Twelve (eight per cent) were addicts, 17 (13 per cent) had organic illnesses, five (four per cent) had reactive depressions, and 12 (eight per cent) suffered from endogenous depression. This left 101 (69 per cent) whose symptoms were simply a cry for help—the famous *cri de coeur* of the hysteric. It looks as if the hysteric is as up to date as the schizophrenic—no paralyses for him, but a great deal of depression and anxiety. Of these 47 (32 per cent) have marriage and sex problems, 29 (20 per cent) can't cope with modern life, and 26 (17 per cent) are simply selfish.

We were a little shattered to find that marriage has more to answer for than any other reason, thus confirming the truism that interpersonal relationships remain the most important element in people's lives. We may therefore conclude that the novelist still has a major role to play in our modern world in holding up the mirror to life!

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Sir,

We find the classification of disease as described and used by Dr W. E. Dobson-Smyth (December *Journal*) interesting and practical and we intend to use the classification in our practice. We would take issue with him, however, over his criteria for diagnosis. To require specialist aid in some of the categories described is quite unnecessary, but in other ways our faith in general practice is restored. We are allowed to diagnose, totally unaided, when a patient has lost a limb or an eye!

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Reference

Dobson-Smyth, W. E. (1976). *Journal of the Royal College of General Practitioners,* **26,** 934-937.

ERRORS IN THE MORBIDITY STUDY

Sir,

Dr M. J. Jameson recently commented on the use of patient identity as a "denominator of general research" (November *Journal*) and quoted a range of 1-20 per cent as the non-match rate from the practices in the National Morbidity Study (NMS) 1971. We should like to point out that, taken out of context, these figures are rather misleading. The 1-20 per cent range related to the number of episodes (or parts of episodes) of illness for which a suitable identity could not be found in the practice register at a fairly early stage in the final processing cycle.

When the study files were complete, the distribution of non-matched people was as follows:

Percentage of non-matched people	*Number of practices*
0-	8
1-	25
2-	17
3-	6
4-	3
5-	—
6-	—
7-	1
8-	—
9-	—
10+	—
Total	60

These non-matches included a small number of temporary or private patients who should not have been included in the study and were therefore quite properly not matched in the register of NHS identities. This was particularly appropriate in the practice with the highest proportion.

The problems of linking the morbidity records to the practice registers in the NMS, using three letters of surname, initial, date of birth, and sex of the patient as the identifier, were fully detailed in the report but it may be helpful to emphasize two major sources of difficulty:

1. Transcription errors were possible at three different stages: from the MREs to the practice register cards, from the MREs to the diagnostic index sheets, and from the source documents to the computer input.

2. For new patients the participants were required to record morbidity and complete a register card from the time that the patient indicated his intention of joining the doctor's NHS list, even though this anticipated formal documentation and the receipt of the MRE from the Executive Council. Occasionally morbidity data were processed before receipt of the corresponding registration record.

Despite these problems over 80 per cent of the practices had rates of non-matching below three per cent and only one practice was above five per cent, and some of these were properly excluded as being the result of over zealous morbidity recording.

The method of calculating the population denominator from the data in the practice registers is described in the report in the chapter entitled "Some Statistical Considerations".

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References

Department of Health and Social Security, Office of Population Censuses and Surveys, and the Royal College of General Practitioners (1974). *Morbidity Statistics from General Practice (1970-71).* London: HMSO.

Jameson, M. (1976). *Journal of the Royal College of General Practitioners,* **26,** 843.

AN AID TO THE TREATMENT OF STASIS ULCERS

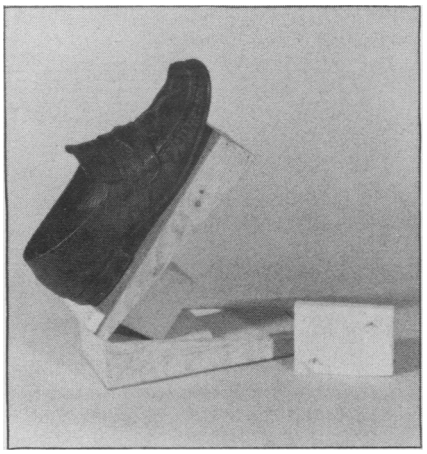
Sir,

When I was a clinical assistant in dermatology my chief would bet me one pound that he could heal any stasis ulcer in three months. I can recall his losing only once: his recipe for success was active movement of the ankle.

Stasis ulcers—erstwhile varicose ulcers—occur in the 'spat' area, the lower third of the leg above the ankle. They are one of the commonest and most chronic of skin problems that present in general practice. With proper and energetic treatment the majority can be healed, which is very rewarding to both patient and doctor. The cause of the skin breakdown is stasis and oedema. Treatment is by pressure either by elastic stockings or by adequate elastic bandages properly applied, perhaps with the additional pressure of a sponge rubber pad. The choice of dressing is a matter of personal preference and relatively unimportant.

Exercise materially assists in dispersing both oedema and induration. In addition, it re-educates the patient's lower leg muscles. I used to exhort my patients to spend some time each day either playing the foot pedals of a harmonium or the old-fashioned treadle sewing machine. Those who did improved so rapidly that it was apparent that a simple ankle exerciser was desirable, and so the present apparatus was born, as shown.

It consists basically of two pieces of wood, hinged at one end, with a resistance in between to increase or decrease the pressure necessary to pedal. The simplest resistance has been found to be a cube of foam rubber, with an arrangement of steps of wood to vary the load.



It has been found that even the most immobile of patients can use the pedal for a set time, say half an hour, twice daily, gradually increasing the load. This simple exerciser actually shortens the time taken to heal even the most stubborn ulcer.

I am indebted to the Isle of Wight Branch of the Rehabilitation Engineering Movement Advisory Panel (REMAP) for producing this apparatus. It can be made simply and cheaply, and I recommend your readers to apply to their local branch of REMAP to help.

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RUBELLA IMMUNIZATION

Sir,

I feel I must comment on the article on rubella immunization and contraception (November *Journal*).

Whilst I am sure that Drs Rose and Mole had the best of intentions, I feel that the conclusions they come to are based on too small a sample to have much significance, and their study design has some defects. However, there are lessons to be learned from what they did.

In their article they state that "a total of 70 women had to be interviewed in order to obtain these 50 results". This is very misleading as in fact when they offered the venepunctures at the surgery they had only one refusal out of 45. Thus the first 18 drop-outs were presumably due to the inconvenience of having to go to the laboratory rather than reluctance to have blood taken.

After explaining the problem of rubella in pregnancy and taking a blood sample, they let up to two months elapse before attempting to notify seronegative women that they needed immunization. With so great a lapse in time it is little wonder that enthusiasm waned and the response rate was so poor. The patients should have been notified with a prescription and an appointment as soon as the negative result was obtained which, in our experience, is about ten days later. Perhaps this explains why only one in three of those needing immunization returned (though one other claims she was vaccinated elsewhere).

On this evidence of poor patient cooperation they put forward a case for vaccinating all adult women without prior screening. This surely is not only unethical but potentially dangerous. Despite strict instructions to avoid pregnancy for two months following vaccination, it has been known for women to become pregnant during this time. If we do not know their pre-existing immune status, testing for antibody levels in early pregnancy introduces a delay before a decision can be taken, and as it is not always possible to guarantee that the result is 100 per cent reliable, to err on the side of caution, a perfectly healthy fetus may be unnecessarily aborted. All in all I feel there has been insufficient evidence to condemn the whole scheme of checking for immunity and I would disagree strongly with their conclusions as to the possibility of this scheme.

We have carried out a similar scheme in our own practice where we took blood samples from about 280 patients and found only two subjects who were unwilling to have blood taken. Of those tested, we found about 20 per cent to be seronegative and, of these, 80 per cent were in fact vaccinated. Furthermore, 80 per cent of those vaccinated have even returned for a second sample of blood to be taken so that we could assess the effectiveness of the vaccine.

Our findings are currently being statistically analyzed and we hope to publish them in the near future. I think they will confirm the policy of the DHSS, that this is a very feasible way of lessening the number of people in our communities who are susceptible to having a child congenitally deformed by rubella.

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Reference

Rose, A. J. & Mole, K. F. (1976). *Journal of the Royal College of General Practitioners,* **26,** 817-821.

SOCIAL WORKERS IN GENERAL PRACTICE

Sir,

I support Dr Ratoff (November *Journal*) in his statement that social workers see themselves as autonomous and independent professionals and not as medical ancillaries, and that they should work in close liaison with general practitioners. This is logical both from the point of view of having one portal of entry to the medical and social services and because medical and social problems are so often interrelated.

The principles put forward in Dr Paine's paper (September *Journal*) are also worthy of support in that there may be a reservoir of persons who cannot undertake full-time work with a social services department and would prefer part-time work of the type he described. It is, however, important to ensure that the patient's access to the social worker is not confined to referral by the general practitioner; patients should be encouraged to make their own approach independently of the general practitioner. In addition, there will undoubtedly be occasions when the general practitioner refers a patient to a social worker.

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References

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A MATHEMATICAL APPROACH TO EPIDEMIC CONTROL

Sir,

The paper by Dr Damms and his colleagues (December *Journal*) is most encouraging and should stimulate discussion and further work on an important and difficult subject. May I start the ball of friendly criticism rolling by voicing one or two dubieties:

1. The model depends (apparently) on the epidemic appearing in "waves occurring at fixed intervals". The corrected numbers in Figure B are said to show nine waves. There appear to be only seven or possibly eight in the figure although the uncorrected numbers show nine waves. If the model is so wave-dependent there is a more important criticism. The dates are said to be the days of doctor/patient contacts (except for the averaging of Sunday and Monday). It has been our experience that contact with influenza patients