

I am grateful to Dr. Wilfrid G. Harding, medical officer of health, London Borough of Camden, for his interest and encouragement.—I am, etc.,

R. ROUTLEDGE

Shenfield, Essex

- 1 Axelsson, B., *Odontologisk Revy*, 195, 6, No. 1.
- 2 Murdock, H. G., *Journal of the American Medical Association*, 1946, 131, 1103.
- 3 Harris, D. K., *British Journal of Industrial Medicine*, 1953, 10, 25.
- 4 Ehrlicher, H., in *Kongress für Arbeitsschutz 1961*. Darmstadt, Steinkopf, 1962.
- 5 Karpov, B. D., *Trudy Leningradskogo Sanitarnogigienicheskogo Meditsinskogo Instituta*, 1953, 14, 43.
- 6 Karpov, B. D., *Gigiena i Sanitariya*, 1954, No. 10, 25.
- 7 Raines, L. A., *Gigiena Truda i Professional'nye Zabolevaniya*, 1957, 1, 56.
- 8 Harris, D. K., *British Journal of Industrial Medicine*, 1959, 16, 221.

Making Hospital Geriatrics Work

SIR,—It is interesting to read that one of the consequences of Drs. H. M. Hodkinson and P. M. Jeffery's approach to "Making Hospital Geriatrics Work" (2 December, p. 536) is the maintenance of the morale and professional satisfaction of "ancillary staff." May I, as a physiotherapist working in this particular arena, put a different point of view?

Paramedical staff involved in the geriatric service frequently experience feelings of impotence and frustration. This is one of the major causes for poor recruitment in this field of medicine and I do not believe that the situation can be remedied by increasing patient turnover.

Rehabilitation of the elderly patient is a lengthy and detailed procedure. Generally it is not so much the acute medical problems that concern the therapist but, to quote Drs. Hodkinson and Jefferys, "the unavoidable [case load] of patients with greater disability." If such patients are to return once again as viable members of their community and maintain optimum independence there, then much time needs to be given by all those involved in their reablement. In these situations, the therapist will need medical support over a long period rather than medical "pressure" to carry out such a programme effectively. Drs. Hodkinson and Jefferys may be able to concede "less than complete therapeutic results," but in rehabilitation of older patients there should be no such compromise. The process cannot be hurried. The rate of turnover may be slowed down in consequence, but the alternative for the patient is breakdown at home and eventual hospital readmission, and for the therapist the knowledge that one has been prevented from giving one's professional best.

After three months in hospital, in Drs. Hodkinson and Jefferys's view, discharge becomes very much harder because of "institutionalization" and "the withering of the patient's ties with the community." One might venture to suggest that perhaps it is those with the greatest disability who tend to have the longest stay in hospital. If a patient has adequate incentive and his reablement programme is both realistic and appropriate, it has not been my experience that "institutionalization" occurs, however prolonged his hospital stay may be. Moreover—and this is essential—if relatives, friends, and supporting social service personnel are involved from the beginning,

need there be this inevitable "withering" of community ties? Rehabilitation after all, is an exercise in vivo and not in vitro.—I am, etc.,

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Sickle-cell Anaemia

SIR,—Sickle-cell anaemia was unknown to medicine until 1905, when James B. Herrick of Chicago, an experienced haematologist in a country with a large negro population, seems to have got the shock of his life on seeing the sickling phenomenon in the blood film of a negro with severe anaemia.¹ I have been informed by a haematologist that of course sickle-cell anaemia was well known before 1905. However, at the beginning of the century there were numerous books on haematology with coloured illustrations of the bloods of all known anaemias, and at least in British, American, French, and German books there is no mention of sickle-cell anaemia or thalassaemia, with its almost equally arresting blood picture. These two words seem to have been unknown to the official nomenclatures of those countries. Can anyone refer me to any evidence in black and white in any language that these two diseases were known to exist before 1905?—I am, etc.,

H. GALL

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¹ Herrick, J. B., *Archives of Internal Medicine*, 1910, 6, 517.

Nitrazepam: Another Interesting Syndrome

SIR,—A 55-year-old woman for many years accustomed to taking five 100 mg tablets of butobarbitone during the night was admitted to hospital for treatment for her alcoholism. She was immediately changed to nitrazepam 10 mg at bedtime, something I had been unable to achieve in her home environment. Six weeks later for the first time, and after her discharge home, she complained of pins and needles in both hands and that the fingers were clumsy and losing their power. Her symptoms were worse in the morning and gradually improved as the day progressed. On examination there was no evidence of peripheral neuritis, and no other obvious cause was found. The severity of her symptoms increased, and when she was woken during the night by the tingling in her hands she resorted to taking another nitrazepam tablet to obtain sleep.

Her hands became useless in the mornings; she had to stop knitting and could not hold a needle to sew on a button. By late evening her hands were almost back to normal. One night she omitted her nitrazepam because she had to see her son off at 5 a.m. She noticed for the first time in weeks that her hands felt normal. She took her nitrazepam at 5 a.m., and within two hours she woke with her hands tingling and feeling numb once more. Nitrazepam was immediately stopped and she has had no recurrence of the symptoms since.

I am drawing attention to this case because when my patient was wakened by her symptoms she took another dose of nitraze-

pam, thereby inadvertently aggravating them. I did not elicit the history of improvement as the day wore on until afterwards. It would appear that when a patient complains of acroparaesthesiae for which no other cause can be found an inquiry into the taking of nitrazepam should be made.—I am, etc.,

HAMISH MACLEAN

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Internal Fixation of Secondary Deposits in Long Bones

SIR,—We would like to question the finding of Campbell,¹ quoted by Mr. Malcolm Fidler (10 February, p. 341), that malignant tissue is not disseminated along the shaft of a long bone by the insertion of a Küntscher nail.

It is our clinical experience to have discovered, in some cases, further neoplastic deposits at the opposite end of the bone to the point of entry of the internal splint, some months after the operation and local radiotherapy. Because of this it has been our policy for some years now to irradiate (preferably with megavoltage) the whole length of the shaft postoperatively.—We are, etc.,

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A. J. BANKS

WILLIAM G. JONES

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¹ Campbell, C. J., in *Palliative Care of the Cancer Patient*, ed. R. C. Hickey, p. 313. Boston, Little, Brown and Co., 1967.

Anthrax

SIR,—Dr. Robert Lamb's article on anthrax (20 January, p. 157) was most valuable for doctors working in the U.K. but did not cover the full spectrum of the disease as seen elsewhere.

During my service a good many years ago as a pathologist in the Gold Coast (now Ghana) it was not very uncommon to encounter anthrax in the necropsy room, although a malignant pustule was never seen. The story was usually that the body had been found under a tree, supplemented occasionally by evidence that the deceased was one of many people who had eaten the meat of a cow which had been killed when moribund. The ratio of reported fatalities to incidents was usually unity, and it seemed likely that the common mode of infection was by ingestion and that the infectivity of the organism by this route was very low.

Soon after my arrival at the Accra laboratory I was taught, by Dr. George Robinson, that it was a good plan to remove the skull-cap before opening the trunk when doing a necropsy. A bulging purple dura with haemorrhagic meningitis was suggestive of anthrax, which could be confirmed by puncturing the membranes and withdrawing a drop of cerebrospinal fluid for examination; in this way further opening of an infected body could be avoided. My curiosity once led me to do a full necropsy on one of these patients, in whom large masses of mesenteric lymph nodes, which looked like ripe Victoria plums, convinced me that the gut had indeed been the portal of entry of the infection.

On one occasion only was I able to diag-