leviathan, but with the hospital constellation I have described why should not the governors of this constellation be the supreme authority responsible for the whole of the personal health services of their area; domiciliary as well as institutional, nursing as well as medical? General practitioners could be in contract with them instead of the executive councils, which together with the present regional boards and boards of governors could link arms and descend together, unlamented, into the limbo.—I am, etc.,

London W.1. T. Rowland Hill.

Coeliac Disease in Childhood

Sir,—In Professor Douglas Hubble's admirable review of this subject (September 21, p. 701) he raises the question, "Why Try the Experiment?"—of returning to a gluten-containing diet. In attempting an answer he balances the disadvantage of a possible relapse in health against the psychological and social advantages of a normal diet, and suggests that if a change-over is to be made it should be delayed beyond 11 years of age in order to reduce the likelihood of a relapse.

Knowing of three such children who changed to a normal diet without any obvious upset and who now, in early adult life, have a megaloblastic anaemia associated with pregnancy or recurrence of the steatorrhoea, I suggest that there will not be a satisfactory answer to this question until children with coeliac disease have been followed through adolescence and early adult life. For myself, I now am encouraging such patients to stay on a gluten-free diet into early adult life.—I am, etc.,

George Komrower.

Manchester 20.

Cystic Degeneration

Sir,—I have read with interest the two papers (October 15, pp. 847 and 849) on cystic degeneration of the popliteal artery. It surprises me that no one has drawn attention to the similarity between this lesion and the condition which is variously described as cystic or myxomatous degeneration or ganglion of the lateral politeal nerve. The latter condition has been well described in recent years by Brooks,[1] Clark,[2] and Parkes.[3] It consists of a swelling in the lateral popliteal nerve which at operation is found to be cystic and filled with a glairy, jelly-like fluid similar to that which is present in a simple ganglion. The pathological findings in the published cases of cystic degeneration of the popliteal artery and in the single case of which I have personal knowledge resemble closely those which are found in the nerve lesion, and this raises the question as to whether the two conditions might not have a common aetiology. Parkes[3] has provided convincing evidence that the cystic swelling on the lateral popliteal nerve is related to the superior tibio-fibular joint; a communication between the so-called "ganglion" in the nerve and this joint can always be found if it is sought for, and ligation of this communication is sufficient to effect a cure. If the communication is not dealt with the lesion recurs.

I write this letter in the hope that anyone who encounters a case of this rare arterial lesion will consider this possibility and look carefully for any communication between the cystic lesion in the popliteal artery and a nearby joint—probably the back of the knee-joint. A point which is against this hypothesis is that, while "ganglia" have occasionally been described in nerves other than the lateral popliteal nerve, so far as I am aware the lesion has not been described in the internal popliteal nerve as it runs behind the knee-joint.—I am, etc.,

R. L. Richards.

Western Infirmary, Glasgow W.1.

References

1 Brooks, D. M., *J. Bone Jt Surg.*, 1952, 34B, 391.
2 Clark, K., ibid., 1961, 43B, 778.
3 Parkes, A., ibid., 1961, 43B, 784.

Postgraduate Training in Obstetrics

Sir,—I am not an obstetrician, but I wonder whether Dr. M. J. Ball (September 28, p. 806) has not himself missed some of the points, in his letter criticizing general-practitioner obstetric training?

If the practitioner's surgery is not the place for antenatal history taking and examination, this is not to say that no general practitioners are competent to undertake these exercises; rather, that proper clinic accommodation and facilities should be a requirement and should be provided for all those on the obstetric list, as in some places they already are.

If the majority of clinical decisions resulting in maternal deaths are made by general practitioners, how much the more should we applaud the Chelmsford scheme (Dr. David B. Brown, September 7, p. 597), and seek to extend it. There should be no grounds for Dr. Ball's assumption that the two-week attachment is the practitioner's single training experience. It can be repeated (Dr. J. A. Richards and others, October 6, p. 868), and ought to be; it is to be hoped that many regional hospital departments will extend their postgraduate teaching on something like these lines, to make this generally possible. It ought to be additional to previous obstetric experience as S.H.O. or registrar, and among the younger doctors it commonly is.

Finally, on the issue of domiciliary *versus* hospital midwifery, do not Dr. Ball's remarks confuse the issue? If more maternity beds are provided, will they all be in consultant departments? Is it not likely (and to be hoped) that many of them will be in general-practitioner maternity units? How is the continuing obstetric education of the practitioner to be provided, to fit him and keep him fit for his work in these units, if not by such schemes as those at Chelmsford or elaborations of them?

Mr. Brown's reference to continuity is important. The teaching activity of the unit should be a continuing and normal, not an intermittent and exceptional, one if the practitioners are to benefit fully during their short attachments without disruption of the department's clinical routine.

The relevance of the Chelmsford ideas to disciplines other than obstetrics should certainly be explored, for the educational value of even short residential attachments must be potentially greater than that of intensive lecture-demonstration courses. Here is one more example of the need to increase the residential accommodation at our hospitals.—I am, etc.,

Oxford. A. W. Williams.

Sir,—If a recent attender at the Chelmsford course may reply to Dr. M. J. Ball (September 28, p. 806), it should be stated that Mr. David Brown is not a defender of home confinements but rather of general-practitioner maternity units working in close liaison with a consultant and specialist unit. Dr. Ball would be impressed by a visit, for instance, to the G.P. Unit at Maldon, Essex, where there is statistical evidence of excellent work.

Dr. Ball also attacks the practice of antenatal care in the surgery. I think that this criticism is by itself of small importance. All progressive general practitioners allocate a special time for antenatal clinics, and this practice is fast becoming the rule.—I am, etc.,

Hereford. William G. Dawson.

Infectious Disease in London

Sir,—Miss Iris Busby's special article (September 21, p. 737) on the need for infectious diseases beds in a London area raises the question as to the wisdom of the policy projected in the Hospital Plan. In this it is envisaged that the Western Hospital (209 beds), to which she refers, will be closed by 1975. Cases of infectious disease from the West London boroughs will then have to seek accommodation either in fever hospitals much further afield or in a few isolation beds in the local general hospitals. The assumption appears to be that as fevers have substantially diminished in quantity and severity there is little if any demand for fever hospitals.

It is insufficiently appreciated that in an area such as this there are many visitors, students, nurses, and temporary residents with infectious conditions living in hotels, hostels, colleges, clubs, nurses' homes, boarding-houses, and bed-sitters, in which there are no friends or relatives available to look after them and in which they cannot be left or isolated. There are also those living in overcrowded and over-occupied houses in multiple occupation, where isolation and treatment are impos-