Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Old People in the Cold

SIR,—With the onset of winter there is an urgent need to remind ourselves of the effects of cold on old people, and their need for better nutrition, summarized in your leading article of January 26 (p. 203) and subsequent letters and surveys.

Drs. J. A. P. Trafford and A. Hopkins[1] stated hypothermia to be a common condition of elderly people. There are records of eight deaths in 14 cases.[1,2] The West London coroner is reported to have said, "Many of our old people died last winter because they lacked the means to obtain the warmth necessary to survive."[3] Are all who care for the elderly, district nurses, social workers, doctors, sufficiently aware of the need to prevent hypothermia or suspect it early enough?

Low-reading mouth thermometers were difficult to obtain last winter. They should be in general use. Are supplies available? Most cases of hypothermia are missed because ordinary clinical thermometers in general use do not record the condition. Last winter I recorded room temperatures of old people's bedrooms with a minimum air thermometer. The air temperature of those without continuous heat during the night was an average of 3° F. (1.7° C.) above the outside air. Bedroom temperatures of 7° F. (−13.9° C.) were recorded (25° F. of frost). These old people had no money for heating after early evening.

A recent Ministry of Labour *Family Expenditure Survey*[4] gives the average expenditure of an old-age pensioner on £4 weekly, living alone, as 32s. 4d. a week or 4s. 7½d. daily on food. Last winter I found expenditure on food to be below 4s. daily with some old people, as they spent everything available on heating.

Surveys of old people in Britain record protein and vitamin deficiencies following years of poor feeding.[5,6] My own observations[7] show the frequency of anaemia and tongue and mouth conditions characteristic of the deficiency of the B group of vitamins. Many old people obviously cannot afford enough protein and fruit and vegetables. There are no national figures available of the extent of these problems in Britain, but the evidence shows that hypothermia and undernutrition of the elderly are not uncommon but often unrecognized. Recently hypothermia in African children has been related to protein deficiency and malnutrition.[8]

As we as a profession are more aware of these problems than others, I suggest we should ask the Ministry of Health to initiate and co-ordinate detailed research into the needs of old people for food, warmth, housing, and amenities *immediately* this winter.

As *emergency* measures, until the results of this research are available, I suggest that an extra allowance for winter heating (the equivalent of a hundredweight (50.8 kg.) of coal as a minimum weekly) be given to all old-age pensioners. And also as an attempt to remedy undernutrition one pint (0.6 litre) of free milk be given to all old-age pensioners.

Finally, low-reading thermometers should be made available to all who have the elderly in their medical care, with a statement on the dangers of hypothermia and undernutrition.—I am, etc.,

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Teaching in Regional Hospitals

SIR,—The useful discussion between Messrs. O. Gayer Morgan (September 21, p. 743), I. A. Tumarkin (November 23, p. 1340), and R. G. Macbeth (November 2, p. 1127) upon the aim and content of the F.R.C.S. examination ought to remind us that before examination we must teach and educate. Recent letters should not allow us to forget that the examiners may have a teaching hospital background, while those of us who have to train some of the candidates are not in such a fortunate position.

Teaching and the provision of suitable experience is important in the peripheral non-teaching hospitals, where 75% of the National Health Service work is carried out. It is increasingly difficult to attract the right sort of man, for many of them realize that study for an academic examination is impossible in a department with a heavy load of routine work. With the clearance of long waiting-lists, filling them again rapidly from out-patient clinics, a fair burden of emergency work, and a staff–patient ratio below that of the teaching hospital, the keen edge of ambition may be replaced by frustration, and the clinically experienced but academically unproved registrar takes himself abroad. He cannot walk over to a physiology laboratory in the afternoon or spend a couple of hours each day in the dissecting-room when the nearest medical school is 50 miles away, and the Inland Revenue Department decrees that such travelling expenses, even if he could afford the time, would be a capital expenditure. At the age of 28 or 30 he will have done more clinical work than his colleague in a teaching hospital who has just passed the primary F.R.C.S., but he cannot obtain a senior registrar appointment since this examination is a prerequisite for such posts, which are increasingly restricted to teaching centres.

It is essential that higher qualifications should be seen to be of a high standard, and the thoughtful and responsible would not have it otherwise. The implication is that the N.H.S. must provide better opportunities for training registrars in peripheral hospitals. They should be granted realistic periods of study leave of up to six months within a three-year contract, their jobs held open, and all expenses paid for approved courses of full-time study. The problem of locums will have to be met, but there must be enough far-sighted seniors in our profession who could cope with this situation in some way or another. Administrative arrangements must be made to help this hard-working group maintain their loyalty to the hospital service and to ensure a succession of competent men for the future.

Before the last war salaries in teaching hospitals were less than those at the periphery, but this should be the day of fringe benefits to even the score and lessen the gap. There will be inevitable bureaucratic objections, but in an experimental and scientific age, such as we claim this to be, these objections must be overcome. The N.H.S. is now a big nationalized industry and should follow the lead of the Coal Board, British Railways, the armed Services, and other public undertakings by investing money in its staff. Local authorities send their assistant medical officers on courses for the D.P.H., and nursing and administrative staff are given opportunities and expenses for full-time study. Education at all levels and proper use of our national manpower is the one means by which this country can survive, and the N.H.S., being a large and important functional element of our national life, can no longer afford to ignore the training of its medical staff, nor to cling to recruitment methods that were successful 30 years ago under a different socio-economic system.—I am, etc.,

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Rheumatoid Oto-arthritis?

SIR,—A female out-patient aged 54 was seen recently who had suffered with rheumatoid arthritis for nine years. The onset of this disease had been acute and severe, but there had been several long periods of clinical remission subsequently. She had, however, gradually become almost chairbound. This patient informed me that during her last two "flare-ups" of pain and peripheral joint swelling she had suffered also with partial deafness.

This had lasted until the acute arthritic process died down, when her hearing reverted to normal. Another patient, hearing of this, reported that her experience had been similar; and I was able to observe her during an exacerbation of her arthritis. Her deafness was of conductive type, and there was no familial history or evidence of middle ear infection, past or present; nor was there any excess of cerumen. The ear-drums were normal in appearance, and the Eustachian tubes patent. Rinne's test was reported negative, and "air conduction much diminished."

Subsequently I questioned many patients, and so found a third case in whom an active phase of rheumatoid arthritis was associated with temporarily impaired hearing, and in this case with the addition of tinnitus; her deafness was also of conductive type. All aural clinical findings again proved normal. She said that she could hear more clearly in a room full of people or when travelling in a car, and also that children's voices were more audible than those of adults. Deafness disappeared rapidly after the institution of steroid therapy, as did the inflammatory signs and symptoms of her poly-arthritis.

It is suggested that the temporary interference with the transmission of sound impulses from the ear-drum to the auditory nerve in these patients was due to impairment of the articular movements of the chain of small movable bones which normally transmit these vibrations to the inner ear. The handle of the malleolus is attached to the inner surface of the tympanic membrane, and the joint between this bone and the body of the incus, and the articulation joining the latter and the stapes, are both of diarthrodial type with a synovial capsule. They presumably contain synovial fluid, as do joints of this type elsewhere. If for any reason movements of the joints in this ossicular chain become impaired, vibrations can no longer be conducted from the ear-drum to the inner ear and auditory nerve, and deafness of conductive type results; although sounds can still be transmitted normally through the bone direct to the cochlea, which remains unaffected.

The usual known causes of interference with mobility of the ossicular chain are obstruction or infection in the middle ear or Eustachian tubes; and also the poorly understood condition of otosclerosis, in the course of which the footplate of the stapes becomes ankylosed. This, however, results in permanent deafness, which is progressive and unremitting. It is suggested that deafness in the cases described may be due to the active rheumatoid process involving the synovial cavities of the small interossicular joints, and so producing a temporary defect in the mechanism whereby sound is conducted from the air to the inner ear. Such an association may prove to be of comparatively common occurrence. Audiographic studies during and after acute exacerbations of arthritis associated with deafness would be of interest, and will be included in any further studies made.

My thanks are due to my colleague Mr. Kenneth Rotter, F.R.C.S., who assisted me with this report, and who tells me that he can find no reference to the association of deafness with rheumatoid arthritis in oto-rhinological literature.

—I am, etc.,

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Thalidomide Neuropathy

SIR,—I have previously corresponded with you about the neuropathy associated with thalidomide. All who have seen this condition will agree that there is a typical clinical picture which has been well described by Fullerton and Kremer.[1]

I have made some suggestions about its possible nature.[2,3] With the withdrawal of the drug it seemed unlikely that more would be learned about this interesting toxic neuropathy. I now write to place on record that it appears to have a quite unusual natural history which I have not experienced in other toxic neuropathies. During the last year I have been seeing patients who have had symptoms and signs of thalidomide neuropathy since the drug was withdrawn from the market, but who have continued to deteriorate. To-day I have seen a typical case which certainly developed at least a year after the patient had discontinued the use of "distaval" as a night hypnotic. I would be interested to know if others have had a similar experience.—I am, etc.,

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Psoriasis and Arthritis

SIR,—We are surprised that Dr. M. H. Pappworth (November 16, p. 1267) is unaware that in psoriatic arthritis the joint disease may precede the psoriasis. In the largest series published in this country,[1] 27 of 118 cases presented in this way and other authors have made similar observations.[2,3] In our own published series[4] of 53 cases the arthritis preceded the psoriasis in seven.

Dr. Pappworth then says that we "proceed to label some patients as psoriaform (*sic*) arthritis" because they had negative Rose-Waaler tests and a family history of psoriasis in addition to "arthritis of the hands." Our description of their arthritis was in fact more precise than this, as in each case we pointed out clinical and radiological features previously described in psoriatic arthritis. In the case we classified as "definite psoriatic arthritis" there was a characteristic erosive arthritis in the hands confined to the terminal interphalangeal joints.

Dr. Pappworth's reluctance to follow our argument seems to arise from his failure to realize that a proportion of patients with seronegative arthritis turn out to have conditions other than rheumatoid arthritis. For example, 11 of 61 cases of seronegative "rheumatoid arthritis" followed up by Dixon[5] over an average of 5.4 years proved to have some other condition.—We are, etc.,

London. H. BAKER.
Newcastle upon Tyne. D. N. GOLDING.
M. THOMPSON.

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Oral Neomycin and Anaesthesia

SIR,—We were interested in the Medical Memorandum by Dr. E. D. T. Ross and others (November 2, p. 1109) reporting a case in which they thought that oral neomycin might have given rise to difficulty in reversal of curarization. Earlier this year we had similar trouble with two patients suffering from subtotal obstruction of the large bowel to whom 8 g. of neomycin had been given by mouth during the two days of pre-operative preparation.

Case 1.—A man of 64, otherwise in good health, had suffered from intestinal obstruction for one week prior to operation. The obstruction had been partially relieved by enemata, but some intestinal distension remained. There had been no vomiting, and there was no disturbance of serum electrolytes. Premedication and induction of anaesthesia were according to generally accepted principles: papaveretum, mg. 15, hyoscine, mg. 0.3; thiopentone, mg. 200, and succinyl choline for intubation, mg. 35. When respiration was fully re-established, D-tubocurarine chloride, mg. 25, was given and intermittent positive pressure respiration (I.P.P.R.) commenced with 75% N_2O/O_2. The operation of colonic resection for carcinoma took slightly over four hours, during which supplements of curare were given as judged necessary according to marked diaphragmatic action and muscle tone. A total of 60 mg. curare was administered. During this period the patient received no other drugs, but 2 pints (1.1 litres) of blood and one of plasma (0.6 litre) were given. After the operation, reversal of curarization was obviously incomplete after atropine, mg. 2, and neostigmine, mg. 5, in divided doses. Edrophonium ("tensilon"), mg. 10, had only slight effect. I.P.P.R. was therefore continued for a further hour. Subsequently atropine, mg. 0.6, and neostigmine, mg. 1.25, were given with some effect. Calcium gluconate, 1 g., caused a further marked improvement. A few minutes later atropine, mg. 1.2, and neostigmine, mg. 2.5, were given and the respiratory activity was thereafter satisfactory by clinical signs. The mixed venous P_{CO_2} (estimated by the rebreathing method) remained at 46 mm. Hg