school-days. Furthermore, according to the illustration, there seems to have been a remarkable drop in incidence at the week-ends. A very obliging "virus," this! I must admit that it is not so easy to explain, on the basis of my suggestion, the adult and pre-school home-contacts which are said to have occurred. But since this strange phenomenon excited much interest in the public health department and in the local press it may also have communicated itself too vividly to the imaginations of the patients, their associates and relatives, and even their family doctors. Consequently many cases, in reality unconnected with the epidemic, but which presented with the characteristic symptoms admitted by the authors as being "relatively common psychogenic manifestations," may have erroneously been included in the epidemic contact group. Similarly the concentration of attention which must have been focused on the affected children by those around them may well have prolonged the duration of their symptoms.

While I would be the first to admit the presumption inherent in any hypothesis postulated by someone not in possession of first-hand knowledge of the problem, I submit that my ideas on the aetiology of the "epidemic collapse" in Coventry, on the basis of the presented evidence, can be no less valid than this "ash-bucket" concept of "virus infection."—I am, etc.,

Edinburgh 5.

ALEXANDER FRAME.

Forceps Delivery

SIR,—As a general-practitioner obstetrician I would like to make a few observations on your leader "Forceps Delivery" (26 December, p. 1610). The majority of forceps deliveries occur in consultant units, but quite a few low-forceps deliveries are performed by general practitioners in cottage hospitals, and it is from this standpoint that I write. You quote an article,¹ which summarized says: (1) between one-third and one-quarter of infants born in the U.S.A. are forceps deliveries, the majority being low forceps; (2) the incidence of forceps deliveries from hospital to hospital varies from 10% to 60%; (3) comparing hospitals of high forceps rate with the low forceps rate there is no statistically significant difference regarding perinatal mortality or maternal and neonatal morbidity. It would appear, therefore, that a great many unnecessary low-forceps deliveries are effected. Yet, should not a procedure which does not increase maternal and neonatal risk but terminates quickly the second stage of labour be welcomed? Your leader partly answers this question when it says "the benign nature of the forceps operation can be accepted only with considerable reservation." The major reservation you seem to favour is that the operator should not suffer through lack of practice. Now, I have always felt that for a low-forceps delivery repetitive practice is not necessary in order to effect a competent delivery when the need arises: what is more important for the general practitioner is to be able to appreciate this need as dictated by the history and/or the physical signs referable to the mother and/or foetus. This he should be able to do within his present allowable obstetric categories for domiciliary confinement, provided (a) he has a basic obstetric training, and

(b) he personally attends a minimum of approximately 20 confinements per year. His forceps rate will not be high, but I do not see that his lack of practice is going to tarnish any obstetric survey. I would qualify this point by referring to your definition of ideal conditions for a low-forceps delivery—namely, "head on the perineum, with the anus dilating with each pain, with the sagittal suture in the antero-posterior diameter of the pelvic outlet." To this I would add that the occiput should be anterior. The technique of forceps delivery is much the same whether, under the above conditions, the occiput is anterior or posterior, but the latter demands a larger episiotomy. The important point is that the practitioner appreciates (a) the position of the occiput is important, and (b) he is able to identify that position. Whether he has done six or only one forceps delivery in the past three months is not going to affect his acquired technique.

My remarks are confined to low-cavity forceps because they constitute the majority of all forceps deliveries, and are likely to be the only ones a general practitioner will and should perform. Further, all low-forceps deliveries lend themselves to local anaesthesia and thereby eliminate a real hazard—the general anaesthetic.—I am, etc.,

T. M. WINSTANLEY.

Ruthin, Denbighshire.

REFERENCE

- ¹ *Amer. J. Obstet. Gynec.*, 1964, **89**, 568.

Chlorhexidine

SIR,—In your issue of 12 December we have read with interest the review of antiseptics under "To-day's Drugs" (p. 1513), but we would like to draw your attention to some minor inaccuracies which appear in the section describing chlorhexidine (Hibitane).

Both the acetate and the gluconate are soluble in water and also in alcohol.

The forms of chlorhexidine are: chlorhexidine acetate, chlorhexidine gluconate (20%) B.P., and chlorhexidine hydrochloride B.P.

The formulated preparations are the antiseptic and obstetric creams (1%), a liquid concentrate for all general purposes, and an aerosol tincture.

No powder containing 0.1% chlorhexidine is available, but chlorhexidine hydrochloride is used at 1% strength in dusting powders extemporaneously prepared for wound application.

This information could usefully supplement that provided by your reviewer, and if you can find space for a suitable insertion we feel that our comment would be helpful to readers.—I am, etc.,

Pharmaceuticals Division, B. C. BRYANT.
Imperial Chemical
Industries Limited,
Alderley Park,
Macclesfield, Cheshire.

Education in First Aid

SIR,—With reference to Mr. Norman Capener's letter (19 December, p. 1596), I should like to urge the widest possible spread of simple first-aid teaching to persons aged 12 and over. I am confident this would reduce significantly the average figure of

approximately 60 accident deaths per day in this country at present.

The two most useful points to teach would seem to be: (1) stopping severe external bleeding by direct pressure over the wound¹; (2) artificial respiration, by mouth-to-mouth method. Since 1962 about 700 people have attended a two-hour course here, which was confined to these points, and was suitably illustrated with film, as well as a demonstration of artificial respiration on a model.

In order to assess memory retention, 114 attenders were selected at random three to six months after the course, and asked: (1) to stop bleeding from a simulated wrist laceration; (2) perform artificial respiration on a model. No assistance was given to those being questioned, and opportunity for last-minute revision was prevented. Results showed that 45% were able to perform both measures and 15% could do neither. The remainder performed one or other satisfactorily. Comments suggested better figures would have resulted if the course permitted individuals to operate the manikin.²

These results are encouraging and would probably not have suffered if the instruction had lasted one hour instead of two. Therefore I think it justifiable for all schools, large industrial concerns, and local authorities to sponsor such instruction. Television certainly could give invaluable help.—I am, etc.,

R. G. ORR.

Health Physics and
Medical Division,
Atomic Energy Research
Establishment,
Didcot, Berks.

REFERENCES

- ¹ *First Aid in the Factory*, Lord Taylor, 1962, 2nd ed., p. 34.
- ² *Ibid.*, p. 93.

Is Collagen Inert?

SIR,—In your leading article, "Is Atherosclerosis Reversible" (12 December, p. 1477), it is stated that "fibrosis or sclerosis of the intima would be expected to be irreversible because collagen is metabolically inert." May I point out that this observation needs some qualification.

Although collagen throughout the animal kingdom shows remarkable uniformity from creatures at the level of marine sponges up to that of the human being (both in biochemical and electron-microscopic features) and although there is little, if any, antigenic reaction produced by the collagen of one species transplanted into another, the collagen is not one solitary substance. There are various forms within any individual, and the collagen laid down as a consequence of inflammatory process and repair is not identical with that present in the parent tissue.

Lord Anson, writing of his experiences during his voyage round the world in the *Centurion*, remarked that scurvy caused the breakdown of previously healed wounds. It can be shown experimentally that scurvy will cause collagen resorption. It is therefore not impossible that this process could occur with scar tissue produced in arterial degeneration. It is, after all, a common experience to find that adhesions in the peritoneal cavity disappear after an interval of several months—only the densest persisting once the exciting cause has been removed. The labile nature

of this collagen is also demonstrated by the rapid deposition and absorption which occurs in granulating tissue in a healing wound.—I am, etc.,

Birmingham 15.

GEORGE T. WATTS.

****** Most collagen in the mature animal has little metabolic turnover and is relatively inert in studies with labelled aminoacids. Some components of collagen may have a fast turnover, as does whole collagen in the involuting uterus and granuloma. It is not certain what role ascorbic acid plays in the maintenance of mature collagen nor is it clear whether deficiency of this vitamin leads to accelerated turnover. The mechanisms involved in collagen "resorption" are little understood, but they need not depend on metabolic lability (i.e., increased turnover) of the protein. Resorption of collagen could well result from proteolysis or macrophage activity in the tissue. In this way metabolically inert mature collagen could be removed. However, no specific collagen-splitting enzyme has been identified in the arterial intima.—Ed., *B.M.J.*

Herpes Zoster in Infancy

SIR,—Since I believe herpes zoster in infants to be rather unusual, I venture to send the following case report.

A. B., aged 24, had an attack of chicken-pox when 14/52 on in her third pregnancy, in January 1964. On 14 July she had a normal delivery of a boy, birth weight 7 lb. 12 oz. (3.5 kg.). On 10 November, aged 4/12, the child had lobar pneumonia, needing penicillin and daily visits for almost a week. On the third day of the illness vesicles appeared on the outer side of the right leg, inner border of right foot, and the right side of the upper border of the sacrum. These appeared to cause no pain or discomfort of any kind. They were almost unchanged when visits ceased at the end of a week.

I mentioned the case to a colleague, who confirmed the diagnosis and showed that there was slight muscular weakness in the affected leg. Presumably the child had been infected with the virus when *in utero*.

I should be interested to know if any of your readers have met with a case like this.—I am, etc.,

Leeds 10.

P. WINTERSGILL.

Accidents on Mountains

SIR,—As an unfit middle-aged hill walker, and therefore a potential victim, may I comment on the previous letters? Dr. I. A. Olson's last sentence puts the matter in a nutshell (15 December, p. 1462), but in some of the wilder areas of Scotland, so attractive to those of us who enjoy solitude, looking in at the "local" police station is quite impracticable. There isn't one.

Climbing alone has one safer side to it than climbing in company. There is no temptation to go a little faster than you should, to keep up; and nothing is more dangerous than getting exhausted, especially in blizzard conditions, when vital items like gloves and compass are better tied on.

Some remediable deficiencies exist, at least in Scotland. Maps are obviously essential, yet of all the U.K. only the mountainous areas of Scotland are not covered by the 2½ in./

mile (6.5 cm./Km.) Ordnance Survey map. And the Ordnance Survey depot in Edinburgh tells me that they won't be printed at all. This is scandalous. These maps do exist for my own local area in Galloway, and I use them and know their superiority to the 1 in. map for climbers. Are the Cairngorms, or Glencoe, or the mountains north of the Great Glen supposed to be safer?

Some area climbing handbooks give the safest way down off a mountain—life-saving information at dusk in unknown territory, but these are apparently not available in a single pocketable guide to all the mountainous regions of Scotland.

Clothing could do with some publicity, too. Not just what to wear, but where to get it, and what it costs. In the two recent severe winters many a wildfowler lay or sat exposed to conditions almost as severe as those on the mountains, and yet managed not only to survive but to remain reasonably warm, and even shoot the odd duck. Perhaps they and the mountaineers could pool their knowledge of protective clothing. Service medical departments could obviously help too. But information is useless if it is inaccessible. If the B.M.A. had published a booklet on some of these matters, it might have earned more praise and less censure than *Doctors' Orders*. After all, the first objective of all mountain walking is to walk out again, alive.—I am, etc.,

H. A. LANG.

Newton Stewart, Wigtownshire.

Help for the District Nurse

SIR,—The report of the Public Health Committee of the British Medical Association (*Supplement*, 5 December, p. 201) refers to the need for a "third worker" to undertake domiciliary nursing.

The Queen's Institute has for many years recommended that some of the district-nursing duties should be delegated to lesser qualified nursing staff, thus enabling the State-registered and district trained nurse to concentrate on the tasks requiring her skills and to be the "ward" sister of the district nursing team. With this end in view a course of in-service instruction for State-enrolled nurses working on the district was first drawn up by the Institute in 1950 and was revised in 1962. During the past two years 149 State-enrolled nurses have taken the course.

The group or team method of working already functions in a number of urban areas. The highly skilled district nursing sister is assisted by State-enrolled nurses and other less experienced staff who work as members of the team and under her supervision. In some highly populated areas nursing auxiliaries and bath attendants are also employed. These workers usually have no nursing qualifications but are given simple instruction to enable them to take over patients who require nothing more than bathing in bed or in the bathroom.

The British Red Cross Society and St. John Ambulance Brigade in consultation with the Queen's Institute of District Nursing drew up a nursing-aid scheme some years ago to assist district nurses with the more simple tasks at times of pressure.

The work is entirely voluntary and is undertaken only by those members who have had previous practical nursing experience.

This scheme functions well in some areas but could no doubt be used more widely.—I am, etc.,

L. JOAN GRAY,
General Superintendent,
Queen's Institute of District Nursing.
London S.W.1.

Dangerous Ice-cream Vans

SIR,—I was delighted to read of the condemnation of ice-cream vans by the Committee on Medical Science, Education, and Research (*Supplement*, 28 November, p. 191).

About two years ago I tried in vain, through the local council and by letters to the local newspaper, to have this type of trading limited on account of the noise nuisance and the danger factor. During the preceding year there had been two fatal accidents involving young children purchasing ice-cream from such vans in Swindon.

It would be very interesting, and I fear horrifying, to find the national figure for such accidents, and I hope that the Ministry of Transport and the Association of Chief Constables will take the appropriate action in banning the vans from streets altogether.—I am, etc.,

Wroughton, Wilts.

PETER J. GLADDERS.

Code for Drugs

SIR,—The answer to the problem of tablet identification should be less difficult than would appear from recent correspondence. Identification is mainly required when a locum, deputy, or other doctor wants to know what has been prescribed previously, and occasionally in cases of suspected poisoning. In both events a container can nearly always be produced. Since it is rarely necessary to have to identify loose tablets there is no need to go to the trouble and expense of stamping every tablet with a letter and number as one manufacturer appears to have done (12 December, p. 1527). Nor is it wise to encourage hypochondriacs by writing the actual drug name on each label.

All that is needed is to have a simple universal code number printed on the label of each bulk container so supplied by manufacturer or wholesaler, together with an appropriate key available to doctors, nurses, etc. The pharmacist, when dispensing, simply copies the code number from the bulk container on to his own prescription label, thereby making quick identification easy.

Whereas the die-stamping of all commonly prescribed official and proprietary tablets would probably take some years to achieve, the above simple method could quickly become operative and should prove acceptable both to doctors and pharmacists.—I am, etc.,

Belfast 4.

H. J. CRONHELM.

Expensive Isolationism of London's Teaching Hospitals

SIR,—I have read with great interest the letter by Professor W. C. W. Nixon (26 December, p. 1657) on this matter and would like to venture one or two comments.