his food supplies for him by regular inspection and control? Would he also be likely to object to the fact that the water he drinks is treated and its standards of purity rigidly controlled?

If he regards these remarks as irrelevant, let me ask him whether in fact he has taken the opportunity of testing the vision and hearing of his 6-year-old daughter, matters of great relevancy in the education of his child and factors that will undoubtedly be attended to by the School Health Service.

Nowadays the practice of medicine should surely be a co-operative effort between the curative, preventive, and Public Health Services. I am afraid such attitudes as displayed by your correspondent do not help in the achievement of these ideals.—I am, etc.,

R. JOHN GOURLAY.

Department of Social and Preventive Medicine,
University College of the West Indies.

SIR,—It is clear from Dr. Letitia Fairfield's letter (January 19, p. 187), that when the School Medical Service was started in 1908: "the London County Council and many other responsible authorities—decided . . . that whatever their legal powers might be there should be no compulsion for routine examinations." Dr. R. G. Newton has obtained this agreement with his complaint (January 5, p. 57).

Of course persons who are about to be gainfully employed raise no objection to preliminary medical examinations, because they expect to gain materially if they are accepted. Similarly one expects to be examined for a fair-sized life policy. Of course drivers of public vehicles must expect to be examined, because they could be a menace to others, even if they do not worry about their own safety. Children attending school do not come into any of the adult categories. They are only gainfully employed in the sense of gaining knowledge.

I must say that I am not opposed to these inspections by our brethren in the School Medical Service. I never despise or denigrate their findings, and I am always thankful when they offer to save me trouble by referring a child to an appropriate specialist for his views. The five pound fine, however, is the obstacle. Can anyone imagine Mr. Aneurin Bevan in his heyday declaring in July, 1948, that every general practitioner was entitled to summon every patient on his list, at a time convenient to him, to a compulsory examination as part of the National Health Service, with a possible fine of £5 to those who refused to attend without reasonable cause? Would he not have been howled down in the House? I suggest that most G.P.s would have been staggered at such a concession and refused to implement it.

It is, I believe, due to the fact that compulsory attendance at State schools has always been accepted that the compulsory element in State school medical examinations has been allowed to creep in unchallenged in the Education Acts of 1908 and 1944. The price of liberty is indeed eternal vigilance.—I am, etc.,

Slough, Bucks.

N. C. HYPHER.

Rheumatology

SIR,—For many years I have advocated that the rheumatic diseases should be a specialized branch of medicine sufficient in its many classifications and types to be considered as an entity in itself—a whole-time specialty.¹

In the tables printed by the Ministry of Health and Department of Health for Scotland (*Supplement*, January 19, p. 12, and January 26, p. 18) are listed the specialties requiring full-time senior medical staff and consultants in the National Health Service. There is no heading of "Rheumatology."

Since 1948 there have been regular international congresses on the rheumatic diseases. The 10th International Congress of Rheumatism was held two years ago in Rome; the 5th European Rheumatism Congress takes place this year in Sweden. All countries recognize the need for research into the rheumatic diseases. In 1958, during a period of correspondence in the *B.M.J.* on this matter, one correspondent¹ wrote that he had left England for Canada because the National Health Service did not recognize the rheumatic diseases as a whole-time specialty. Dr. W. S. C. Copeman² pointed out that the Universities of London and Manchester have chairs in rheumatology, an innovation that could well be copied elsewhere. We are aware that in the N.H.S. the North-east Metropolitan Regional Hospital Board now have a centre for rheumatology with peripheral units, as suggested by the Royal College of Physicians (report on Chronic Rheumatic Diseases in 1951).

Individuals fighting for a good cause rarely procure results unless some of those in the established regime rise in sympathy and make their voices heard, perhaps at the risk of losing their own label as rheumatologists. The practice of the rheumatic diseases is an enormous field of medicine embracing the need of surgeons, radiologists, physical medicine experts, and others. Let rheumatology have its own flag of nomenclature or else it will soon be seen that the future hospitals will not cater for the rheumatically affected population adequately.

Will the medical world allow the specialty of the rheumatic diseases to be buried amongst the other diseases and thus lose the public interest?—I am, etc.,

London W.1.

MARJORIE M. DOBSON.

REFERENCES

- ¹ Mandel, L., *Brit. med. J.*, 1958, **1**, 1482.
- ² Copeman, W. S. C., *ibid.*, 1958, **1**, 1303.

Rheumatoid Pericarditis

SIR,—The letter from Dr. J. H. Glyn and Dr. J. H. Pratt-Johnson (January 26, p. 262), reporting constrictive pericarditis associated with rheumatoid arthritis, encourages me to record the following case.

The woman, then aged 53, was first seen in 1956 suffering from rheumatoid arthritis of six months' duration. The disease followed a progressive course and in 1960, after other forms of treatment had failed, she was started on prednisone 5 mg. t.d.s., later reduced to 5 mg. b.d. In November, 1960, she became increasingly breathless, developed gross oedema of the ankles, and the jugular venous pressure was found to be raised. Her symptoms increased despite a change of steroids to dexamethasone and the use of diuretics.

She was admitted to St. Mary's Hospital on July 24, 1960. The jugular venous pressure was raised, giving pulsation 4 in. (10.2 cm.) above the sternal angle; pulsus paradoxus was present, the ankles were grossly oedematous, and the liver enlarged. The heart was not enlarged and a loud early diastolic sound was heard at the apex. Absence of cardiac enlargement and diminished pulsation on radiocopy confirmed the diagnosis of constrictive pericarditis. Bilateral pleural effusions were present. The result of other investigations were: Rose's agglutination test positive 1/256.

Latex agglutination test positive. Mantoux test 1/1,000 negative. E.S.R. 51 mm./hr. Repeated tests for L.E. cells negative. Serum albumin 3.3 g./100 ml. Serum globulin 3.5 g./100 ml. Electrophoresis showed increase in α_2 - and γ -globulins.

No real improvement followed medical treatment, and on October 11 Mr. L. L. Bromley explored the pericardium. No evidence of tuberculosis was found and the thickened parietal pericardium stripped easily. There was, however, 60 ml. of dark brown fluid in the pericardial sac and the visceral pericardium was markedly thickened and densely adherent to the myocardium. Both ventricles were unusually small. The parietal pericardium was largely resected, the fluid sucked out, and a very limited removal of the visceral pericardium carried out owing to the fibrous tissue extending deeply into the myocardium. Adhesions from the parietal pericardium to the apex and undersurface of the left ventricle were freed. Section of both layers of pericardium showed non-specific inflammatory changes and no evidence of tuberculosis. The pericardial fluid was sterile and contained only a few leucocytes: culture for *Mycobacterium tuberculosis* was negative. Operation was followed by a gradual fall in jugular venous pressure and disappearance of dyspnoea and oedema. Diuretics were continued for six months, but in May, 1962, all diuretic treatment was stopped without return of oedema or rise in jugular venous pressure.

Gimlette¹ reported that five of his 62 patients with constrictive pericarditis had rheumatoid arthritis, which preceded pericarditis in four cases and followed it in one. It seems probable that rheumatoid arthritis is a more important cause of constrictive pericarditis than is usually recognized.—I am, etc.,

St. Mary's Hospital,
London W.2.

J. W. LITCHFIELD.

REFERENCE

- ¹ Gimlette, T. M. D., *Brit. Heart J.*, 1959, 21, 9.

Progesterone and Abortion

SIR,—So far as I can see, the only significant finding in Dr. R. P. Shearman and Mr. W. J. Garrett's report of their double blind study of the effect of 17- α -hydroxyprogesterone caproate (17 AHPC) on abortion rate (February 2, p. 292) is that a low or falling level of pregnanediol does not mean the pregnancy is jeopardized. This is well known. Similarly, an arborization effect in the cervical mucus does not necessarily mean that abortion of any kind is likely.

If the 50 selected patients were given solution A up to the 34th week, and in the following pregnancy solution B, again to the 34th week, the results, I submit, would be quite different and show the real value of 17 AHPC in these cases. The fact that there was approximately an 80% salvage rate despite discontinuing the steroid at 24 weeks is puzzling, for I have found that to do so courts disaster. This suggests to me that a similar salvage rate without treatment of any kind would have occurred in this series.

Presumably 23 or 27 of these patients received 17 AHPC. This is an extremely small series—too small to reach any reasonable conclusion. If, as is stated, the study is continuing, I suggest the patients be used as their own controls. In this way it will soon be revealed whether the placebo is as effective as 17 AHPC, and from my experience of this steroid unless the women of Sydney are quite different from those of this country the placebo trial will show a high abortion rate and the 17 AHPC trial a high salvage rate.—I am, etc.,

Havant, Hants.

JOHN J. FOLEY.

New Methods of Resuscitation

SIR,—Dr. G. M. Hunter (January 26, p. 261) says there is only one indication for mouth-to-mouth respiration, and that is when external cardiac massage is being undertaken.

The argument against this, of course, is that there are other instances in which mouth-to-mouth respiration is the only method which can be employed. For instance, how else can one ventilate the lungs of a drowning person while in the water? Unless it is quite impossible to do so, mouth-to-mouth respiration should be commenced immediately an unconscious body has been brought to the surface. Half a dozen deep breaths at this moment may be all that is necessary to restore consciousness. In drowning, time is the vital factor, and unless conditions are very adverse there should be no delay. Trying to carry a body, especially if it is over rocks, may cast away the vital moments which could save a life.

As regards mouth-to-mouth respiration in cases of drowning, the commonly illustrated position is supine. In this, there must be a constant risk of water regurgitating from the stomach and being aspirated. A reclining position may be better. Certainly, an easier position too for the administrator. A recent film on the subject of mouth-to-mouth respiration advises against preliminary drainage. Is this sound? I wonder, perhaps, would someone with wider experience please advise? My own feeling at present is that a short delay for drainage is justifiable—for example, jack-knife the patient head downwards for a few moments.

In connexion with this problem of preliminary drainage, I would like to draw attention to a method of resuscitation which combines both drainage and ventilation. This is the method of rocking from the sitting position—sometimes called the "pump" method because of the vast quantities of water which it empties from the patient. Unfortunately the method can only be used with children or lightly built adults, unless an assistant is to hand. Resuscitation can be commenced using this method and later changed to mouth-to-mouth ventilation. The patient is placed on a low stool or seat of some sort. The airway is cleared, and, holding the patient by the base of the neck, the body is flexed so as to bring the head between the knees, where it is held for a few moments. This is rhythmically done about 16 or 17 times a minute, timing with the rescuer's own breathing. The swing at first is quick and then slowed down to avoid injury to the lower ribs or abdominal viscera. This method produces good ventilation and vast quantities of water flow from the patient, probably most from the stomach, but one would think from the lungs as well. In the head-downwards position the posture is similar to that used for draining a bronchiectatic case. It seems likely too that this method affords some measure of cardiac massage. It is highly efficient. A small boy, picked up from the bottom of a swimming pool, recovered consciousness in just over a minute.—I am, etc.,

Belfast 9.

DOUGLAS BOYD.

SIR,—We were most interested to see the letter from Dr. B. S. Baker (February 16, p. 467). Although, as he says, Great Britain entered the field rather late, the voluntary aid societies have not been slow in accepting the methods of respiratory and cardiac resuscitation