"honourable" behaviour on the part of Air Canada.

On (mildly) protesting Air Canada's generosity to me and enquiring if they had other such problems in the airport itself, I was informed that almost every day one or more emergencies occurred that the on-site nurse deemed to warrant a public-address appeal for the assistance of a physician. While having no statistics, the Air Canada officials said they had reason to believe that doctors were often in the huge terminal 2 but did not respond to urgent appeals for assistance, for whatever reasons. I suspect that the officials are probably correct and thus conclude that Air Canada, in some of its operations, may be more "honourable" than the medical profession in its response to the airline's needs. I think Hippocrates would agree and understand why, though he surely would never agree with or understand the monstrosity we know as terminal 2!

Brian Rutland Webster, MD
70 Manor Rd. E
Toronto, Ont.

Task Force on the Allocation of Health Care Resources

In her article on the report of the Task Force on the Allocation of Health Care Resources (*Can Med Assoc J* 1984; 131: 1106, 1109–1110, 1112) Deidra Clayton misses my point on several issues.

Her report suggests that I favour a two-level council for the assessment of new technology. Actually, I commented that this proposal was possibly unduly complicated, but there is no doubt that more needs to be done. I noted that the federal government has a role to play in assisting provinces in that area.

Although I am reported as saying that with regard to nursing homes the federal government "definitely should assume a leadership role, especially in terms of accreditation", I don't recall discussing accreditation at all. In fact, I do not think that accreditation is an appropriate federal government role.

Finally, I did not say that the federal government would be proposing a special federal–provincial committee on services to the elderly. Rather, I referred to that as only one of several mechanisms that are available for federal–provincial consultation on such issues. I did, however, report that I had organized a special meeting of federal and provincial deputy ministers of health and social services to discuss that subject.

Maureen M. Law, MD, FRCPC
Associate deputy minister
Department of National Health and Welfare
Ottawa, Ont.

Digital deformities from frostbite

Consequences of frostbite injury to the hands of adults have been well studied. However, very few cases of such injury with resulting arthritis and deformity have been described in children, who are often susceptible to frostbite injury and frequently are inadequately protected. Frostbite injury in children is unique because of the potential involvement of the growth plate. A recent report described abnormalities of digital growth in two children 10 to 16 months after frostbite injury had occurred.[1]

We recently had the opportunity to examine a 9-year-old girl who had had frostbite to both of her hands at the age of 3½. She had fallen outside her house, and her unprotected hands had been in contact with snow for approximately 10 minutes. The ambient temperature was $-20°C$. Examination at the time of the injury showed cyanosis, erythema and blister formation affecting both hands. Two weeks later all her fingernails except those of the thumbs fell off, and she had peeling of the skin as well.

At the age of 9 the girl had obvious swan-neck deformity and ulnar deviation of the fingers of both hands. Significant shortening of her digits was noted. An x-ray film of the hands showed evidence of past epiphyseal injury (Fig. 1).

We hope that other physicians are aware of the significant consequences of frostbite injury in children. Let us also not forget that frostbite injury is preventable. Children should wear mittens when they

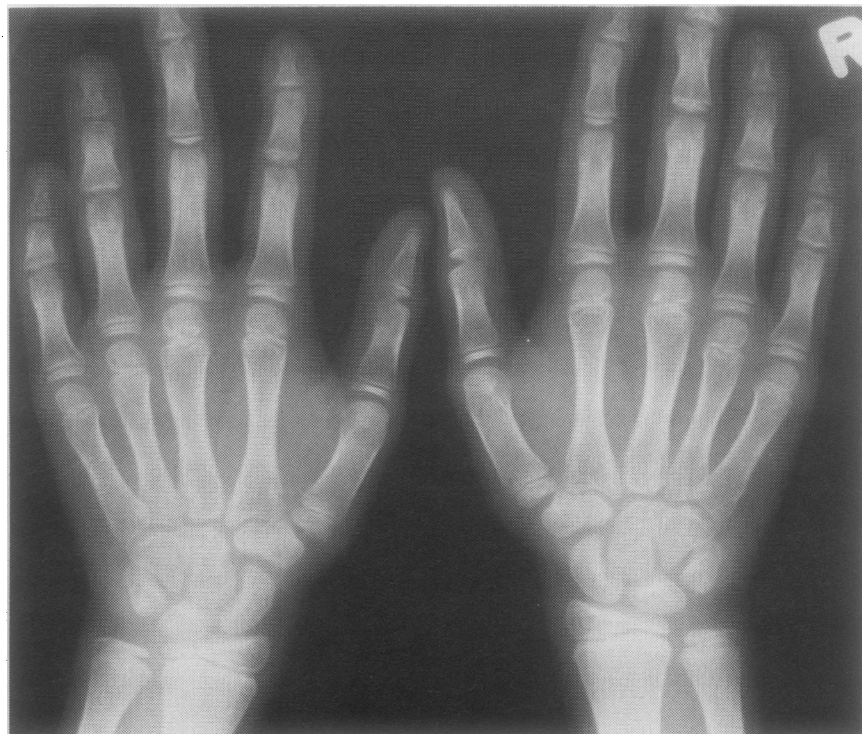

Fig. 1—X-ray film of hands of 9-year-old girl, made 6 years after frostbite injury to both hands, with sparing of thumbs. Note uniform loss of epiphyses of middle and distal phalanges of second to fifth fingers except those at base of middle phalanx of left third finger and right second finger.

are exposed to subfreezing temperatures.

Alexander K.C. Leung, MB, BS, MRCP, FRCPC, FAAP
Clinical assistant professor
Patrick C.W. Lai, PhD, MD
Research assistant
Department of Paediatrics
University of Calgary
Calgary, Alta.

Reference

1. Brown FE, Spiegel MD, Boyle WE: Digital deformity: an effect of frostbite in children. *Pediatrics* 1983; 71: 955–959

Delfi symposium of psychoanalysts

Jacqueline Swartz' report "Delfi symposium: Psychoanalysts go back to their roots" (*Can Med Assoc J* 1984; 131: 936–942) is more than a little reminiscent of the advice given to doctors by Henry Miller in "First Impressions of Greece" (Capra Press, Santa Barbara, California, 1973: 18):

> Each year there ought to be a congress of physicians meeting at Epidaurus. First the medicos should be cured! And this is the place for the cure. I would give them first a month of complete silence, of total relaxation. I would order them to stop thinking, stop talking. Stop theorizing. I would let the sun, the light, the heat, the stillness work its havoc. I would let them become slightly deranged by the weird solitude. I would order them to listen to the birds, or the tinkle of goat bells, or the rustle of leaves. I would make them sit in the huge theatre and meditate — not on disease and its prevention but on health which is every man's prerogative. I would forbid cigars, the heavy black cigars of the Freudian school, and above all books. I would recommend the cultivation of a state of supreme and blissful ignorance. I would give them each a string of beads, gratis. And grapes warm with sunshine. Then I would have a shepherd come and blow a few wild Anatolian notes on a broken flute. . .

Appropriately, the psychoanalysts went to the seat of a famous oracle rather than to the site of a temple devoted to the healing cult of Asclepius. Swartz also makes clear that they did not entirely follow Miller's advice in other respects. But she leaves us completely in the dark as to what they did about their cigars.

Don G. Bates, MD
Department of Humanities and Social Studies in Medicine
McGill University
Montreal, PQ

Unusual manifestation of esophageal foreign body

A 27-year-old woman visited her family physician complaining of vomiting and chest pain that had begun suddenly during dinner the previous evening. The pain was intense and colicky, had a pleuritic component and was localized directly over the midportion of the lower sternum. She also reported a vague sensation of "something caught" in the midretrosternal area and dysphagia.

She had had no recent viral illness and had no history of musculoskeletal, esophageal, biliary or cardiopulmonary disease. A physical examination gave normal results except for marked tenderness directly over the lower sternum, not involving the costochondral or xiphisternal junctions. The initial clinical impression was precordial catch syndrome, and rest, topical heat and indomethacin were prescribed.

The following day the woman returned complaining of persisting dysphagia and vomiting, increasing superficial lower sternal pain, and right upper quadrant abdominal pain. Again, the results of a physical examination were normal except for exquisite tenderness directly over the lower sternum and now involvement of the xiphoid process and right upper quadrant. While in the office she suddenly retched up a 2.5-cm cube of undigested meat, and all the symptoms immediately and completely resolved. At a return visit 5 days later she affirmed that no symptoms had recurred.

Comments

Sensory afferent fibres serving the midportion of the lower chest wall and upper abdominal wall are present in the third through sixth thoracic dermatomes. It is well recognized that the thoracic and abdominal viscera are also served by sensory fibres from the corresponding spinal cord levels. Specifically, innervation of the thoracic and abdominal esophagus is derived from branches of the sympathetic trunks and greater splanchnic nerves that involve these spinal segments and from the vagal trunks.[1]

Typically, irritative lesions in the esophagus and other thoracoabdominal visceral structures produce deep, visceral, poorly localized pain. In this case, however, a foreign body causing esophageal obstruction and subsequent esophageal spasm resulted in somatic, localized tenderness of the midportion of the lower chest wall and the right upper quadrant abdominal wall.

Esophageal obstruction should be considered in the differential diagnosis of chest wall tenderness. This case illustrates the importance of careful, perceptive history-taking in arriving at a correct diagnosis.

Mark Bigham, MD
Medical officer
Canadian Forces Station Holberg
San Josef, BC

Reference

1. Warwick R, Williams PL (eds): *Gray's Anatomy*, 35th ed, Saunders, Philadelphia, 1973: 1254

Moderate drinking: an alternative treatment goal for early-stage problem drinking [correction]

We apologize to Drs. Marion C. McIntosh and Martha Sanchez-Craig for two errors that appeared in their article (*Can Med Assoc J* 1984; 131: 873–876). On page 874 the first paragraph of the third bulleted section should have read (with the correction in italics) "Never exceed 20 drinks per week. (In a previous study we found that patients who were most successful with nonproblem drinking did not have more than *12* drinks per week for 2 years.[12]) In addition, Dr. Sanchez-Craig's degree is PhD, not MD. —Ed.