end of the paper referred to, our conclusions on the cases positive for asbestos bodies and their origins were as follows:

"In most cases this would appear to be the result of contamination of the urban atmosphere, and the bodies were scanty and not associated with pulmonary changes. In 6% of the males the bodies were numerous and were presumably of occupational origin."

What we did suggest was that in the future, in 20 or 30 years' time, basal asbestosis *might* be acquired by the ordinary urban dweller. We still think that this is a possibility worthy of consideration, on the grounds that asbestos fibres too long to be dealt with by histiocytes tend to move by gravity to the lung bases, before they are converted into asbestos bodies. The young urban dweller of to-day has in front of him a life-time's exposure to asbestos available for concentration at the lung bases, unlike the older man, who in his earlier years had little opportunity of inhaling asbestos fibres.

Dr. Gross's remarks on animal experiments using fine asbestos dust, "substantially shorter than 3 μ ,"² are hardly relevant to a discussion of basal asbestosis, as dust of this diameter can be phagocytosed by histiocytes and transported by lymphatics, and is unlikely to gravitate to the lung bases. Basal asbestosis would appear to be concerned with much longer asbestos fibres.

It is significant that Dr. Gross talks of asbestos dust and 1 of asbestos fibres. Perhaps to make the difference more clear I should have used the term employed in the German literature—"asbestos needles." We are all familiar with the distances sharp-pointed structures such as needles can travel in the human body; in the lung long asbestos fibres can behave in a similar fashion and work their way down to the lung bases. If the lung is otherwise healthy and free from fibrosis, as in the subjects we have in mind, this downward movement is likely to be more rapid and more complete.—I am, etc.,

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Amiphenazole and Lichen Planus

SIR.—I would like to add another case of severe lichen planus eruption in a patient taking "daptazole" (amiphenazole), to the four mentioned by Drs.

Harvey Baker and J. S. Pegum (December 7, p. 1473).

An emphysematous patient, a miner aged 58 years, was put on amiphenazole one tablet t.i.d., in December, 1962. The dose was reduced to one tablet b.d. in January, 1963, because the patient said that they made him excessively sleepy. So far the patient maintained that amiphenazole had given him relief with breathing.

In February he developed a severe attack of lichen planus. At first it was not realized that amiphenazole could be the cause of the eruption, and it was not until after the drug had been stopped that improvement was noted.

By September the lichen planus had cleared up. After a further interval of one month the patient was tried out again on one half tablet of amiphenazole and within a few hours he experienced severe skin irritation and the rash tended to return. No further amiphenazole was administered and the patient has had no further skin trouble.

—I am, etc.,

Atherstone, Warwicks.

J. D. SIMPSON.

Drug Advertisements

SIR.—In his letter on this subject (December 14, p. 1533) Dr. Cramp objects to the sum of £112 per annum per doctor being spent for the promotion of drugs. Assuming that the cost of each doctor's N.H.S. prescription amounts to approximately £1,600 annually (based on a total cost of approximately £80m.), then £112 represents 7%. Is this too high a figure to pay for communicating the specific findings of the constant research and development carried out in the pharmaceutical industry?

In Communist-controlled countries no such system of free enterprise is carried out, nor has any drug of any importance yet been developed by them. In this country, where doctors can choose whatever drugs they consider most suitable for their patients, it is essential that they should be kept fully informed of the drugs available.

If Dr. Cramp objects to receiving promotional literature through the post most manufacturers would be willing, at his request, to withdraw his name from their mailing lists, and he can, of course, refuse to see medical representatives.—I am, etc.,

MAURICE KEATING.

Harley Publishing Company Ltd.,
London W.C.2.

Drainage-tube Milking Forceps

SIR.—Suction and water-seal chest drains used after thoracotomy have to be "milked" at frequent intervals to clear the clot that forms inside them. This has been done by occluding the proximal part with one hand, while squeezing it away from the patient with the other. This method is tedious, and painful to the fingers.

An instrument for doing this was designed and made, consisting of a pair of flanged rollers fixed at right angles to the jaws of a pair of pincers by screws, and it proved most successful and labour-saving in use. The drain is gripped

between the rollers and the instrument is drawn down it, away from the patient. On discussing this instrument with the instrument curator at University College Hospital, he produced the forceps that I illustrate. He said that he had had them lying around for years, and had never been able to find out what they were for,

despite his inquiries of several instrument makers' representatives. The only mark they have is "Made in Germany."

This instrument is of nickel-plated steel with chromium-plated brass rollers. The handles resemble those of sequestrum forceps, and the instrument is seven inches long. It has proved itself during several months' use at University College Hospital, and Messrs. Down Bros. have said that they can readily reproduce this instrument in stainless steel.—I am, etc.,

London W.C.1.

M. V. L. FOSS.

Cinchona

SIR.—The older generation of doctors visiting the Goya exhibition at Burlington House will have nostalgic memories aroused by the prominent portrait of the Countess of Chinchon, after one of whose predecessors—wife of a Spanish viceroy of Peru—the most important drug known to medicine was named. It is probably untrue that she was ever cured of malaria by its means or that she brought cinchona bark to Europe, but her name liveth for evermore although cinchona products seemed on their way out.

Reliable reports have now appeared to the effect that in parts of the world as far apart as Colombia and Malaya the parasite of malignant malaria (*P. falciparum*) has developed resistance against chloroquine, mepacrine, pyrimethamine, and proguanil—the whole gamut of synthetic antimalarials—but that quinine continues to be completely efficacious against all strains and species of malaria parasite everywhere, as it has been for over 300 years. We are told that newer and better antimalarials are being synthesized. They will be welcome, but what is really needed is some fundamental research on why the natural alkaloid does not induce parasite resistance whereas all known synthetics do. This, of course, involves basic investigation into intracellular chemistry and molecular biology and is further proof, if any is required, of the urgent need to spend a higher proportion of research funds on the basic biological sciences.—I am, etc.,

Ewell, Surrey. GEORGE R. MCROBERT.