of each partner or assistant such as qualification dates, appointments, courses and dates of attendance, articles written, etc. Changes in partnership shares, holidays, illnesses, etc.

Income tax. Including accountant's letters. Receipts for tax.

Income. Executive council pay-slips and statements. Payments received from insurance examinations, private patients, appointments.

Cheque books and stubs. Pay-in bank book; bank statements.

Bank safe. It is a good idea to deposit with the practice bank, a small steel deed-box containing a copy of the partnership agreement, title deeds of any practice property, old accountant's balance sheets. A list of the contents is kept in the surgery safe, along with a list of contents in safe-keeping.

D.D.A. book along with any loose D.D.A. drugs in a small locked cupboard.

The secretary should also keep up-to-date:

A cash float from which to pay petty accounts, cleaner, stamps, tea and sugar.

Stamp book with stamps and an account of cost.

Phone book in which to record date and origin of outgoing trunk phone calls.

Appointments register. Doctors' duty roster.

Stationery supplies of all kinds including NHS forms; and ball-pen refills.

P.A.Y.E. literature and forms for each employee in personal envelopes.

Correspondence

Each outgoing letter should have a carbon copy, and a simple reference system is necessary. This need only be made up from (1) the abbreviation for the subject file, i.e. LEG for legal, EC for executive council, INS for insurance and so on; (2) a number representing the previous letter in that file plus one, i.e.; 4 indicates that there are three letters in the file already; (3) the last two figures of the year, i.e. 67. Thus the outgoing letter reference would read LEG/4/67; the next letter would be LEG/5/67 and so on.

Finally, as many doctors already appreciate, a tape-recorder can be of the greatest use to both doctor and secretary.

CLINICAL NOTE

MERALGIA PARAESTHESIA

A report of three cases in general practice

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Symptoms referrable to the lateral cutaneous nerve of the thigh constitute a disorder called meralgia paraesthesia which was first classified by Roth in 1895. Cases have been reported since then and numerous reviews of the literature have been published. Recurrent minor trauma in men,

and pregnancy in women are the usual precipitating factors (Price's *Textbook of Medicine*). Unusual factors which have been reported include typhoid fever (Cohen 1941), trichinosis (Cohen 1946) and tuberculosis (Graziosi 1936). It has been reported following pelvic surgery (Schneiderman and Bomze 1967), and as a sequel to typhus fever (Weismann-Netter 1946).

Symptoms are usually unilateral and middle-aged men are affected more often than women (Martin and Elkington 1956). Bilateral cases have been recorded by Ecker and Woltman (1938) who reported 32 in a series of 150 cases, an incidence of 22 per cent. A bilateral case was also reported by Weismann-Netter (1946).

Four cases occurring in an average size practice gives an unusual local concentration. An incidence of over 1:1,000, with one bilateral case, may obey mathematical laws of chance, but is none the less remarkable and justifies reporting.

Case 1. Male, B.S.P., aged 44—June 1966. Symptoms intermittent for three years. Right side only affected. Pain and hyperaesthesia dominant symptoms. No precipitating factors, though driving posture considered a possible one. An unrelated general limitation of flexion of the spine present since early childhood. The patient has since changed his car and though amelioration has occurred driving posture cannot be definitely established as a cause.

Case 2. Male, M.T.W.R., aged 45—May 1967. Presented complaining of pain, numbness, and tingling in the right side. Symptoms had been intermittent in this side for about a year. Patient then stated that the left side was usually worse and had started some months before the right side. On questioning he thought that fishing in thigh-length waders probably induced attacks.

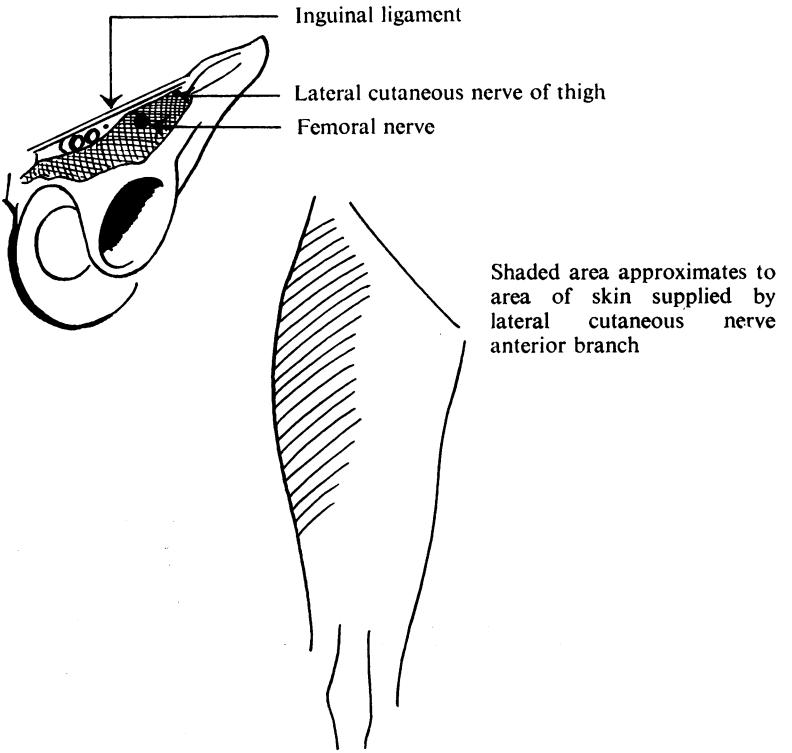
Case 3. Female, J.E.D., aged 41. Symptoms had started a year previously when the patient resided in Rhodesia. Attacks were very severe but of short duration, five to ten days. This patient was rather obese and 'flabby'. Pressure over the lateral end of Poupart's ligament caused severe pain, felt both locally and in the area of the skin supplied by the nerve. An explanation of the nature of the disease gave the patient a feeling of relief. She had obviously been suffering a considerable overlay of anxiety.

Case 4. Female, J.E.K., aged 51. Wife of a publican—June 1967—complained of severe pain for three days. Associated with numbness and stabbing pain in the distribution of the R. lateral nerve of the thigh. Admitted to two or three slight attacks over the last year. This patient has been slimming, and has lost over a stone in weight in two months.

The lateral cutaneous nerve of the thigh is a branch of the lumbar plexus L. ii and L. iii. It passes into the thigh either through the substance of, or deep to the lateral end of the inguinal ligament, divides into two branches, a small posterior and a large anterior. The posterior branch supplies the proximal part of the lateral side of the thigh, and also the skin of the lateral and inferior part of the gluteal region. The anterior branch traverses the fascia lata at a more distal level and supplies the skin on the fibular side of the thigh extending distally as far as the knee (Buchanan's *Manual of Autonomy* pp. 553–554). It passes anterior to the sartorius muscle.

Resection of the nerve as it penetrates Poupart's ligament, or other surgical measures, are occasionally required, though advice on posture,

dietary habits, with analgesics for acute attacks, appears to be all that is needed in the majority of cases.



The incidence of the disease in the general population is low. Not one was encountered amongst 13 cases of 'neuritis' in a comprehensive survey covering one year in general practice (Davies 1958). It probably masquerades under neurological disease in other surveys. Fry does not mention it specifically (Fry 1957). It is unlikely to remain undiagnosed, as the symptoms are such that the patient would demand attention. In some respects it resembles the scalene syndrome, though as this nerve is sensory only, no motor involvement occurs. In view of the 'anatomical' factor it is interesting that it is a relatively uncommon disease.

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MEDICAL NEWS

DONCASTER POSTGRADUATE MEDICAL TEACHING CENTRE

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THE FORMAL OPENING OF THE Doncaster Postgraduate Medical Teaching Centre took place on Saturday 16 March 1968. The three guest speakers were Sir George Godber, chief medical officer to the Ministry of Health, Dame Annis Gillie, past president of the Royal College of General Practitioners and Mr W. J. Lytle, postgraduate dean, University of Sheffield. In the evening an inaugural dinner was held when the postgraduate Medical Teaching Centre was handed over by Mr S. T. Firth, J.P. chairman of the hospital management committee to the chairman of the Doncaster Postgraduate Medical Federation, Mr A. J. Sinclair.

The centre was built and equipped out of exchequer funds for the furtherance of postgraduate education in the area and the authority for its running has been vested in the Doncaster Postgraduate Medical Federation. The Federation Committee consists of seven members of the hospital medical staff and seven doctors appointed by various medical bodies outside the hospital, four of whom are general practitioners, plus one dentist appointed by the Doncaster Dental Society. The committee is responsible for the promotion of postgraduate education and social communication among all medically and dentally qualified persons in Doncaster and district as well as the management of the premises. The hospital management committee for their part are responsible for the care and maintenance of the building including heating, lighting, telephone services, cleaning, catering services at cost, the appointment of a full-time secretary and the cost of stationery and postage. In addition, the hospital treasurer acts as banker and accountant to the Federation.

The premises are an integral part of the Doncaster Royal Infirmary. The large entrance foyer has the servery on one side and the dispense bar on the other. Easy chairs, tables and a plush carpet provide a congenial