

spent \$43.10 on teeth alone and \$109 on smoking (Statistics Canada, Winnipeg branch: personal communication, 1974).

The proposed abridged periodic health examination is untested and, in my opinion, hazardous. If it becomes official policy, doctors forced to comply should be given legal protection when they miss important diagnoses through doing such skimpy health care monitoring.

L.C. BARTLETT, MD, FRCS[C]
1620 Medical Arts Building
Winnipeg, Man.

References

1. BAIRD RJ, GURRY JF, KELLAM JF, et al: Abdominal aortic aneurysms: recent experience with 210 patients. *Can Med Assoc J* 118: 1229, 1978
2. KLEIN LA: Prostatic carcinoma. *N Engl J Med* 300: 824, 1979

Atlantoaxial dislocation and Down's syndrome

To the editor: Dr. C.R. Palmer (*Can Med Assoc J* 1980; 123: 610) raises two separate but possibly related issues in response to our article on atlantoaxial dislocation and Down's syndrome (1980; 123: 35-37). His first concern was with the treatment of the handicapped. I suspect it was not the fecal incontinence or the cardiac murmur of our patient that incurred Dr. Palmer's dismay but rather the "low mental status". Attitudes have changed (including mine) in the past 25 years, although perhaps more slowly among the medical profession than among the general public. I believe it is helpful to consider handicapped persons as but one part of the entire human spectrum, who as such are entitled to treatment at least equal to that given those more fortunate. It was Sir Winston Churchill who reminded us that "no society should be judged in any way except by how it treats its least advantaged".

Dr. Palmer's second concern relates to the economics of medical care. Costs are skyrocketing, and it is difficult to know what portion of funds should be designated for intensive care units and what portion for facilities for the mentally retarded. Our financial resources are limited. I think all so-called health

care providers have to look closely at their various budgets, but not to the exclusion of any one group in our society.

W. JOHN WHALEY, MD
Sunbeam Home
Kitchener, Ont.

Detecting and preventing glaucoma

To the editor: Dr. P.C. Whitehouse has questioned whether the eyes should be dilated during an eye examination (*Can Med Assoc J* 1980; 122: 867-873). There is no doubt that dilation of the pupil facilitates examination of the retinal periphery, but refraction is not necessary when prescribing lenses. Dr. Whitehouse suggested that general practitioners should examine the retinal periphery by having patients sit in a darkened room until their pupils dilate. This is a very impractical suggestion because it would take far too long and an extra room would be needed. Besides, sitting in a darkened room, a predisposed patient with a shallow anterior chamber and a narrow drainage angle may be at risk of acute glaucoma. Indeed, in some centres the intraocular pressure in patients in whom glaucoma is suspected can be measured before and after they have sat in a darkened room.

More surprising was Dr. Whitehouse's statement that "many general practitioners would be . . . willing to perform, in a crisis where minutes count, an emergency peripheral iridectomy or iridencleisis." I wonder whether Dr. Whitehouse was confusing occlusion of the central retinal artery and acute glaucoma. An emergency paracentesis would help the first condition. However, in treating acute glaucoma it is usually better to decrease the intraocular pressure first, thereby making eye surgery safer.

From his experience in Ontario Dr. Whitehouse found that mydriatics were often used in ophthalmologists' offices without prior measurement of the anterior chamber depth. I do not think any ophthalmologist would admit to dilating the pupil without first checking the normality of the anterior chamber depth and the pupillary reactions.

After all, this is what we are taught to do.

Dr. Whitehouse was concerned about the danger of using a cholinesterase-blocking miotic such as echothiophate iodide because it leads to pupillary block. I think he has exaggerated this danger; echothiophate iodide is usually used only after the crystalline lens has been removed. This significantly reduces the likelihood of pupillary block.

C.M. MAILER, MD
409-450 Central Ave.
London, Ont.

To the editor: It is apparent that Dr. Whitehouse is not fully conversant with the educational background of optometrists (*Can Med Assoc J* 1979; 121: 1447-1448).

With the aid of an intensive 4-year study program optometrists are adequately trained to "detect disease or incipient disease" and to "diagnose other disorders from the condition of the eye". This program has recently been updated and lengthened to 6 years to provide better trained optometrists for the future.

I suggest that Dr. Whitehouse take a trip to the University of Waterloo school of optometry, where he will see how wrong he is in his estimation of an optometrist's skills and capabilities.

EARL A. LAUTENSCHLAGER, OD
Morden Medical Centre
Morden, Man.

[This topic of correspondence is now closed.—Ed.]

Rhinitis medicamentosa

To the editor: I was pleased to see the excellent review article on rhinitis medicamentosa by M.J. Black and K.A. Remsen (*Can Med Assoc J* 1980; 122: 881-884).

Rhinitis medicamentosa is commonly encountered by allergists as well as otorhinolaryngologists. It is my impression that the condition is not widely recognized by the medical profession; however, this review will help remedy the situation.

The abuse of nasal decongestant drops and sprays is in many cases a severe habituation, if not a true

addiction. Therefore, it is often very difficult to obtain patient compliance in discontinuing the medication. As with other habituations, patients often claim abstinence while using the drug surreptitiously. Among patients who do "kick the habit", there is a high rate of recidivism, especially in the absence of vigorous continuing treatment. In my experience the habit can be broken in many cases if patency of the nasal airways and greatly improved nasal airflow are achieved. Treatment with antihistamines, decongestants, nasal corticosteroids or cromoglycate sprays, or a combination of these, is often unsuccessful. Black and Remsen consider the oral use of corticosteroids inappropriate in the treatment of rhinitis medicamentosa. However, in many cases the liberal oral use of corticosteroids is essential for maximum clearing of the nasal passages and for permanently breaking the decongestant habit. Prednisone, 20 to 30 mg once every morning for 14 to 21 days, is quite safe for otherwise healthy patients if there are no specific contraindications. With the oral use of corticosteroids patency of the nasal airways is achieved and the patient is able to stop taking the decongestant, thereby allowing the nasal mucosa to recover its integrity and normal function. Improvement can then usually be maintained by the use of non-absorbable corticosteroid sprays, such as beclomethasone dipropionate or flunisolide, while the use of oral corticosteroids is gradually decreased and then stopped. Oral antihistamine and decongestant therapy may also be helpful. When specific allergies are responsible for the underlying rhinitis, immunotherapy can be effective in selected cases.

W.B. CHODIRKER, MD
Department of clinical immunology
and allergy
University Hospital
London, Ont.

The investigation of transport accidents

To the editor: I read Dr. H.E. Emson's editorial on transport ac-

cidents (*Can Med Assoc J* 1980; 123: 169-171) with interest.

Dr. Emson expressed concern that "a situation could arise of a forensic pathologist charged with performing an autopsy and subsequently ordered by one investigating agency to release information and by another to withhold it." Autopsy reports are not the property of the pathologist when the autopsy has been commissioned by a medico-legal official. Another investigating agency would find itself in conflict only with the medicolegal official (i.e., the coroner/medical examiner) and not the pathologist. Therefore, when death is associated with an aircraft accident or a military incident the pathologist should know for whom the autopsy is being performed and have proper consent from that person.

J.C. BUTT, MD, MRC PATH
Chief medical examiner
Calgary Health Sciences Centre
Calgary, Alta.

How will the new wave of women graduates change the medical profession?

To the editor: I am writing with reference to the article by Charlotte Gray entitled "How will the new wave of women graduates change the medical profession?" (*Can Med Assoc J* 1980; 123: 798-804).

There is a great deal in the article that we in organized anesthesia find encouraging. Ms. Grey quite rightly identifies the marked increase in the numbers of female medical students and speculates on the potential impact this will have on medical manpower.

The discipline of anesthesia has long welcomed women, and we are encouraged by recent studies indicating that anesthesiology may be an attractive discipline for female physicians. However, the discipline may be attractive for reasons different from those Ms. Gray suggests. She stated that anesthesia is popular with women "because they don't have to work long hours or buy a lot of equipment."

Canadian studies on physician manpower have consistently placed anesthetists among the Canadian

physicians devoting the most hours per week to their specialty. A great deal of time on call is required by practising anesthetists; unlike a great many other specialists they may be regularly incarcerated in the hospital during significant portions of the time on call.

Thus, I suggest that the attractiveness of anesthesia to women physicians is in the opportunity for working part-time as opposed to working short hours.

D.V. CATTON, MD, FRCP[C]
President
Association of Canadian University
Departments of Anaesthesia
McMaster Clinic
Hamilton General Hospital
Hamilton, Ont.

Management of the umbilicus with crystal violet solution

To the editor: Several studies have indicated that application of triple dye solution to the umbilical stump of the newborn is effective in reducing colonization by *Staphylococcus aureus*.^{1,2} It appears that many authorities are recommending the routine use of triple dye solution for the umbilicus of all newborns.³ They advise that the solution be applied as soon as possible after cutting the umbilical cord to prevent colonization of the stump by staphylococci; the dye is less effective once colonization has taken place. Thereafter the stump may be left untreated or the triple dye solution or alcohol may be applied. However, triple dye is less effective in reducing infection of the umbilical stump by group B streptococci⁴ and, indeed, the dye may enhance colonization by these organisms.² It is also less effective against colonization by *Escherichia coli* and other gram-negative bacteria.⁵

Triple dye solution is prepared from a mixture of brilliant green, crystal violet (also known as gentian violet) and proflavine hemisulfate. Commercial gentian violet is adulterated with pentamethylpararosaniline chloride and tetramethylpararosaniline chloride,⁶ which are derived from amino-substituted aniline derivatives or from amino-acridine, and are generally known as triphenylmethane dyes.