

that should be pursued between teacher, child, and parents.

There is evidence that the pendulum phenomenon is now heralding an era of "narrow punitive education associated with the bullying of children and adolescents,"³ and that this would be welcome in some quarters. Let us hope that sufficient people feel strongly enough to ensure that the next decade does not provide further inspiration for the Pink Floyd.

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¹ McCann E. *Schoolmaster and Career Teacher* December 1977:168-72.

² Koerner JD. *Reform in education*. New York: Delacorte Press, 1968:159-60.

³ Whitehead T. *World Medicine* October 1975:77-81.

Physical indicators of emotional abuse in children

SIR,—A letter (17 November, p 1290) from Dr W R Guirguis requested the recording of physical indicators of emotional abuse in children.

During the last 10 years I have been the medical officer to a primary school for mildly educationally subnormal children where most children have some degree of maladjustment. In the last four years I have also been medical officer to an all-age school for maladjusted children. Both these schools are in Southwark, south-east London, where there is a preponderance of children from social classes IV and V. From this experience may I offer my observations on a sign which I consider is frequently present in maladjusted children? This is a very characteristic indrawing and thinning of the upper lip, which is to me instantly recognisable.

I have never heard anyone else comment on it either verbally or in writing. I have christened it, for local convenience, "Ewart's sign." Not all maladjusted children show this sign but all children who show it are in my opinion maladjusted and, while I have not yet attempted to correlate any sign with emotional abuse, most of the children exhibiting it come from backgrounds of social and emotional deprivation. In addition, it is known that many children who have been overtly abused and neglected suffer emotional damage and because of associated intellectual difficulties and maladjustment require education in special schools¹⁻³. There seems sufficient evidence at least to consider the possibility of emotional abuse in any child who exhibits this characteristic facies.

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¹ Lynch MA. *J Child Psychol Psychiat* 1978;19:175-180.

² Roberts J, Lynch MA, Duff P. *Ther Educ* 1978;6:25-31.

³ Martin HP, Beezley P. *Develop Med Child Neurol* 1977;19:373-87.

The uneasy oesophagus

SIR,—Your leading article "The uneasy oesophagus" (19 January, p 136) began by quoting the words of "the physician out to reassure his worried patient who believes that he has heart disease." It is often the physician himself who first needs that reassurance. The oesophagus has, of course, long been recognised as a source of symptoms masquerading as cardiac pain but the dif-

ferential diagnosis is not always easy. On the one hand, cardiac pain cannot always be excluded by a normal 12-lead exercise electrocardiogram and a normal coronary arteriogram; on the other hand, there has been no entirely satisfactory means of establishing oesophageal spasm as the cause of the intermittent symptom in question.

We have recently reinvestigated 21 patients who had previously had normal coronary arteriograms but continued to experience "angina," leading in many cases to enforced retirement from work and in all except one case to at least one readmission with suspected myocardial infarction.¹ In 16 (76%) of these patients we were able to show that the pain was not cardiac but due to oesophageal spasm. The pain appeared indistinguishable in character from that of cardiac pain, often though not predictably related to exertion, relieved by nitrites, and frequently associated with minor electrocardiographic changes. Full cardiological investigation confirmed the absence of coronary artery stenosis, ergometrine-induced coronary artery spasm, metabolic evidence of myocardial ischaemia, and other cardiovascular disease. Ergometrine (500 µg intravenously) did, however, reproduce the pain. This offered the means of confirming that the pain was due to oesophageal spasm by oesophageal manometry (recorded through perfused triple-lumen tube), which showed the development of characteristic abnormal motility patterns coincident with the development of the pain.²

The majority of these patients had no other symptoms suggestive of oesophageal disorder and had normal routine barium swallows. Oesophageal spasm appears to be more common than we had appreciated. We suggest that ergometrine provocation offers a means of confirming the diagnosis, though it should be used with caution until coronary artery disease has been excluded.

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¹ Dart AM, Alban Davies H, Dalal JJ, Ruttle MST, Henderson AH. *Eur Heart J* (in press).

² Dart AM, Alban Davies H, Lowndes RH, Dalal JJ, Ruttle MST, Henderson AH. *Eur Heart J* (in press).

SIR,—Our hollow viscera cause much misery and your recent leading article (19 January, p 136) "The uneasy oesophagus" is important to any practising doctor on several counts, but particularly because you stated that oesophageal pain in the chest can be mistakenly considered to be "anginal" by patient or doctor. After 40 years of listening to accounts of chest pains I am sure that oesophageal pain is the commonest to be misdiagnosed, regrettably, as cardiac; and we can do few greater disservices to our patients than diagnose ischaemic heart disease wrongly—but it is commonly done.

Whatever the precise mechanism of the oesophageal pain it is certainly connected with oesophageal contraction, as I have proved at least to my own satisfaction. I have experienced the symptom for at least 15 years, beginning in my 50s, and it can be most unpleasant and, until diagnosed for what it is, most alarming. It mimics anginal chest pain

closely, being retrosternal and radiating to both shoulders; but it is not related to exertion. It is prone, as you say, to occur at night and awakens the victim, and is not typically related to food. I have experienced it when driving the car, without any warning, and it is distracting. Duration is about two to 15 minutes.

My reason for writing to you is that there is a very simple practical method of proving that the pain is arising in the gullet and not the heart: important to me personally because I also have coronary artery symptoms. The trick when you or your patient experiences the pain is to swallow saliva hard, and as the wave of deglutition which you have started descends the pain will subside in seconds; it will usually come back rapidly, but can be repeatedly dispatched by the act of swallowing. Anxiety thus dispelled and equanimity restored, the pain can be tolerated: in the morning small hours, when even the cardiologist's ego is at its lowest, a small tot of neat whisky seems especially efficacious. The whole clinical entity reminds me of proctalgia fugax, an even more catastrophic example of gut contractions gone mad, but obviously without the "angor animi" of the introspective cardiac.

I like your designation of the "uneasy" oesophagus: it matches well the "unhappy colon" of Sir Arthur Hurst. May I suggest "perverted rectum" to take the blame for the atrocious symptom. How fortunate that the pains of the gullet and rectum are fugaceous, though alas not those of the colon.

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Troxerutin in Raynaud's syndrome

SIR,—We read with interest the paper of Dr A J Dodds and others (10 November, p 1186) on the treatment of patients with Raynaud's syndrome by weekly plasma exchange. We would like to report our own results in similar patients, also based on an attempt to improve the rheological properties of blood, using intravenous and oral administration of hydroxyethylrutosides (troxerutin) in the form of Paroven capsules. It has previously been shown that this compound in high doses will reduce red cell aggregation and whole blood viscosity at low shear rates and will increase red cell deformability.^{1 2}

We have so far studied a group of seven patients with severe Raynaud's syndrome: three could be classified as having primary Raynaud's syndrome (no demonstrable cause found); one had scleroderma; one had involvement of hands and feet from Buerger's disease; one had vibration-induced disease of the arteries of the hands; one had a vasculitis involving both hands and feet with additional "vibration disease." All patients had severe pains in the digits and some degree of ulceration. They were all investigated by conventional angiograms and also with our recently developed dynamic fluorescein angiography technique.³⁻⁵ These techniques showed organic changes in the arteries of the hands in five patients; the other two patients showed pronounced vasospastic tendencies.

The patients received hydroxyethylrutosides intravenously at a dose of 2-3 g/day (in two injections) for two to four weeks, followed by oral treatment at a dose of 3-6 g/day (in three to four doses) for maintenance therapy. During the parental treatment period all patients showed clear clinical improvement, with fewer episodes, healing of ulcers, and a pronounced relief of pain. Five patients showed a definite improvement in peripheral blood flow as shown by fluorescein angio-

graphy. During the oral treatment period the increased blood flow was maintained or improved further, as shown by the following fluorescein angiograms. Tolerance to these high doses, both intravenous and oral, was excellent.

A similar trial is also running in advanced cases of chronic ischaemic legs, unsuitable for reconstructive arterial surgery, using high doses of intravenous hydroxyethylrutinosides. We have about 20 cases in this study to date; and most results, both clinically and with serial fluorescein angiography are similar to those reported here for Raynaud's syndrome. These results will be reported in full when we have finished a detailed analysis of the material.

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- ¹ Schmidt-Schönbein H, *et al. Vasa* 1975;4:263.
² van Haeringen NJ, *et al. Bibl Anat* 1973;12:459.
³ Lund F. *Acta Chir Scand* 1976;60, suppl 465:60-70.
⁴ Lund F, *et al. In: Gefässwand, Rezidivprophylaxe, Raynaud-Syndrom*. Baden-Baden: Witzstrock, 1979: 480.
⁵ Lund F. *Bibl Anat* 1979;18:322.

Not a career for academic high fliers?

SIR,—The Finniston Report on the engineering profession¹ illustrates a serious deficiency in the way we manage our affairs. A technologically based society—and all advanced societies and most others have to be—needs good technicians, scientists, and engineers. Of course, medics are also important, but—like their nostrums—only in moderation. We must moderate our desire for ever more and brighter students, and for two reasons: firstly, because medicine has the jobs for only a few academic high fliers—bread-and-butter medicine does not use or satisfy their special abilities—and, secondly, because (as the Finniston Report demonstrated) there is a much greater need for the bright ones in other branches of science and technology. Society cannot afford a medicine which scoops up too many scientists, particularly academic high fliers.

The fact that medicine is so attractive to our bright school leavers has less to do with the merits of the subject, or the needs of society, than to medicine's high rating as a career. Our deans must act with unaccustomed humility: the corollary to Finniston is fewer medical students and three Cs as the going grade; a special case must be made for taking more than a few with higher grades.

Medics like to take credit for a concern for individuals and society: now is the opportunity for us to show we deserve it.

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¹ Committee of Inquiry into the Engineering Profession. *Engineering Our Future*. Cmnd 7794. London: HMSO, 1980.

Patients first

SIR,—I write to point out what appears to be an error in the title of the consultative document *Patients First*. Should not the title be *Hospital Patients First*? With this correction

the document reads well and the changes suggested seem reasonable. If, however, the title is not in error I must express concern about other than hospital patients in the care of the NHS—for example, those who are the responsibility of the primary care and preventive health services.

What is not clear from the consultative document is how the NHS, particularly at local level, will serve all patients and not just those in hospital. It is suggested that there will be a triumvirate at the district general hospital, or its equivalent, of senior and experienced people, paid accordingly, to administer the hospital. Will they also be responsible for the majority of patients who are cared for outside hospital, or will there be a second triumvirate to promote the health of the total community of the catchment area of the hospital, with a responsibility for the primary care and the community health services (for example, the child and school health services)?

The suggested philosophy of the consultative document is to bring health services nearer to the patient. It is therefore essential that local administrative and management arrangements are right. It would seem that insufficient thought has been given to this by those who have prepared the document. Although there has been much criticism of the reorganised Health Service, there appears to be an acceptance that one of its benefits has been the bringing together of previously fragmented health services. We need to build on this important advance and not by new (some may say a return to old) administrative changes create a partite structure within the reorganised health service.

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Cleaning hospital wards

SIR,—In your leading article (22-29 December, p 1610) you make a plea for the ward sister again to have responsibility for the day-to-day control of the ward cleaners; but let me add a word of support for the hospital cleaning departments, which have a responsibility for training domestics and providing them with the necessary equipment. Surely the best arrangement would be for the domestics to be on the sister's staff for day-to-day control, but under the general supervision, so far as standards of work are concerned, the domestic supervisor. In the good/bad old days the matron's staff was responsible for buying the cleaning equipment, and this was far from satisfactory. Today at least domestics have the appropriate equipment for cleaning and are instructed in its use.

There is another aspect to this problem beyond the control both of the ward sisters and of the domestic supervisor. Going round a number of London hospitals last year I noted with dismay the numbers of wards and, even more, kitchens where there was a high-tide mark at six feet (1.8 m). Below this level the walls can be cleaned by the domestics, but above they may be washed only by the painters.

With the continuing problem of cross-infection there is a medical aspect and there should be good liaison with the hospital consultant hygiene officer. I remember a patient in a side ward who damped down the enthusiasm of the ward cleaner who had set to

work on a cupboard: "Hi! Stop! That's where I keep my streptococci." He was right, and unhappily he almost died from a severe postoperative wound sepsis.

There are simple answers, such as long-handled mops with self-squeezing mechanisms, or re-establishing the routine of pulling the beds out and having the walls washed down. I remember this was done in half a morning at Bart's, where under the eagle eye of Professor L P Garrod the wards really were kept clean.

Clean hospitals are important. Like Minerva (5 January, p 53), I look forward to the time when the DHSS awards a handsome prize to the domestic supervisor of the hospital judged to be the cleanest in England and Wales.

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Medically qualified preclinical academics

SIR,—I fully agree with Mr N A Green and Professor R E Coupland (12 January, p 116) that medically qualified preclinical teachers are essential for the medical direction of education, particularly in anatomy. In these days of shortened anatomy curricula there is an enormous advantage in having medically qualified staff who are able to select the clinically relevant facts from the vast amount of anatomical knowledge. Furthermore, as the late Professor W J Hamilton frequently pointed out, medically qualified staff are usually much more versatile than their non-medical colleagues, being able to teach cytology, histology, embryology, and neuroanatomy as well as gross anatomy.

I also agree that a clinical presence in preclinical courses can be of great value, particularly in motivation of students. I have been co-ordinator for a number of years of a clinical neuroanatomy course which includes contributions from neurologists, neurosurgeons, otolaryngologists, and ophthalmologists; and have participated in limb anatomy courses which are jointly run by the departments of anatomy and orthopaedic surgery. I willingly acknowledge the value of these courses.

I am not, however, convinced that by doing clinical sessions preclinical staff would in any way improve their teaching standards; nor do I believe that clinical sessions would be of any value in improving recruitment and retention of junior staff, for the simple reason that the basic salaries of preclinical and clinical lecturers do not differ greatly. The major difference is in the payment of UMTs, which presumably would not be paid for two sessions a week. The problem is not unique to preclinical staff but has also severely affected recruitment to paraclinical laboratory disciplines. Unfortunately it seems likely that the new consultant contract will aggravate the situation by extending the salary differential in laboratory disciplines to the consultant grade.

There are numerous practical difficulties involved in finding appropriate clinical sessions for the majority of preclinical teachers. Many clinicians argue that it is not possible to develop clinical expertise where clinical contact is restricted to one or two sessions a week and would strongly oppose clinical involvement of preclinical staff at anything higher than SHO level, a point of view which is understandable. The most valuable type of