The health visitors of the local authority to act as investigators in the homes along with the sanitary inspectors, and "specialized" health visitors to be attached to the various medical, nursing, and clerical teams operating at the hospital group and local authority levels.

Taking the tuberculosis service as an example. The primary notification of tuberculosis would be visited by the health visitor, who would report on the housing conditions and general sociological circumstances. The primary notification would by law be sent to the local medical officer of health as chief epidemiologist, who would delegate the subsequent measures to the senior tuberculosis officer of the hospital team; the subsequent visits to be carried out by the "specialized" health visitors who attend the various clinics and are kept informed of everything affecting the patient and his family; the senior medical officer of the team to work in close harmony with the medical officer of health, particularly as regards housing and other necessary conditions. So far as after-care is concerned, this should be in the hands of the committee at the hospital group-local authority level and advised not only by the senior medical officer but also by the medical officer of health.

The framework could be extended to meet the needs of all other services, but modified according to the special needs of this service. Once the framework is accepted, the details can easily be filled in provided there is good will and a wide understanding.—I am, etc.,

Bradford.

HAROLD VALLOW.

SIR,—There are two facts apposite to the impending changes in the tuberculosis service which have so far received scant recognition. The first is that the relationship of the patient to his domestic, social, and economic background, which is now receiving so much attention and which to general medicine is a relatively new conception, has in fact been the everyday concern of the tuberculosis officer for many years. Secondly, the anti-tuberculosis organization as it has developed since 1914 has given us the nearest approach we have known to a public medical service providing hospital, clinic, and domiciliary treatment at a high clinical level for sick persons in large numbers. Despite certain inherent weaknesses and inequalities, and despite in some quarters official apathy and parsimony, it has emerged with a record of which it may well be proud.

For these two reasons the views of tuberculosis workers claim the special attention of those who will formulate the new regional schemes. It is to be hoped that the well-timed suggestions put forward by Dr. Lissant Cox (April 26, p. 577) will stimulate a lively discussion prior to the Minister of Health's address in July. Dr. Lissant Cox rightly stresses the need for medical teamwork. This can only be obtained where all concerned are responsible to the same employer. If only one person—for instance the health visitor—owes allegiance to a different authority from that of the tuberculosis officer, almoner, and clerk there is a sense of divided loyalties and the team spirit suffers accordingly.

Each tuberculosis area within a region will require a headquarters with office accommodation. It will be years before new establishments are available, and until then I suggest that in some areas the smaller institutions could, with minor alterations or extensions, be adapted for this purpose. Beds would continue to be available as before, and in those institutions where x-ray facilities are already provided out-patient clinics could be held as in country districts; this would be an added convenience for patients. In this way the institution would become a strongly defined centre, clinical and administrative, for the area.—I am, etc.,

Chichester.

J. E. WALLACE.

Sanitary Control of Ice-cream

SIR,—May I draw your attention to an inaccuracy in the epidemiological note (April 26, p. 583) on the above subject? The maintenance of a sufficiently low temperature after freezing and until sale is required in the case of a cold mix product as in the case of a pasteurized mix. Circular 69/47, which was issued with the regulations, points out in respect of the complete cold mix that after conversion of the reconstituted product into ice-cream Regulation 4 shall apply.

This regulation forbids the sale or offer for sale unless one of two conditions is met. One requiring further heat treatment should the temperature of the ice-cream be found to be above 28° F. (−2.2° C.) cannot obviously apply to the complete cold mix product; the other stipulates that ice-cream shall not be sold unless it has been kept at a temperature not exceeding 28° F. since it was frozen.

I should be grateful if you would draw the attention of your readers to this rather important aspect of ice-cream control.—I am, etc.,

Birmingham.

W. R. MARTINE.

Massive Penicillin Doses

SIR,—Dr. D. P. Wheatley (April 19, p. 530) has shown that the daily parenteral administration of penicillin can accelerate the resolution of localized septic foci if the doses are large enough. Thus, for the treatment of what he calls "seven cases of minor conditions commonly met with in general practice" he used 4,550,000 units of penicillin. The total period of convalescence from the commencement of treatment was at least 30 days.

From the few cases that I have treated I have been under the impression that a more rapid cure can be achieved by the combined use of local penicillin and free surgical drainage. The solution recommended for local use by Roxburgh contains between 500 and 1,000 units per ml. of distilled water and gives satisfactory results. In one case a pyogenic abscess of three days' duration was opened by a 1-in. (2.54-cm.) incision, and a cavity 1/2 in. (1.25 cm.) in diameter was found. A drain was inserted and penicillin was instilled. Twelve hours later the discharge was slight, and the drain was removed. On the fourth day, after daily instillations of the penicillin solution, the cavity was obliterated and the skin incision was clean and dry and healing rapidly. (Total amount of penicillin used was 4,000 units.)

If, as Dr. Wheatley has noted, the systemic treatment with penicillin is commenced early enough, the inflammation will abort. But, in cases where there is some delay in starting treatment, the generalized symptoms of toxæmia and the signs of inflammation will subside, leaving a localized collection of pus which requires surgical treatment. It is suggested that, once it is decided that the inflammation is progressing to abscess formation, but before localization is complete, the area should be incised to relieve the local tension and pain. The level of penicillin in the blood stream will prevent a spread of infection through the channels opened up by the incision. Thereafter the systemic penicillin may be discontinued as soon as the general condition of the patient merits it—usually three injections of 30,000 units each is the total amount of penicillin required. The local treatment is continued daily until the purulent discharge ceases, when the further treatment is the same as for a clean surgical wound. Such a procedure, however, could only be justified if the organism is sensitive to penicillin. This can be assessed by the progressive localization of the inflammation under the systemic treatment.

In this way greater economy in the use of penicillin can be achieved, the discomfort of repeated intramuscular injections is reduced, and the patient's convalescence is shortened. In addition it is suggested that a stronger scar and a better cosmetic result is achieved because the tension of the abscess is relieved before the overlying skin has become stretched and atrophic.—I am, etc.,

Ayr.

C. O. KENNEDY.

REFERENCE

Penicillin: Its Practical Application (Dermatological Section). Edited by Sir Alexander Fleming. London: Butterworth and Co. 1946.

Rubella in Pregnancy and Congenital Defects

SIR,—Because of the interest taken in this association this single case may be worth publishing. It was the mother's first pregnancy and resulted in a normal full-term delivery, birth weight, 5 lb. 9 oz. (2.5 kg.). The boy was born on Jan. 14, 1947, and was seen for the first time a month later at an infant welfare centre in South London, when his mother was having considerable difficulty in getting him to suck satisfactorily. He was found to have bilateral cataracts and a loud systolic murmur heard over the whole left chest; he was never cyanosed. He

reacts sluggishly and appears to be deaf. He has progressed slowly and is now, at the end of April, 8 lb. 10 oz. (3.88 kg.).

The father is 29 and healthy. His sister had rheumatic carditis at the age of 14 and his father had a "displaced heart," which never made him ill. The mother is 22 and robust. On inquiring about her health during the pregnancy she said that she was very well except that she "caught German measles from her sister during the first month." The attack had apparently been mild and had not made her feel at all unwell. The Wassermann reaction, taken at the antenatal clinic, was negative. Her sister and the other members of her family, father and mother, are all well.—I am, etc.,

London, S.E.21.

G. D. PIRRIE.

Treatment of Post-operative Pulmonary Atelectasis

SIR,—In an effort to prove that his pen is mightier than the spear, Mr. R. C. Brock, in his letter (April 19, p. 543), out-Quixotes Quixote by tilting at illusory windmills. Indeed, all must agree with practically everything he says, but the tone of his letter requires that I should explain myself in rather more detail.

In saying that bronchoscopic aspiration is the ideal method of treating post-operative atelectasis I of course meant that it was the most effective (as Mr. Brock himself admits), not that it had no imperfections; nor must he condemn me as ignorant of the well-known benefits of prophylaxis and of conservative methods of treatment simply because, in describing one particular manoeuvre (this word suggests less of charlatanism than "trick"), these benefits were not stressed; nor, of course, is it material to that manoeuvre whether water be introduced into the trachea by injection through the windpipe or by instillation through the glottis, so long as coughing results. Incidentally, injection is not so unpleasant as it sounds, and there is little to choose between the two methods.

On all the above points Mr. Brock and I are in agreement. Where we really differ is on his statement that the objections to bronchoscopic aspiration are, first, that it encourages laziness, which might more reasonably be used as an argument against penicillin or the sulphonamides, and, secondly, that bronchoscopy is dangerous in unskilled hands. This latter may be true, but it is no more an argument against bronchoscopy than it is against appendectomy; on the contrary, it is an extremely good reason why anaesthetists should become, as I said in my last letter, experts in bronchoscopic aspiration and in thoracic disease.—I am, etc.,

Newcastle-upon-Tyne.

M. H. ARMSTRONG DAVISON.

Treatment of Ingrowing Toenail

SIR,—I was very interested to read the remarks by Dr. S. J. D. Esser (Jan. 4, p. 33) on the above subject, and entirely agree with him. I have performed a similar operation on over fifty patients, only one of which was temporarily unsatisfactory. The patient, a very conscientious engineer officer, would not remain in bed but got about immediately, with the result that convalescence was delayed. Some of my more athletic patients played football a month after the operation with no ill effects.

I first came across a description of the operation in question some years ago in a French medical journal; the writer was a French surgeon; unfortunately at this date I cannot recall his name. In his description a diamond-shaped portion of the soft tissue is removed, the knife cutting down to the bone; three salmon-gut sutures are inserted—the end ones being tied first, the middle one last—and there should be little or no tension. Performed in this way the final result is a linear scar, the overhanging soft tissues being drawn well away from the lateral margin of the nail. He emphasized the importance of a thorough preparation of the part prior to operation and insisted on complete rest afterwards until removal of the sutures. This, although rather irksome to the patient, is essential if a good result is to be obtained.

Following these instructions I have never had to perform a second operation for the relief of this condition. As Dr. Esser says, there is no doubt about the operation being simple, logical, and effective, and I congratulate him on bringing it to the notice of the profession.—I am, etc.,

W. E. ROBERTS,

Surgeon Commander, R.A.N. (retd.).

Sydney, Australia.

Safety in Electric Convulsion Therapy

SIR,—I have read the letter by Dr. R. A. Sandison (April 26, p. 579), and I am very gratified by such common-sense thought. His experience is entirely in accord with my own over seven years' experience of electric convulsion therapy. I have treated a large number of cases both as in- and out-patients by this method in the last two years without traumatic occurrence, and between 1940 and 1945 had only three cases which showed evidence of compression of one vertebra after x-ray examination. I came to the conclusion that this compression was more a radiological disease than a pathological one, and I have not seen any disability resulting from it.

I always use a firm surface with a pillow placed under the thoracic spine and no other mechanical restraint. It is, therefore, in my opinion quite unnecessary to use curare. As far as lessening the apprehension by means of thiopentone, as Dr. Sandison says, patients are not afraid of the treatment but sometimes are upset by the amnesia and confusion, which as a rule are only transient, and again are very readily relieved by a chat with the patient following treatment, or by warning the patient before that such symptoms may arise for a short time. No advantage, therefore, in my opinion can be obtained by the use of curare or thiopentone apart from the very dangerous results which may follow its use.

Again let me congratulate Dr. Sandison.—I am, etc.,

Bromsgrove.

J. P. MCGUINNESS.

The Shortage of Nurses

SIR,—The purpose of this letter is twofold: first, to bring to the notice of the medical profession a very real danger to the future supply of nurses; and, secondly, to ask whether the theoretical training of the modern nurse has not reached the stage when it is endangering the practice of nursing.

It seems to me that the following decision of the General Nursing Council has not received sufficient attention in the medical Press—namely, that as from May 31, 1937, no hospital with less than an average of 100 occupied beds per day will be recognized as a complete training school. By this decision the General Nursing Council would appear to be following the present-day trend of the pursuit of ideologies without regard to the practical issues involved. The law of economics is one of demand and supply; if the supply is inadequate and further demands are put upon it the result must be chaos.

The smaller hospitals throughout this country have for many years supplied a large number of trained nurses. They have instructed and individually spoon-fed girls who, from lack of primary education, would have failed to stay the course in the larger hospitals, and have turned them into reliable nurses. In the future these smaller hospitals can never be staffed by senior nurses, and they will have great difficulty in attracting junior nurses, who will prefer to enter the complete training schools.

It is generally acknowledged that the standard of education of the present-day nursing recruit is not as high as it was ten years ago. Yet with insufficient grounding the nurse of to-day is expected to have a knowledge of medicine, surgery, gynaecology, and many other subsidiary subjects that would not disgrace the average medical student. Of what practical use is the nurse full of theory who cannot make her patient comfortable, and, who, for example, though she can quote correctly the precise figures of the normal blood urea, yet is unable to see that her patient is in the early stages of renal failure by his drowsiness, his breath, his tongue, and his diminished output of urine? The nurse should have sufficient textbook knowledge to enable her to take an intelligent interest in her work. She should be trained not to the theory of medicine but to the art of nursing: the class-room can never replace the ward. In my opinion it will be cold comfort for the patient when a graduate nurse does his dressing, a student nurse gives his enema, an assistant nurse washes him, and an orderly looks after his meals, with a complete change of personnel for every eight-hour shift. Not one of them will look upon him as her individual responsibility, and the faith of the patient will be correspondingly lessened.

It is admitted that the smaller hospital is no longer an economic unit, and that the larger one of 400 to 500 beds is the hospital of the future. At the present rate of building it may well be twenty years before the latter comes into existence.