shift worked is "only" 19 hours but this occurs at the end of the week of nights, as the third of three long shifts (16, 16, and 19 hours), and is particularly exhausting.

Having moved from Southmead to a 1 in 3 obstetric post with a similar out of hours commitment, I find that the traditional rota is less tiring, since there are two clear weekends to recuperate. The system would best be improved, however, by emulating most anaesthetic rotas: after a night on call the senior house officer has the next day off. A busy night would be much easier to endure if some sleep was guaranteed the next morning.

Although the shift system described has some advantages it has failed to achieve fully its original purpose of improving both the care of the babies and the working patterns of the senior house officers.

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The need to make rugby safer

SIR,—As an orthopaedic surgeon and a former first class rugby prop forward I think that Dr H C Burry's and Mr C J Calcinai's article (16 January, p 149) has no great message for rugby football. The paper which they quote seems to be the only scientifically followed epidemiological research on injuries from playing rugby.¹ In Wales the incidence of serious cervical cord injuries has risen to a steady level of two or three a year. Recent changes in the front row scrummaging rules have had no effect on this, and scrummaging injuries account for 44% of the total. Two suggestions for immediate action are the banning of the practice of "popping" opposing front row props out of the scrum and education of the second row forwards about the danger of continuing forward momentum in the collapsed or lifted scrum.

I was perturbed by the comments of Messrs D A D MacLeod and P H Pattison (13 February, p 498). There is no place for complacency in this disturbing situation. Pressure on the flexed cervical spine is dangerous and must be minimised if we are to make rugby safer.

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1 Williams P, McKibbin B. Unstable cervical spine injuries in rugby football: a 20 year review. *Injury* 1987;18:329-32.

Tardive dyskinesia

SIR,—Dr Thomas Barnes (16 January, p 150) states unequivocally that tardive dyskinesia is a "disorder of movement caused by dopamine antagonist drugs," ignoring a detailed historical literature that suggests this is not true. Nineteenth century descriptions of chronic psychotic illness, reflecting Kraepelin's classic delineation of dementia praecox,¹ constantly refer to grimacing and gesticulations as typical features. More recent work by Brandon *et al.*,² Owens *et al.*,³ and Waddington⁴ has emphasised the presence of tardive dyskinesia among psychotic patients never treated with dopamine blocking drugs. My own research into Victorian casebooks supports such findings, all of which logically point to tardive dyskinesia as resulting primarily from the intrinsic disease process itself, mediated by dopamine antagonists.

The importance of refuting Dr Barnes's statement lies in the need to understand, and appropriately research, neurochemical aspects of

psychotic illness, as well as in the possible malpractice suits that might ensue, in these increasingly legalistic times, from patients with tardive dyskinesia making claims against those treating them. It also underlines the fundamental necessity of a historical perspective.

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- 1 Kraepelin E. *Lectures in clinical psychiatry* (trans Johnstone T). 3rd ed. London: Ballière, Tindall and Cox, 1913.
- 2 Brandon S, McClelland HA, Protheroe C. A study of facial dyskinesia in a mental hospital population. *Br J Psychiatry* 1971;118:171-84.
- 3 Owens DGC, Johnstone EC, Frith CD. Spontaneous involuntary disorders of movement. *Arch Gen Psychiatry* 1982;39:452-61.
- 4 Waddington JL. Tardive dyskinesia in schizophrenia and other disorders: associations with ageing, cognitive dysfunction and structural brain pathology in relation to neuroleptic exposure. *Human Psychopharmacology* 1987;2:11-22.

Charging patients for eye tests

SIR,—We entirely support Dr John Yudkin's plea (2 January, p 64) for the free eye test to remain and take issue with the subsequent correspondence from Messrs Smith, Scott, and Flanagan (23 January, p 290).

We participate in a cooperative system of diabetic care in Newham in which one of us (PK) sits with local general practitioners in diabetic clinics held in their surgeries. This system of care has also sought the help of optometrists for detecting diabetic eye disease. Since the publication of Dr Yudkin's letter four patients have been referred by optometrists with a suspected diagnosis of diabetes mellitus, two with incidental findings of diabetic retinopathy and two because of a recent deterioration in vision due to refractive changes. All of these patients had attended the optometrists for an eye test, but we accept that the optometrists were alerted because of the local interest in diabetes. We agree that general practitioners should screen the eyes of their own diabetics including dilatation of the fundi; indeed, we ensure that this is regularly performed in our own shared care clinics. In these circumstances, however, the examination is done in a designated surgery; patients are warned not to drive to the surgery, and a diabetologist is present to help instruct the general practitioner. We suspect that the situation is not so ideal in most practices. For this reason the participation of optometrists in a system of free eye tests will, at the very least, widen the possibility of early detection of diabetic eye disease.

Any payment levied on patients will deter those who are most at risk.

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SIR,—I agree with Mr Redmond Smith (23 January, p 290) and Mr Rolf Black (6 February, p 431), who suggest making greater use of ophthalmic medical practitioners to relieve the pressure on the hospital eye service.

The "medical eye centre" (which ironically was created to cope with the rush for free eye tests in the early days of the NHS) never developed its full potential. The medical aspect was overshadowed by the retail aspect of the business houses who endowed these centres, and for some obscure reason the government never permitted ophthalmic medical practitioners to prescribe even eye drops on NHS forms. Nevertheless, some medical eye centres still provide a valuable neighbourhood service to both general practitioners and the public.

Many, like myself, must be able to recall picking up cases of ocular or systemic disease whose morbidity would have been dangerously increased by delay in treatment.

Now that the ethical restrictions on the optical profession have been relaxed I fear that the patient has become a "customer" and the consulting room a small part of a boutique selling fashion frames. To whom can the family doctor send patients with indefinite symptoms and suspicious signs which could be resolved by slit lamp examination, gonioscopy, applanation, or field testing at a medical eye centre but for which they might have to wait months at a hospital?

Is there any reason—apart from penny pinching—why the ophthalmic medical practitioner should not be contracted to examine patients either on a sessional or per caput basis at a health centre or as part of a general practice?

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** This correspondence is now closed.—ED, *BMJ*.

Inappropriate dental care in casualty departments

SIR,—There is serious concern in this unit about incorrect treatment for children and adolescents who have knocked out permanent incisor teeth and who have been taken to casualty departments in district general hospitals.

This was shown recently in two cases, one in an 8 year old girl and the other in a boy of 13. Both children had had upper permanent central incisor teeth knocked out during the evening. In each case the patients had been seen by a casualty officer at hospital within 30 minutes of the accident. After examination the parents were advised that nothing could be done and were told to take their child to a dentist the next day. In neither case was the hospital dentist on duty called to see the patient. When the children were seen the next morning it was too long after the accident to replant the teeth, and they are now required to conceal the unsightly gap by wearing a denture. This is an extremely unfortunate and avoidable outcome of this type of accident in a young child.

In children and adolescents a tooth that is replanted into its socket within 30 minutes of being knocked out has a 90% chance of reattaching itself to the bone and becoming fully functional. There is then a deterioration in prognosis, related to time after the accident, until it becomes poor after two hours and hopeless when several hours have elapsed.¹ Thus it is essential that the appropriate action is taken without delay.

When a child presents at the casualty department having knocked out a permanent incisor tooth the tooth should be immediately placed in physiological saline while the history and examination are conducted. No effort should be made to disinfect the tooth or scrub it clean. If the tooth is dirty it should be gently flushed with physiological saline to avoid damaging the delicate periodontal membrane on the root. If the tooth has not been brought to the hospital efforts should be made to retrieve it if this can be done expediently. The hospital dentist should be contacted and asked to attend the patient immediately. If there is likely to be any delay the casualty officer should replant the tooth as soon as possible and then get the patient to bite on a pad of gauze to hold the tooth in position. No anaesthetic is usually required for this operation and the blood clot should not be removed from the socket before replantation. An antibiotic should be prescribed and the need for tetanus vaccination

checked. When the dentist arrives the tooth should be splinted and appropriate follow up treatment arranged.

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1 Andreasen JO. *Traumatic injuries of the teeth*. Copenhagen: Munksgaard, 1981.

Medical hijack

SIR,—The paper on colonoscopy and barium enema (16 January, p 167), with its correspondence chorus (20 February, p 571), is the third in as many years following a set pattern.^{1,2} A small group of enthusiasts compare their own performance in a current project with the everyday work of their colleagues, who are unwitting contributors. When taxed there are standard responses: "We made no effort to ensure equality of expertise between radiologist and colonoscopist because we were interested in the 'real world' rather than the rigid and unreal confines of a clinical trial"; "[it is] essential to compare colonoscopy with the routine method and reporting . . .";³ together with your authors' recent reply (20 February, p 572).

Are there not three good reasons for asking editors about their responsibility in publishing work where unwitting contributors provide half the material? Firstly, there is science. If these are not clinical trials in the proper commonly understood sense of what value are the conclusions beyond the merely local? Secondly, there is the principle of informed consent for the subjects of experiments. Why are professional colleagues excluded? Thirdly, there is courtesy. Is medical hijack, like fraud (6 February, p 376), another hazard for editors?

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- 1 Aldridge MC, Sim AJW. Colonoscopy findings in symptomatic patients without X-ray evidence of colonic neoplasms. *Lancet* 1986;ii:833-4.
- 2 Durley P, Weston PMT, Williams NS. Colonoscopy or barium enema as initial investigation of colonic disease. *Lancet* 1987;iii:549-51.
- 3 Aldridge MC, Sim AJW. Colonoscopy and barium enemas. *Lancet* 1986;iii:1331.
- 4 Williams NW, Durley P, Weston PMT. Double-contrast barium enema. *Lancet* 1987;iii:793.

Points

Malaria in Britain

Dr ELIZABETH D A MCCALL-SMITH (Bruntsfield Health Centre, Edinburgh EH10 4EY) writes: the article by Mr P A Phillips-Howard and others (23 January, p 245) highlights the high risk of malaria in young children and suggests poor compliance with prophylaxis as a factor. I have two small children and have twice recently visited malarial areas with them. The current recommendations on prophylaxis for children under the age of 3 years are so difficult to comply with that only rarely is the regimen likely to be followed accurately. The problem is prophylaxis for areas where there is chloroquine resistance. The recommended regimen is usually daily proguanil and weekly chloroquine. Proguanil is available only in tablets, and these must be crushed for a small child. The drug tastes very bitter and as soon as children are old enough to do so they usually spit it out. If crushed proguanil is administered in food a small child will just refuse to eat. The dose taken is at best an estimate when part is spat out and part left in unfinished food. On a recent visit to Zimbabwe I had to abandon the

recommendation of chloroquine and proguanil. Instead I used the locally recommended product—Deltaprim, a combination of pyrimethamine and dapsone, which is unavailable in Britain. Taken weekly in syrup form it was palatable to our children. Acceptability to young children must be an additional factor in deciding on malaria prophylaxis, and a simple regimen of a weekly dosage in syrup form is most likely to be successful.

Dr R S BHOPAL (Department of Community Medicine, University of Glasgow, Glasgow G12 8QQ) writes: P A Phillips-Howard and colleagues have shown that 63% of cases of malaria among British residents over the decade 1977-86 were accounted for by "immigrants visiting friends and relatives" (23 January, p 245). Most of these were visitors to the Indian subcontinent. The nub of the problem is that few take malaria prophylaxis and their attitudes towards malaria prophylaxis are negative.^{1,3} The authors observe that those visiting the Indian subcontinent may make lengthy visits (making compliance with prophylaxis more irksome) and may believe that malaria has been largely eradicated or that immunity acquired in their country of origin is retained. However, ignorance of the availability and value of prophylaxis is likely to be the explanation in most cases. Although the Health Education Authority produces health education materials adapted for use with ethnic minorities,⁴ I could find nothing about the hazards of travel or malaria prophylaxis. Those interested in the health education of ethnic minorities need to act.

- 1 Walker E. Attitudes to malaria prophylaxis. *Br Med J* 1981;283:411-2.
- 2 Bhopal RS. Asians' knowledge and behaviour on preventive health issues: smoking, alcohol, heart disease, pregnancy, rickets, malaria prophylaxis and surma. *Community Med* 1986;8:315-21.
- 3 Phillips-Howard PA, Blaze M, Hurn M, Bradley DJ. Malaria prophylaxis: survey of the response of British travellers to prophylactic advice. *Br Med J* 1986;293:932-4.
- 4 Health Education Council. *Health education for ethnic minorities: publications and teaching aids*. London: Health Education Council, 1984.

The Acheson report

Dr GLYNIS DOUBLE (London SE5 8TL) writes: My reservation about the Acheson report (23 January, p 231) is the proposal that the district control of infection officer would normally be accountable managerially to the director of public health. The fact that the director of public health will be professionally concerned in the same subject as the control of infection officer could lead to the latter being seen as a "second rung" post. Instead both professionals should be working—and be seen to be working—in cooperation at an equivalent level. There is also a good case for having both the district control of infection officer and the director of public health on the district management board.

Walking sticks

Dr J B MILLARD (Enham Village Centre, Andover, Hants SP11 6HJ) writes: Following Dr Graham Mulley's excellent article on walking sticks (13 February, p 475) may I, as chairman of the British Standards Institute committee on walking aids, remind colleagues of the existence of standards which cover safety in use, construction, and design. These standards are about to be rewritten and revised if evidence is received to substantiate any changes. Anyone wishing to suggest alterations should contact the secretary of the walking aids committee, British Standards Institute, 2 Park Street, London W1A 2BS. An international standard is also almost finalised.

Elastic stockings

Dr G V JOHNSON (Orthopaedic Department, Leicester Royal Infirmary, Leicester LE1 5WW) writes: Dr Alan J Whitley (6 February, p 413) provides a useful review on the choice of elastic stockings, but may I add

a cautionary note. I have recently seen several pressure sores, usually in elderly patients, attributable to these stockings. These have developed at prominent but unusual sites—for example, over bunions, over hallux rigidus osteophytes, over the lateral malleolus, and above the heel over the tendo Achillis—and often in ambulant patients. In some cases stockings of an inappropriate size may have been prescribed, but as stockings are readily available on the wards in small, medium, and large fittings appropriate measurements are not always made. Secondly, the stockings are difficult to get on and off. Despite adequate instruction, compliance may still be a problem. Thirdly, these patients often have insensitive feet, which increases the risks of pressure sores.

Smoking in aircraft and trains

Dr FRANK PRESTON (British Heart Foundation, London W1H 4DH) writes: As a former medical director of British Airways and now the medical spokesman of the British Heart Foundation, I believe that Minerva will be pleased to hear that I have already taken up the matter of smoking in aircraft (30 January, p 362) with Sir Colin Marshall, the chief executive of British Airways, and to be fair to the airline it is already considering a ban on smoking on certain flights. Unfortunately, the British Heart Foundation's approach to British Rail was not so successful because British Rail, having announced a ban on smoking on its suburban services after the disastrous King's Cross underground fire, then changed its mind after some public protest.

The private hospital and the surgical trainee

Professor D N BARON (Department of Chemical Pathology and Human Metabolism, Royal Free Hospital, London NW3 2QG) writes: Professor Harold Ellis (16 January, p 152) refers to the need for "excellent . . . pathology services." There are very few private hospitals in Britain with pathologists on site; most consider that their responsibilities are satisfied by seeing that there is a courier service to a centralised laboratory, where there may be full time or part time consultant pathologists. Modern clinical pathology in any discipline cannot be practised fully at a distance. It is not just a matter of supplying laboratory results, just as radiology is not just a matter of supplying images. All pathologists have the responsibility to patients of advising on the choice of tests, trying to reduce the number of unnecessary investigations coming to their laboratories, and providing help in the interpretation of the results. As Professor Ellis also states, the pathology department "should actively teach junior staff"; this cannot be done by absent pathologists. A patient in a private hospital should not receive a less complete pathology service than does a patient in an NHS hospital. The problem does not exist when private beds are part of an NHS hospital. When privatisation of pathology is being considered these functions of pathologists within the hospital must be appreciated. Provision of facilities only for laboratory results, however accurate and precise, lowers the standard of patient care.

Rediscovering the diaphragm

Dr DERMOT MURRAY (Special Clinic, Royal Infirmary, Derby DE1 2QY) writes: Dr Peter Stott is in error in stating that chlamydia and gonorrhoea are primary vaginal infections (6 February, p 377). The main site of infection for both *Neisseria gonorrhoeae* and *Chlamydia trachomatis* is the cervix.^{1,2} The distinction I draw is not academic. If the original statement is allowed to stand unchallenged it may persuade practitioners that a high vaginal swab is sufficient for the diagnosis of these pathogens. Nothing is further from the truth: an endocervical specimen containing dislodged endocervical cells is essential to establish the presence of chlamydia or gonococci.

- 1 Roberts RB. *The gonococcus*. New York: John Wiley, 1978.
- 2 Darougar S, ed. *Chlamydial disease*. London: Churchill Livingstone, 1983.