sounds and cannot be silenced until the oxygen runs out of the cylinder or pipeline completely. The button can be reset when a full cylinder is installed or pipeline pressure re-established.

The patient failsafe system consists of pipelines connected from the oxygen regulators to each of the other gas regulators, the oxygen pressure acting in place of the usual spring. When oxygen fails the regulators shut off. At the same time as the supply of gases is cut off from the patient an inspiratory valve (which is normally kept closed by these gases) is allowed to vent to atmosphere, ensuring that the patient can still breathe.—I am, etc.,

R. J. DAVIES
Director of Research and Development, Medical and Industrial Equipment Ltd.
Walton-on-Thames, Surrey

Traveller's Ankle

SIR,—I recently wrote to you about this condition (14 July, p. 109), which I thought had not been previously described, and I made a suggestion about how it might be prevented. This was entirely theoretical, for I had not had an opportunity to try it out. I also promised that if any doctor who tried my suggestion were to write to me and describe the result, I would report a summary to this journal in due course.

Already I have had a great many letters, and it seems that the condition is far commoner even than I had imagined. I had remarked that car drivers seemed to be immune, and I guessed this to be because they worked their ankles adequately. One letter was from a doctor who had bought a new car with a self-changing gear. For the first time he had developed traveller's ankle, but only on the left side. As he pointed out, the left foot now had nothing to do.

Another letter came from a doctor who had been medical officer to a bus tour of Europe. On the way out five of his 18 passengers complained of painful swelling of the ankles. In Basle he was shown my letter and reported it to his passengers. They all followed my suggestion, and on the return journey none got ankle swelling.—I am, etc.,

H. DAINTREE JOHNSON
London N.6

Postgraduate Training in Developing Countries

SIR,—Professor J. H. Hutchison's Personal View, (4 August, p. 288), the subsequent correspondence (1 September, p. 503; 13 October, p. 108), and your leading article reporting the recent Oxford symposium on orthopaedic training (6 October, p. 4) all discuss different aspects of the same problem.

It is agreed that postgraduate education in developing countries should largely take place in these countries. A majority view holds that help is required from the West in providing at least temporary manpower. Professor Hutchison suggests seconding men of senior lecturer status for three-monthly periods to help in establishing training programmes; he recognized that it is difficult for staff who hold appointments in Britain to be absent for longer periods. At the Oxford symposium it was pointed out that younger men (so far as orthopaedics is concerned) have little experience of the diseases they would meet overseas. Hence it was agreed that senior, experienced teachers should go —and "for at least six months and preferably for some years."

Apart from a few retired men, where are such staff to be found? Surely in many branches of medicine a big contribution could be made by a succession of men on one co-ordinated programme, each going for a shorter period (for example, three months). There are many who would be available provided the schemes were officially organized and had the blessing of their employing authority in this country. Closer co-operation between the Department of Health, the Overseas Development Administration, and other organizing bodies in promoting such programmes would, I am sure, produce an expansion of overseas medical training to the benefit of all concerned.—I am, etc.,

A. G. QUINLAN
Scarborough Hospital, Scarborough

Penicillamine in the Treatment of Rheumatoid Arthritis

SIR,—We were interested by your recent leading article on this subject (1 September, p. 464) in which it is stated, in paraphrase, that penicillamine should be used only for patients with acute, active, rheumatoid arthritis.

The multicentre trial[1] to which you refer was carried out on patients who had had rheumatoid arthritis for a mean duration of 11 years (range 2-28 years) and at least 20% of whom had extra-articular manifestations of the disease. Such patients can hardly be said to have early-onset acute disease. This view is confirmed by the statement in the original paper that "all these patients had erosive changes of such severity as to obscure minor differences between pre-treatment and post-treatment films."

In addition to misinterpreting the original study, your article perpetuates the archaic misconception of "advanced, largely burnt-out" rheumatoid arthritis. We presume that by this term you mean to describe low-grade, progressive, granulomatous disease, which in our experience responds well to penicillamine therapy.

We would prefer to have construed your article as a plea for early, active therapy in rheumatoid arthritis and would ourselves support this philosophy. Nevertheless, we must stress that penicillamine may be gratifyingly effective in the later stages of rheumatoid arthritis.—We are, etc.,

JOHN PERCY
A. S. RUSSELL
Rheumatic Disease Unit, University of Alberta, Edmonton, Alberta

1 Multicentre Trial Group, Andrews, F. M., *et al.*, *Lancet*, 1973, **1**, 275.

Non-accidental Injury to Children

SIR,—Most paediatricians, medical officers of health, and other interested people will by this time have read the report of the Tunbridge Wells Study Group on non-accidental injury to children (13 October, p. 96) which has been circulated by the Department of Health and Social Security. It is, of course, a document of extreme importance and value, but I think even greater emphasis should have been placed in the document on the very complex psychodynamics that lie behind many of these cases, and even greater emphasis should have been made upon the importance of involving the child psychiatrist.

The average paediatrician, local authority doctor, or family doctor is naive in regard to deep-seated psychopathology, but it is only by expert understanding of these aspects of the matter that we can hope to make really significant advances in our general understanding of this tragic problem and in the proper management of the individual case. In particular, I think it needs emphasis that the local child psychiatrist is an essential member of the case conference and, in so far as unilateral action is to be attempted in these cases, he should be the co-ordinator of the action of the other people involved. This may be of special importance where the family refuse, in one way or another, direct help of a psychiatric nature. —I am, etc.,

K. R. LLEWELLIN
Clatterbridge Hospital, Bebington, Cheshire

Child Health Records

SIR,—I feel some concern regarding the lack of continuity of child health records at the time of school entry. In many systems currently extant a great deal of clinical and developmental information collected by doctors and health visitors on children in the 0-5-year age range is not available to school medical officers when selections are made for the school entry examination. It has been shown by Lunn[1] and others that selective school entry examination is dependent for its efficiency on being integral with a scheme of continuing assessment and screening, and this in turn depends upon good access to information.

In view of the setting up of the new area health authorities under the forthcoming reorganization of the National Health Service it is, I feel, desirable that we reassess the systems used by different health authorities to date with a view to implementing methods giving increased efficiency. I would therefore be grateful to hear of the ideas and experiences of other authorities in the use of 0-16 record cards to replace the separate 0-5 and school 10M records.—I am, etc.,

G. W. ROBERTS
County Health Department, Mold, Flintshire

1 Lunn, J. E., *Public Health*, 1973, **87**, 173.

Tetracycline-resistant Beta-haemolytic Streptococci

SIR,—I was interested in Dr. M. H. Robertson's observation (13 October, p. 84) that the prevalence of tetracycline-resistant beta-haemolytic streptococci in South-west Essex has fallen over the period 1965-72. Records of the tetracycline sensitivity of Lancefied Group A streptococci (*Streptococcus pyogenes*) isolated from specimens received in this laboratory, both from hospital and general practice, have been kept since 1970.

In 1970 34% of strains were resistant to tetracycline, in 1971 46%, in 1972 54%, and in 1973 to date 35%. It would seem therefore that in this area, at least, there has been no fall in the level of tetracycline-resistant *Strep. pyogenes* over the past four years. The majority of strains isolated continue to come from throat swabs, though many also come from skin sepsis and abscesses. Group B haemolytic streptococci show an even higher prevalence of tetracycline resistance—58% of 74 strains isolated so far this year (mainly from vaginal swabs) were resistant to this drug.

Whether the difference between Dr. Robertson's findings and mine is due to differences in the usage of tetracyclines in the two areas is something on which I cannot comment, but our results illustrate how widely divergent antibiotic sensitivity patterns may be observed in different areas of the country.—I am, etc.,

R. J. FALLON

Department of Laboratory Medicine,
Ruchill Hospital,
Glasgow

Muscle Cramps during Maintenance Haemodialysis

SIR,—The benefits obtained by the use of dialysate with a high sodium content have been recorded by Dr. W. K. Stewart and Miss Laura W. Fleming.[1] However, in reply to their letter (13 October, p. 107) we wish to establish the following points:

(1) A large increase in the weight gained by patients between dialyses is a consequence of using dialysate with a sodium concentration of 145 mmol/l. Dr. Stewart and his colleagues in a study of nine patients have themselves reported a mean weight gain of 4·40 kg.[1] We consider that weight increases of this magnitude are undesirable and, in particular, may constitute a further hazard to patients on home dialysis who, in our experience, frequently have difficulty in maintaining a constant post-dialysis "ideal" weight. The administration of Slow Sodium produced no significant change in the mean inter-dialysis weight gain.

(2) As the results presented in our paper (18 August, p. 389) were obtained from a double-blind trial of Slow Sodium on a group of patients on maintenance haemodialysis, the calculation of mean values inevitably obscured individual therapeutic successes and failures. For example, one patient recorded a reduction in the incidence of cramp from 73% to 13% and two patients who had noted cramp with the placebo experienced none at all while taking the sodium chloride preparation. Moreover, since the trial ended, several of the patients who noted no benefit from 140 mmol of sodium (14 tablets of Slow Sodium) have apparently derived relief from cramp with an increased dosage. It may thus be possible to adjust the dose of Slow Sodium to the requirements of the individual patient.

(3) An increase in the sodium content of the Slow Sodium preparation would certainly be of value in reducing the number of tablets a patient may have to consume. We have found, however, that those patients subject to severe cramp require no persuasion to swallow the tablets.

(4) The administration of Slow Sodium reduced the frequency and severity of muscle cramps in a proportion of patients on maintenance haemodialysis and did so without significant alteration in blood pressure and body weight.—We are, etc.,

G. R. D. CATTO
F. W. SMITH
M. MACLEOD

Department of Medicine,
University of Aberdeen,
Aberdeen

1 Stewart, W. K., Fleming, L., W., and Manuel, M. A., *Proceedings of the European Dialysis and Transplant Association*, 1972, **9**, 111.

Depressed Fracture in the Newborn

SIR,—I have read with much interest the letter from Mr. J. W. Kyle and Dr. D. Jenkinson (29 September, p. 698) regarding the treatment of depressed fracture in the newborn by the use of a Malmstrom vacuum extractor.

This approach to the problem of depressed fracture was originally suggested in the 17th century by Hildanus[1] and subsequently by Ambroise Paré,[2] but in the latter case particularly in relation to battle injury.

In my experience all the depressed fractures which I have encountered in the newborn have, in fact, corrected themselves spontaneously and for this reason one would hesitate to defend the open reduction of such fractures. The use of the vacuum extractor, however, might be undertaken much more readily in case spontaneous reduction does not occur.—I am, etc.,

J. A. CHALMERS

Worcester Royal Infirmary,
Worcester

1 Fabry, W. (Guildhelmi Fabricius Hildanus), *Hildani Opera*, p. 84. Frankfurt-am-Main, Beyer, 1632.
2 Paré, A., *The Works of That Famous Chirugion Ambrose Parey*, trans. T. Johnson, p. 234. London, Cotes and Young, 1655.

Penicillin in Leptospirosis

SIR,—With reference to Dr. L. Clein's letter (11 August, p. 354), a couple of years ago we had an epidemic of leptospirosis in the Thames Valley area in the North Island of New Zealand. As a general practitioner in that area at the time I was most impressed with the efficacy of the following regimen—procaine penicillin, 5 mega units at once followed by 2½-3 mega units daily for the next few days and tailing off to 1·5 mega units for a total course of five to seven days. In most cases immediate improvement was dramatic, with relief of the worst symptoms within 12-24 hours. In one or two penicillin-sensitive patients I did try tetracycline 1g six-hourly with results that were no better than with no treatment at all.

As far as I am concerned, there is no question about the efficacy of high-dosage penicillin and I have many grateful farmers to back this statement. All diagnoses were proved serologically.—I am, etc.,

H. NICHOLLS

Waikato Hospital,
Hamilton,
New Zealand

Strange Encounter

SIR,—Dr. J. C. Kelsey, in his Personal View (13 October, p. 104), refers to "Baron Munchausen" as a fictional character, a mistaken belief which I am sure I shared before I happened to meet his descendant, the present baron.

On a quiet country road near Hanover an Alsatian dog nearly ran under my staff car, to the alarm of its owner, a youngish man on a push-bike. A little later he came up as I was looking at a picturesque *schloss* near the village of Apelern. I asked him who owned the castle and he told me it was Baron von Münchausen. When I said something about being surprised to learn that such a person really existed, he placed a hand on his chest and humorously proclaimed, "*Ich bin es.*" Our brief chat about his famous ancestor was just a little marred for me by my ignorance of the German for "tall stories," and by having consequently had to settle for the less courteous *lüge* (lies).

In fact, the hero of the stories, Hieronymus Karl Friedrich, Freiherr von Münchausen (1720-97), who soldiered in the Brunswick Regiment, was renowned for his after-dinner stories, which he told with a perfectly straight face. It has been said that his life was much saddened after his retirement from the Army when a Hanoverian author, Rudolf Erich Raspe, published his stories and virtually presented him to the world as its best-known liar.

Herr Herbert Hagel, who drove my staff car for some five years in Germany with the *élan* and skill with which he drove his tank in Russia, assured me that he recognized, from his school books, that the young baron whom we met that day possessed the typical Münchausen facies.—I am, etc.,

FRANK RICHARDSON

Edinburgh

Points from Letters

"No Smoking" Ignored

Dr. SYBIL M. RICHARDS (London N.W.11) writes: I have recently paid three visits (non-medical) to a friend in a London teaching hospital and in spite of notices banning smoking all over the corridors and wards, I found patients and visitors smoking on each occasion. When I drew the attention of three visitors at the next bed to the notices I was told it was no business of mine and on appealing to the staff nurse I received a stony glare and no reply. Several patients heard what I had said and told me that smoking often occurs quite openly during the night. . . .

Prescription Charge Anomalies

Dr. C. LIPP (Sheffield) writes: Since when did someone suffering from pernicious anaemia and on Cytamen or Neocytamen injections not have to pay for their prescriptions charges (Dr. D. W. Smith, 6 October, p. 52)? I do not find such disease noted on Page 1 of EC 91.

Injecting Hydroceles—an Unproved Treatment?

Dr. R. G. APTHORPE (Halesworth, Suffolk) writes: I hasten to back up Mr. G. E. Moloney's plea that injection treatment of hydroceles should be used as routine (20 October, p. 170). When I was in general practice in Luton I treated them by aspirating the fluid under a local anaesthetic and then changing the syringe and injected 2 ml quinine and urethane. This is a painless procedure. The fluid would seemingly re-collect, but after a second aspiration and injection it did not recur. I used to preach the doctrine whenever I could, but no one paid any attention. Likewise the patients seemed to think an operation and stay in hospital was a more exciting method of cure and latterly I gave up the battle and sent them off to swell the hospital waiting lists . . .