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CORRESPONDENCE

Correspondents are asked to be brief

Five-day Wards in 1974

SIR,—It seems certain that the shortage of nurses is going to continue and will bring about great changes in the pattern of hospital care of patients. Five-day wards reduce the burden on the nursing staff and can make use of nurses who could not work a seven-day week. They also demonstrate that the traditional patterns of hospital care are not fixed and immutable. Five-day wards are particularly suitable where the medical and technical component of hospital care is large and the nursing component small. My hospital has been running a five-day ward for nearly a year and the service has been mainly concerned with patients undergoing cardiac catheterization, coronary angiography, and bronchoscopy, who are admitted for 24-48 hours.

Your leading article (13 April, p. 71) rightly draws attention to the way in which this service can reduce waiting lists and to the very high turnover and work load involved. Our junior medical staff has responded nobly to this challenge, and the major difficulties have arisen on the secretarial side. A full-time ward clerk is an absolute necessity. The work of the medical secretary is also greatly increased by the high volume of work, and a lot of her time is spent filing reports from the pathology and x-ray departments which did not arrive while the patient was in the ward.

It seems quite impossible to put these simple points over to hospital administrators. I would strongly advise any doctor considering a five-day ward not to begin until a full-time ward clerk is established and until there has been a substantial increase in his secretarial staff. I do not consider it improper for a consultant to be involved in the documentation of patients and the filing of reports, but it should not be a substantial charge on his time, as it is on mine.—I am, etc.,

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Gammaglobulin and Congenital Rubella

SIR,—We were pleased to read Dr. Catherine S. Peckham's report (16 February, p. 259) of the benefits to the fetus from the use of immunoglobulin (gammaglobulin) prophylaxis for mothers exposed to rubella during pregnancy. Dr. Peckham found that the incidence of fetal infection (5/26) and congenital defect (1/26) was much decreased in the infants of mothers who were given immunoglobulin at the time of rubella contact and who subsequently had a subclinical rather than a clinical attack of rubella. This was encouraging to those of us who have long wondered whether there was definite evidence that immunoglobulin could be used to modify the effects of maternal rubella on the fetus.

However, when we looked retrospectively through our own case histories we found that there were 22 pregnant women who had been given immunoglobulin during the first trimester at the time of rubella contact. Only 11 subsequently developed clinical rubella, yet all 22 children were infected—indeed, 10 of the 11 children whose mothers had subclinical attacks had multiple rubella defects (the eleventh child is too young for definite assessment). Our group is only small, and selected because the children were mostly considered defective before they came to us. However, if the effect proposed by Dr. Peckham were true, in our 22 cases we would not have expected the numbers of clinical and subclinical maternal infections to be equal; the majority of mothers should have had clinical attacks.

In addition, we know of two cases in which use of immunoglobulin caused marked delay in the mother's serological response so that a correct diagnosis of rubella was not made during pregnancy, and both infants were born with congenital rubella defects.[1] For this reason we have been cautious when using immunoglobulin for rubella prophylaxis during pregnancy.

There may be many reasons why our findings apparently conflict with Dr. Peckham's. However, we agree with her that if gammaglobulin is used the greatest benefit is likely to be obtained if it is of high rubella antibody titre and is administered as soon as possible after contact. Follow-up of such mothers for seroconversion is essential.—We are, etc.,

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1 Forrest, J. M., Honeyman, M. C., and Murphy, A. M., *Medical Journal of Australia*, 1973, **1**, 745.

Cannulation of Internal Jugular Vein

SIR,—I agree with Dr. B. S. Jenkins and his colleagues (27 April, p. 225) that it would be unfortunate if the report of extensive neurological damage after cannulation of the internal jugular vein by Dr. C. E. Briscoe and others (23 February, p. 314) should discourage the use of a valuable technique.