The total of nine cases during the four months October-January is equivalent to an annual incidence of 27 cases per year, or 3.9 times the incidence before the long hot summer of 1976. It indicates that there exists a higher level of poliomyelitis virus in the population than formerly, and as almost all those paralysed were unvaccinated we feel that more cases are likely to occur.

It seems to us important that an attempt should be made to reach the 15·2%, or more, of the population which is said not to receive the vaccine nowadays, a group which may be increased by the current adverse publicity incurred by other vaccines.

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Backache

SIR,—I must respectfully disagree with some of the views expressed by Dr John Mathews (12 February, p 432). General practitioners and hospital doctors in training, for whom presumably this series of articles is designed, will have been misled by some of the statements and omissions.

I wish there could have been more emphasis placed on the commonest form of backache—namely, postural or occupational—and on the fact that less than 10% of backache results from disc prolapse. In my experience these patients usually complain that their backache is worse at rest and eased by exercise. My own backache, for example, responds to vigorous spinal exercises, especially flexion, and is much worse in the recumbent position. Many of these patients, myself included, respond well to rotary manipulation. Generally speaking, it is this type of backache that the osteopath treats so well, but unfortunately they tell their patients that they are replacing their “slipped discs.” Anyone who has observed a protruding or prolapsed disc at the time of surgery will know that such diagnoses are nonsense.

It is unfortunate that these patients are often kept off work for long periods and are told to go to bed. In fact this is the worst possible treatment for them. Almost as bad is to give them a surgical corset. The only useful treatment for this over-used appliance is in elderly patients; it is occasionally useful as a temporary measure in patients with spondylosis or spondyloarthrosis, an important mechanical problem not mentioned in the article. In all other circumstances the corset simply helps to keep the back warm, considerably weakens the back and abdominal musculature, and assists the neurotic man when he has to explain to his wife or employer that he cannot do certain jobs because “I have a bad back.”

No mention was made of the common condition of low lumbar instability secondary to previous disc damage. It is also a pity that weight reduction was not mentioned as an essential part of treatment whatever the cause.

I submit that in an article of this type controversial treatments of unproven value and not without risk—namely, chemonucleolysis and sclerosants—should not have been mentioned. Instead it would have been more useful to extend the section on the forgotten art of history taking.

Finally, sir, may I plead that the totally meaningless neologism “ostearthrosis” (dreamed up by rheumatologists, I believe) should be dropped from the medical literature.

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SIR,—I was pleased to find that Dr John A Mathews (12 February, p 432) gives due importance to the apophyseal joints as a source of backache. He highlights the fact that it is easy to distinguish an apophyseal joint lesion from a minor disc lesion, but his predecessor at St Thomas's (Dr J Cyriax) dismissed the apophyseal joints as unimportant and an insignificant cause of pain. Manipulation when properly applied is an effective measure in many cases of back pain, and, while it is possible that manipulation can have a reducing effect on a small disc herniation, the explanation that is much more likely is that manipulation releases fixation in an apophyseal joint.

If a disc protrusion is ever reduced by manipulation it would inevitably be reproduced as soon as weight-bearing took place again by the sheer mechanics, whereas an apophyseal joint lesion corrected by manipulation would not be so reproduced; and as so many patients obtain immediate and lasting benefit from a simple manipulation, then surely the explanation lies in the apophyseal joint rather than the disc.

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SIR,—It is encouraging to see that backache is at last being taken seriously enough to be the title of a letter in the Lancet. J Mathews (12 February, p 432). His article is an excellent summary of current thought on this subject. I was a little disappointed, however, by his rationale for treatment. I had thought that we had progressed from the idea that all “mechanical” backache was due to a swelling impinging upon dura or nerve root and that all treatment must be directed to “restoring anatomy.”

As one who spends nearly all his time manipulating, I feel that to talk of the rationale for this kind of treatment as being to “coax a bulge back into shape” is a gross oversimplification and misrepresentation. That improvement in the disc contour can occur has been shown by Dr Mathews’s own work, but I would venture to suggest that in most cases it is irrelevant. Aside from this effect, numerous other effects of manipulation have been claimed—for example, modification of the topographical relationship between a disc hernia and nerve root; decreasing compression and shearing stress on the disc; opening of the intervertebral foramen; increase in posterior joint mobility; muscle relaxation; normalisation of proprioceptive impulses; vasomotor and visceral effects; and psychological effects.

To my mind, by concentrating too hard on any one of these effects of manipulation one is missing the most important and perhaps the most obvious: movement. A spinal joint by careful intersegmental movement palpation is found to be locked, and manipulated. It moves. Gradual elimination over a number of sessions of all such locked segments leads to disappearance of backache in the vast majority of cases. Is it unreasonable to assume that restoration of function in the spinal joints and therefore in the spine as a whole is more important than restoring anatomy?

SIR,—I fear that little progress will be made in coping with the difficult problem of backache as long as doctors share the view of Dr John Mathews (12 February, p 432) that “recumbency and analgesics remain the basic treatment for most mechanical spinal lesions.”

In the experience of doctors who routinely apply the various active medical measures for which Dr Mathews evidently has little enthusiasm good results are consistently obtainable. Indications for manipulation and traction,1 epidural local anaesthesia,2 ligamentous spondylolisthesis,3 and peripheral nerve blockades4 have been set out. Short of a major new approach, the selective application of these methods constitutes the only hope for effective treatment for “mechanical” backache (apart from surgery). All such patients should therefore be given the chance of treatment along these lines rather than, as a primary treatment, being consigned to bed.

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1 Cyriax, J, Textbook of Orthopaedic Medicine, 6th edn. (1957; Bailliere, Tindall and Cassell, London).
2 Coomes, F W, British Medical Journal, 1961, i, 20.
3 Barbote, B, Proceedings of the IVth International Congress of Physical Medicine. Amsterdam, Excerpta Medica Foundation, 1964.
4 Rees, W S, Annals of General Practice, 1971, 16, 126.

Drug promotion

SIR,—I recently received through the post three Mexican jumping beans together with promotional material from Napp Laboratories Ltd for Bradilan (tetracainetanol). Fructose). I was carried the following intriguing message in red: “Contains live jumping beans” and inside I was told that the beans should remain active for several months, particularly if exercised regularly. The advertisement stated (among other things) that “we can't promise to make your patients jump but your claudicants will be able to walk further.”

Admitting there is a dearth of good objective evidence for the efficacy of this type of vaso- dilator,1 but to give doctors Mexican jumping beans as an inducement to prescribe Bradilan is a sad