were seriously to gain ground in the next 20 years!

S. L. HENDERSON SMITH
Portland House
Lindley
Huddersfield
W. Yorks.

DEEP VEIN THROMBOSIS AFTER AIR TRAVEL

Sir,
I was interested in the letter in the January *Journal* (p. 57) from Drs Dove, Capra, and Mitchell-Heggs. I have knowledge of only two cases of deep vein thrombosis after air travel and this stretches over a period of some 23 years.

The first case was a 44-year-old captain who sustained a deep femoral vein thrombosis after sitting in a very badly designed pilot's seat for six hours. Luckily he was treated in hospital and did not develop a pulmonary embolism.

The second case was a 75-year-old lady who travelled from London to Johannesburg without leaving her seat for the entire 16 hours of the journey. She went on to have a small pulmonary embolism but fortunately survived.

We are conscious of the risk of deep vein thrombosis in airline passengers, particularly when they sit for extremely long periods without moving, and in fact cabin crew are trained to encourage people not to sit for long periods. Passenger seat design over the years has, however, improved enormously and many of the bad features in the older type of seat have now been removed.

I think that airline passengers, particularly the elderly, should be advised to take every opportunity of walking around the airport buildings at refuelling stops and stretching their legs from time to time on the aircraft during flight. The large wide-bodied jet encourages movement of this kind and cabin crews are instructed not to prevent passengers from moving about except, of course, in conditions of turbulence.

F. S. PRESTON
Principal Medical Officer (Air)
British Airways Medical Service
Speedbird House
London (Heathrow) Airport
Hounslow, Middlesex TW6 2JA.

Sir,
Dr Dove and his colleagues (January *Journal,* p. 57) ask for cases of deep vein thrombosis seen after prolonged travel. I remember as a house physician admitting an elderly man who developed a deep vein thrombosis, without embolism, a few days after sitting in the passenger seat of a motor car driven from Cornwall to Ipswich. The journey was made in early autumn and lasted about 12 hours. The consultant physician (Dr J. W. Paulley) felt that it was likely that immobility was the cause of the thrombosis.

S. L. BARLEY
72 Buchanan Road
Sheffield S5 8AL.

GROWTH CHARTS

Sir,
Many general practitioners, especially those who have worked in child welfare clinics and hospital paediatric departments, will be familiar with the growth and development records (percentile charts) prepared by Tanner and Whitehouse, and printed in a set of six (two sexes, three age groups) by Printwell Press. These excellent charts measuring 11 × 8 inches are, however, of an unwieldy size for use with the FP 5/6 record envelopes, which I envisage will be with us for many years yet. I understand the Birmingham Research Unit of the College produces a preschool record card which is indeed comprehensive, but applicable to that age group only, and the percentile chart displayed is for weight alone.

I have discussed with Printwell Press the feasibility of their producing their growth and development charts on unfolded card of suitably reduced size with height on the obverse, and weight on the reverse, dispensing with the material on the front and back pages of the larger card. May I, through the good offices of the *Journal,* conduct some market research and enquire as to whether there might be any demand for such cards? (Surely the general-practitioner paediatrician proposed in the Court Report will find a use for these.) Perhaps any fellow members who feel sufficiently enthusiastic about the matter will write to me direct.

P. HICKMAN
The Surgery
North Curry
Taunton
Somerset.

Reference

Court Committee (1976). *Report on the Child Health Services.* London: HMSO.

RECORDS FOR HOUSEBOUND PATIENTS

Sir,
I am looking for ideas in respect of the medical records of housebound patients and I am wondering if any of your readers can help.

I want to be able to leave the A4 record at the home of a patient so that my partners, assistant, or nursing staff can see what has been going on and make entries in the notes.

The problem is, of course, that it will often be inappropriate for the notes to be read by the patient or a relative. I therefore want to find a suitable container that is cheap, durable, capable of holding an A4 folder up to one inch (2·5 cm) in thickness, and having a locking device which would enable it to be opened by selected staff.

I feel that, in order to be a practical proposition, this container needs to cost less than £1. The specification is probably therefore impossible but I would be grateful for any ideas.

D. J. LLEWELLYN
Riversdale House
Merthyrmawr Road
Bridgend
Glamorgan CF3 3NL.

HOW MANY PATIENTS?

Sir,
Reading the first editorial in the January *Journal* (p. 3) in juxtaposition with John Fry's Mackenzie lecture (p. 9), one could perhaps be forgiven for suspecting that the College supports increasing list sizes.

No real attempt has been made to explain the low and reducing workloads quoted. These figures are contrary to the experience of many others who have increasing workloads of seven items per patient year and more.

A great deal depends on patients' expectations, and therefore upon the attitude of both doctor and patient. If John Fry's 15 per cent incidence of emotional states were in reality 45 per cent, then his workload would automatically be increased by 30 per cent. More important, the doctor deserves the patients he gets. Recognition of emotional states attracts emotional patients. It is possible, therefore, that low workloads will get lighter and high workloads heavier.

The argument is, in fact, about the role of the general practitioner. If the often quoted 'pastoral' responsibility is taken in conjunction with the undoubted intention of the DHSS to reduce hospital inpatient care, then an average list size well below 2,000 is required.

A. D. MANNING
1 and 11 Bacon Lane
Edgware
Middlesex HA8 5AT.