

- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

Immunisation against infectious disease

We recently received from the Department of Health and Social Security a copy of the 1988 edition of the memorandum *Immunisation against Infectious Disease*, compiled by the Joint Committee on Vaccination and Immunisation.¹

In the section on tuberculosis and BCG vaccination the committee recommends one of only "two well established methods" of tuberculin skin testing—the Mantoux intradermal test and the Heaf multipuncture test. No reference whatsoever is made to the tuberculin tine multipuncture test. In our view this is a serious and unwarranted omission. The tine test has been used for many years by doctors at the London Chest Hospital and Newham Chest Clinic, which serve areas where tuberculosis remains common, and we think that when it is carefully performed it provides a simple and reliable screening test. When correctly applied and interpreted its sensitivity and specificity are comparable with those of the standard Mantoux test—that is, 10 IU tuberculin.² Furthermore, with the increasing incidence of infection with human immunodeficiency virus in the community, the tuberculin tine test has the added advantage of being a single disposable unit, thus decreasing the risk of transmitting infection.

With regard to interpreting the Mantoux test, many doctors, including us, regard a diameter of 5 mm (not 6 mm) or more of induration to any dilution of tuberculin as a positive reaction.³ Furthermore, the diameter of induration should be measured transversely to the long axis of the forearm.

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- 1 Joint Committee on Vaccination and Immunisation. *Immunisation against infectious disease*. London: HMSO, 1988:44-8.
- 2 Rudd RM, Gellert AR, Venning M. Comparison of Mantoux, tine, and 'Imotest' tuberculin tests. *Lancet* 1982;iii:515-8.
- 3 Caplin M. *The tuberculin test in clinical practice*. London: Baillière Tindall, 1980.

The bends

I would not disagree with anything in the statement on the bends by Surgeon Commander Sykes and his colleagues (20-27 August, p 509). Furthermore, I applaud the work done by the Royal Navy

in providing a 24 hour service for advice and treatment in cases of illness related to diving. I am, however, concerned that their statement, whose aim was to inform doctors, did not highlight how serious the problem of medical ignorance of these conditions is.

Decompression sickness is comparatively uncommon, with only about 150 serious cases undergoing recompression in the United Kingdom yearly. The symptoms are usually cured by early recompression, but if treatment is delayed neurological sequelae are common. As most divers using self contained underwater breathing apparatus (SCUBA divers) are young and as decompression sickness is not usually fatal the morbidity in individual divers and cost to the state of delayed treatment is high. Although in many cases the diver or his companions are aware that he is suffering from decompression sickness, regrettably the doctor whose help he seeks is unwilling to accept the patient's diagnosis.

A few years ago an unconscious young diver with diabetes whose results from biochemical tests were normal was treated for some hours for hypoglycaemia despite his colleagues' assertion that he had the bends. After a considerable delay he was recompressed but he remained tetraplegic. Appreciable compensation was paid.

Since then the situation has not improved, with similar cases every year. Recently a diver sat in a casualty department for several hours with increasing paraparesis. It was only his friends' statements that they would put him back in their boat, put out to sea, and radio the coastguard for a helicopter unless something were done quickly that produced any action.

Indeed, the navy's letter was prompted by a recent case in which a young woman with progressing hemiparesis was advised in one accident and emergency department that it would get better and told by her general practitioner a few days later that he would arrange an outpatient appointment. After seeing physicians and a neurologist the diagnosis was still not made. Only after extensive investigations, including lumbar puncture and computed tomography, did anyone appreciate the significance of the history of symptoms starting the day after diving. She was recompressed after an unnecessary delay with less than complete success. In the past year several divers with clear decompression sickness have been turned away, even from "centres of excellence."

In the eyes of most divers the average doctor when faced with a diving emergency is so ill informed as to be dangerous. In cases of illness after diving divers often contact recompression chambers directly. This has sometimes meant that divers are recompressed without first being examined by a doctor. In one case this had fatal

consequences. Equally worrying is the fact that some divers have elected to treat themselves by re-entry decompression rather than seek medical help. This year alone two young people have become paraplegic as a result of attempting this dangerous manoeuvre.

The most recent survey of the British Subaqua Club shows that for every diver recompressed two developed mild symptoms and elected not to seek treatment, hoping that the paraesthesia or pain would remit. The long term consequences of self limiting, untreated neurological decompression sickness are unclear, although there are concerns that a major neurological deficit in later life will declare itself.

The attempts of the Royal Navy to educate doctors should be encouraged. It is unfortunate that the Department of Health and Social Security does not share the navy's view on the seriousness of diving diseases. The British Subaqua Club has asked the department to cooperate in the issuing of guidelines to casualty departments and to streamline the handling of decompression sickness. The department has stated that action is not required as it is not aware that a problem exists.

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Shoe size and outcome of labour

Dr Tahir A Mahmood and his colleagues found no correlation between maternal shoe size and incidence of cephalopelvic disproportion (20-27 August, p 515). Their study group comprised 563 white primigravid patients with a singleton pregnancy, cephalic presentation, and gestation over 34 weeks. Eighty three women (15%) underwent induction of labour for, presumably, various indications.

We have previously reported the association between maternal shoe size, stature, and outcome of labour in 264 consecutive primigravid white women attending Liverpool Maternity Hospital during 1985.¹ We included only women who had completed 37 weeks' gestation, with a singleton cephalic pregnancy, and who admitted themselves to the labour ward in spontaneous labour. By excluding parous women, malpresentation, prematurity, and induced labour we hoped to avoid any distortion to the results. In our group maternal stature and shoe size correlated with the incidence of cephalopelvic disproportion. The incidence of disproportion was 12% in women with a shoe size of less than 5 compared with 5% in women with shoe size 5 and 3% in women with