Hull measles immunization pilot scheme it was decided to use live measles vaccine, a single injection of 0.5 ml. of Mevelin-L being given to each child. Being a little chary of possible side-effects it was decided to offer immunization only to children over two years of age.

The proposal was given wide publicity through the schools and health clinics, and parents of children over two who had not had measles were asked to sign a form giving their consent to their children being immunized. Altogether the names of 258 such children were obtained.

On the afternoon of 9 December, at the central surgery, with the help of our secretarial and receptionist staff doing the paper work, and two district nurses and the health visitor marshalling the children and parents, and preparing the injections, in the space of an hour 243 children were injected, those with coughs, colds, etc., being told to return when fit. The final figure of the number immunized was 254.

Of all those children injected with live measles vaccine no child developed any side-effect which its parent deemed of sufficient importance to call a doctor.

From 9 December 1966 to 31 May 1967 when there was a moderate outbreak of measles in the area surrounding the practice, in this practice there were nine cases of measles, none of whom had been immunized against measles, giving an incidence of 1.08 per thousand. In the practice which adjoins the greater part of the periphery of this practice during the same period there was an incidence of measles of 10.24 per thousand. It seems reasonable that a figure in this region could have been expected in this practice had not immunization been carried out. The rate of 10.24 per thousand would have meant that this practice could have expected 85 cases of measles, so that immunization probably saved this practice in the region of 76 cases of measles this spring.

From the point of view of the health of the children and also sparing them possible complications from measles, the saving in the loss of school hours and the saving of doctors' time at a busy period of the year, this experiment has been thoroughly worth while.

I would like to thank my partners, Dr A. G. N. Calder and Dr J. E. S. Walker for their help, and Dr R. Andrews for information regarding his practice.

Hornsea. G. ASHFORTH.

Mis-use of words

Sir,

From time immemorial clear thought in medicine has been impeded by the misuse of words; as witness all the '—algias' and '—dynias' of yester-year. Give a thing a name, and you understand it.

In a different way we are presently faced with another example of this misuse—I refer to the new connotation given to the word 'epidemiology'. Dr J. Simpson in his excellent article (*J. roy. Coll. gen. Practit.*, 1967,

14, 5) gives a definition of his subject: which definition is an almost exact paraphrase of that given by the Oxford Dictionary—for endemiology. And this, of course, is what we mean. Lung-cancer, accidents, mental disease, coronary artery disease, pernicious anaemia etc., are always endemic and frequently pandemic, but never, by definition, epidemic.

Endemics may wax or wane, certainly, but if words mean anything at all, an endemic can never become an epidemic. It may reach 'epidemic proportions', but it is still an endemic writ large.

Is it too late to give this subject its correct name?

Cheltenham. J. MILES.

Getting to know the patient

Sir,

Surely the real specialist in early diagnosis in *that particular family* is usually the mother. Your editorials of July are too modest both about the tremendous effort needed to stem any tide of opinion, and about how the College has met this challenge with so few men and resources. But hardly so far has there been time for younger members, often still associates, to improve the business efficiency in the practices they join. A strong lead is now needed from the publications of the College on how best to get to know the patients on first joining the practice, and then, continually, how best to get to know new and old ones better. This subject covers the whole field of communication, both between doctors themselves, doctors and patients, and even between members of the community, whether ill or not, on health matters.

The best example of the problem to be faced is the patient's record folder. When will we get down to sorting this out?

St. Albans. M. J. JAMESON.

Coloured tags on record cards for important diseases

Sir,

In this practice we are following your recommendations of colour tagging important diseases, but find that locally we need extra tags as there is a lot of chest disease here. We therefore are tagging this (and "other heart disease") on the left hand side of the card. We use a brown tag for bronchitis and blue (as you suggest on the right for hypertension) for any other heart condition. We adopted this for our own convenience, and use the right-hand side for your (we hope country-wide) recommendations.

Hull. DAVID FULLERTON.