

[Report 1963] / School Medical Officer of Health, Nottingham City.

Contributors

Nottingham (England). City Council.

Publication/Creation

1963

Persistent URL

<https://wellcomecollection.org/works/kxmdfxxb>

License and attribution

You have permission to make copies of this work under a Creative Commons, Attribution license.

This licence permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. See the Legal Code for further information.

Image source should be attributed as specified in the full catalogue record. If no source is given the image should be attributed to Wellcome Collection.

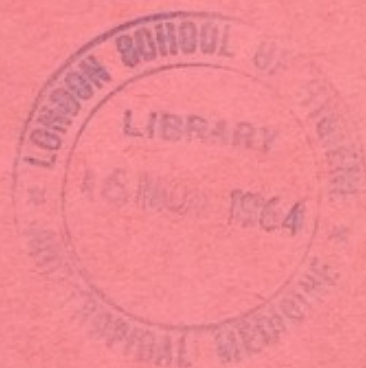


Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
<https://wellcomecollection.org>

458
CITY OF
NOTTINGHAM



EDUCATION
COMMITTEE



PRINCIPAL SCHOOL MEDICAL OFFICER'S

ANNUAL REPORT

ON THE WORK OF THE

SCHOOL HEALTH SERVICE

FOR THE

YEAR 1963



Adopted by the Education Committee at its meeting held on 28th October
1964



R. G. SPRENGER, M.B., Ch.B.,
Principal School Medical Officer.

W. G. JACKSON, B.A., M.Ed.,
Director of Education.



CONTENTS

	<i>Pages</i>
Accidents—school children	32–33
Acne survey	45–47
Audiometry	27–28
B.C.G. Vaccination	37
Cardiac register	38–40
Child guidance	21–22
Cleanliness	26
Colour vision	31
Convalescent homes	38
Deaths of children of school age	52
Dental inspection and treatment	18–21, 61
Diabetes survey	40–41
Diphtheria immunisation	37
Ear, nose and throat, diseases of	27
Educational therapy	22
Electrical treatment	31
Enuresis clinic	48–49
Haemolytic streptococcal infection of removed tonsils	28–29
Handicapped pupils	13–17, 59–60
„ „ Dual or multiple handicaps	17
Hernia survey	43
Hostels for maladjusted children	22–23
Immunisation and vaccination	36
Infectious diseases	36
Medical inspection	8–13, 53–56
„ „ Clifton selective examinations	9–13
Minor ailments, treatment arrangements	62
Ophthalmic service	26–27
Orthopaedic treatment	30–31
Otitis Media survey	29
Overweight children	34–35
Paediatric Consultative Clinic	34
Physical Education—weight lifting	51
Poliomyelitis vaccination	37

CONTENTS—*continued*

	<i>Pages</i>
Road accidents	31-32
School Meals	50-51
School Milk—non drinkers	49-50
School Nurses	36
Sex Education	42 43
Speech therapy	23
,, survey	23-26
Spinal movements survey	43-44
Staff	3-4, 8
Tattooing	50
Tuberculosis in schools	37-38
Urine testing in schools	7

Appendix

Minor ailments—treatment arrangements	62
Medical inspection (Part I)	53-54
Defects found by medical inspection (Part II)	55-56
Treatment of Pupils (Part III)	56-58
Handicapped pupils	59-60
Dental inspection and treatment	61

CITY OF NOTTINGHAM

GENERAL INFORMATION AS AT 31ST DECEMBER, 1963

Population	315,050	No. of Schools	171
Area acres	18,364	No. on Rolls	50,382
Density of Population: 17·16 persons per acre		Average attendance	90·0%

CENTRAL SCHOOL CLINIC,
28 CHAUCER STREET,
NOTTINGHAM.

Telephone: Nottingham 43064.

SCHOOL HEALTH SERVICE

SPECIAL SERVICES SUB-COMMITTEE

(Municipal Year 1963-64)

Chairman: Councillor B. MORLEY (to September, 1963)
Councillor G. DUTTON (from October, 1963)

Vice-Chairman: Councillor Mrs. O. MOSS

Alderman R. E. GREEN
(Chairman of the Education Committee)

Alderman W. DERBYSHIRE
(Vice-Chairman of the Education Committee)

The Deputy Lord Mayor	Councillor C. M. REED, J.P.
(Alderman S. P. HILL)	Councillor H. A. ROE (from October, 1963)
Councillor E. B. BATEMAN	Councillor Mrs. M. WHITTAKER
Councillor G. DUTTON	H. J. PEAKE, Esq., M.A., M.Sc., PhD.
(to September, 1963)	J. D. SUNLEY, Esq., J.P.
Councillor Mrs. I. F. MATTHEWS	

STAFF (31st December, 1963)

Principal School Medical Officer:

R. G. SPRENGER, M.B., Ch.B.

Deputy Principal School Medical Officer:

ELEANOR J. MORE, M.B., Ch.B., D.P.H.

School Medical Officers :

W. M. HUNTER, M.B., Ch.B.
BARBARA WARD, M.B., B.S., D.A., D.C.H.
MARJORIE A. WROUGHTON, M.B., Ch.B.
W. D. SINCLAIR, M.B., Ch.B., D.P.H.

Part-time Specialists:

(By arrangement with the Sheffield Regional Hospital Board)

G. GORDON-NAPIER, M.D., Ch.B., D.O.M.S. (Ophthalmic Surgeon)
J. HORTON YOUNG, M.B., B.S., D.O.M.S. (Ophthalmic Surgeon)
H. FRASER, M.B., Ch.B., D.O. (Ophthalmic Surgeon)

A. R. A. MARSHALL, M.B. Ch.B., F.R.C.S. (Aural Surgeon)—died 10.5.1963
--

J. F. NEIL, M.A., M.B., Ch.B., F.R.C.S. (Aural Surgeon)
A. P. M. PAGE, M.D., M.R.C.P., D.C.H., J.P. (Paediatrician)
A. GORDON, M.R.C.S., L.R.C.P. (Anaesthetist)
ELIZABETH ARKLE, M.D., D.P.M. (Psychiatrist)
D. R. BENADY, M.B., B.S., D.P.M., D.C.H. (Psychiatric Registrar from 1.8.1963)

Part-time Medical Officers:

THELMA M. PHELPS, M.B., B.S.	S. J. HARRIS, M.B., B.S.
W. K. S. MOORE, M.A., M.B., B.Chir. (M.O., Boots' College)	J. K. L. WATKINSON, M.R.C.S., L.R.C.P.

Audiometrician: *E. F. WARD, M.S.A.T.

Principal School Dental Officer:

W. MCKAY, L.D.S.

Dental Officers:

LINDA E. POOLEY, B.D.S.

ERIKA MELLAKAULS, L.D.S.

MARGARET C. ROE, L.D.S.

R. D. BEELEY, L.D.S. (from 2.12.1963)

*N. E. CHETTLE, L.D.S.

*E. A. MEADOWS, L.D.S.

*D. R. DAVIES, L.D.S.

*ENID DURANCE, L.D.S.

(from 12.8.1963)

(from 7.10.1963)

*Dental Surgery Assistants: Eight.**Child Guidance Centre:*

Mrs. J. FRY, M.A., Ed.B.

Miss P. A. E. GRADY, L.C.S.T.

(Senior Educational Psychologist)

(Senior Speech Therapist)

H. A. W. HUGHES, M.A.

Miss. J. S. MYNALL, L.C.S.T.

(Educational Psychologist

(Speech Therapist)

from 23.9.1963)

Miss N. M. GATELY

Miss R. SHONE, L.C.S.T.

(Psychiatric Social Worker)

(Speech Therapist)

Miss M. M. BEESON

Mrs. A. M. TURNER, L.C.S.T.

(Remedial Teacher)

(Speech Therapist from 1.9.1963)

Mrs. E. WILL

Miss J. E. MACKENZIE, L.C.S.T.

(Social Worker)

(Speech Therapist from 1.10.1963)

Administrative Assistant: G. E. D. HANCOCK, D.M.A. (from 1.2.1963)*Superintendent School Nurse:* Miss F. PINDER, S.R.N., S.C.M.*School Nurses:* Nineteen full-time and six part-time.*Nurses Assistants:* Six.*Clinic Attendants:* Nine part-time.*Ward Orderly:* One.*Clerical Staff:* Chief Clerk (J. G. WILSON from 1.3.1963) and twenty-four Clerks.*Hostels for Maladjusted Pupils:*ORSTON HOUSE—*Superintendent and Matron:* Mr. and Mrs. C. A. FITCH.THE GABLES—*Warden and Matron:* Mr. and Mrs. C. COLUMBINE.

*Part-time Staff.

**CITY OF NOTTINGHAM EDUCATION COMMITTEE
SCHOOL HEALTH SERVICE**

REPORT FOR THE YEAR ENDED 31st DECEMBER, 1963

BY

**THE PRINCIPAL SCHOOL MEDICAL OFFICER,
DR. R. G. SPRENGER**

*To the Chairman and Members of the
City of Nottingham Education Committee*

LADIES AND GENTLEMEN,

I have the honour to present to you the 55th Annual Report on the work of your School Health Service.

The routine work of the Department has continued along the usual lines and there have been no changes of staff to interrupt inspection work, which is well up to date as I write.

Defects have been found in the usual proportions in all age groups. While some of these are of a minor nature, there is still a large number of defects which require treatment. Most of these are found, as one would expect, among the "Entrant" group (children in their first year at school). It is especially noticeable that defects are small in number in the "Leaver" group (children in their last year at school). In other words, youngsters in their teens are healthy on the whole, thanks to the health services—both preventive and curative—of the country.

We have continued at Clifton the form of selective medical examinations which we have been trying out these past few years. An analysis of the figures on page 10 gives some interesting facts, and Dr. Wroughton's notes on her own conclusions are of especial interest. It is too easy for the senior medical officer, who is dealing only with the administrative arrangements, to have some lack of understanding of the position of medical officers who are working in the field, as it were. I still feel, however, that extension of the selective system is desirable but, of course, "Entrant" and "Leaver" group examinations should continue on routine medical examination lines.

We hear a great deal these days, both in the lay and medical press, of the happy results of the treatment of tuberculosis. This may give us all a false sense of security about the disease but it is still necessary to continue to be vigilant and this can involve us in considerable investigations in an endeavour to trace a possible source of infection. During 1963, there have been three occasions on which infection has occurred in our schools and when, on the advice of the Consultant Chest Physicians, it has been desirable to check the whole school population of one of the schools concerned, including teachers. The check was by means of a skin test and subsequently a chest X-ray of the positive reactors. These skin test reactions have been complicated by the fact that many of the children had had B.C.G. vaccination which, of course, is expected to give a positive skin reaction when immunity has been built up satisfactorily. In one school, to complicate matters further, one boy who had been vaccinated

was found to have an active tubercular condition. I would like to thank the teachers concerned for their co-operation in these investigations, and apologise for any loss of educational time, but I am sure they will agree that the assurance of a completely clear bill of health in their school, as far as tuberculosis is concerned, made the trouble worthwhile. I am also very grateful to the Consultant Chest Physicians in charge of the Chest Centres and their medical officers for their help so readily given much, I am sure, to the upset of their routine duties.

During the year the Medical Officer of Health drew the attention of the Health Committee to the use and abuse of aspirins by the parents of children. It is easy to understand how these attractively packed and finished medicaments can come into general use. To add to their attractiveness is the fact that they are not objectionable to taste. While we have not come across any widespread use among children, one cannot help but have some fears that there is too ready a tendency on the part of parents to give a child an aspirin on the slightest pretext, sometimes in more serious conditions, before thinking of asking for medical advice. It may well be that for the most part no harm is done and it can always be argued by some that it is good for trade.

I am pleased to note that the staffing position in the dental department shows considerable improvement, there being now the equivalent of 6.3 full-time dental officers. The very short staffing position of a few years ago has meant, of course, a considerable back-log of work to be caught up with. The hope that fluoridation of water supplies would become general policy in most districts does not seem like becoming fact so that this means of preventing tooth decay is as far off as ever. As the topical application of fluoride or the addition of fluoride in minute quantities to the diet will have some effect, I cannot help but wonder if it would not be worthwhile for the chemical firms to put this latter on the market. Its purchase and use would be seriously considered, I am sure, by many thinking parents.

I think at this point I might be forgiven for quoting from an article in *The Guardian* of 10th December, 1963, entitled "The Nation's Teeth" and referring to the pros and cons of fluoridation:—

"What all of us have a right to expect of the fluoridators is that they should now devote some of their zeal to a campaign in favour of measures that would reduce caries even if there were no fluoride in the water".

I should have thought that the dental profession would have given really serious thought to more direct means of preventive dentistry. There are so many protective coatings available nowadays for so many different purposes that one imagines there would be no difficulty in producing one which would be effective on teeth even if it had to be renewed every six months or so, bearing in mind that it is not the opposing surfaces of teeth which develop caries, but the areas which are not automatically cleaned by the tongue or cheeks which become affected. This would be the kind of work eminently suitable for dental auxiliaries and needing the minimum of supervision. To be facetious for a moment, it might be that the ladies could have their protective coatings on their teeth to match their lipstick or even their latest colour of hair.

INVESTIGATIONS:

As usual and to add to the interest of our staff, we have continued old, or developed new, lines of investigation. The School Health Service

is in the fortunate position of dealing with large numbers so that surveys are easily arranged, usually without the need for much additional work on the part of medical or nursing staffs. The fact that they are in close touch with the schools makes a little extra investigation hardly more than routine.

We have continued to observe and look for the spread of **plantar warts and foot infections**, and our **spinal movements** survey has also continued.

The return of **cardiac defects** to the Department of Education and Science has now finished but Dr. Ward takes an active interest in children having this condition. The results of operation or alterations in their disability are her particular concern.

A report on the **infections in tonsils** is included this year and a **survey on acne** was carried out by the medical officers. Dr. Wroughton very kindly summarised the results and her report appears on page 45.

The numbers of **hernias** are so small that it takes some time to get substantial figures.

It will be noticed in the official figures which we submit to the Department that there are largish numbers of defects under the headings 12(b), 13(c) and 14(b), and I felt that a break-down of these figures might give us some findings of interest. These are noted on page 8.

A check on the **urines** of all children in certain inspection groups has been undertaken. This is now easy using albusix and clinistix. 6 children were positive for glucose and 21 for albumin. All but 3 were clear when given a full test at the clinic, the three children were referred to their general practitioner. I have not heard that they have been proved positive.

Children who do not drink milk: Concern as to whether these youngsters were lagging behind physically led me to check on their weights and heights. The results and my conclusions are on page 49.

Otitis media, past and present: We might, just possibly, know how many active cases of otitis media there are in the schools at any one time but we do not know how many past cases there might be and I have endeavoured to get as much information as possible about ear conditions for every child during the usual medical inspections. I would hasten to add that this investigation was set on foot not because of deafness but because in another part of the country it was asserted that many children had otitis media in infancy and I wondered how many had residual defects either functional or physical (or both)—see page 29.

We have quite a reputation in Nottingham for our interest in **fatties** and we have continued this survey and our results and remarks are on page 34.

Enuresis (nocturnal) or bedwetting is a condition which is much more common than one would expect, mainly because both parent and child show some shame over it. Not only have we continued to use the pad and alarm bell apparatus in its treatment but we have also noted the cases which have come into the Tonsil and Adenoid Ward for a period, and our findings are on page 48.

STAFF:

I regret that our Ear, Nose and Throat Consultant, Mr. A. R. A. Marshall, who was seconded to the department in 1940, passed away suddenly on 10th May, 1963. He was well liked by all who came into contact with him. Nothing was too much trouble for him. He could always find time to fit in the extra case or so, to undertake some extra investigation if a medical officer or myself found it necessary or desirable. Our small Ear, Nose and Throat Unit ran smoothly and almost trouble-free with his help. Mr. Neil and Mr. Kaplan who acted as locum, have kept things going while the Regional Hospital Board have been making a new appointment.

Mr. V. C. Carrington, who had been with the dental department since its inception and whose part-time interests latterly had been in orthodontics, finally retired in December. Miss G. Beeton, who had been in the department since 1917, also decided to retire on superannuation. May I wish them many happy years of retirement.

The medical staff has remained unchanged but as I write, Dr. M. A. Wroughton has given notice to leave in May. There have been changes in the nursing and administrative staffs—four school nurses resigned during the year (two to start a family) and we were fortunate in being able to obtain four very good nurses to take their place. Mr. D. R. Freer, who had been Administrative Assistant since January, 1960, moved over to the field of further education as the Deputy Secretary (Administration) of the Regional Advisory Council for the Organisation of Further Education in the East Midlands. We were pleased that Mr. G. E. D. Hancock, who has been in the department since 1951, was appointed his successor. In addition, there have been four resignations from the clerical staff during the year, for which very suitable replacements were obtained.

We were pleased to welcome Mr. R. D. Beeley, School Dental Officer, as an addition to the dental staff in December. The dental auxiliary resigned in September after having been with us for only twelve months. The fact that she was expected to be supervised constantly by professional staff did not make for the best of relations.

MEDICAL INSPECTION:

This work has continued along the same lines as usual. Apart from the Clifton district, we have continued with the routine type of medical inspections, examinations taking place at the ages of five, eight, eleven and fourteen or fifteen years. There has been no difficulty in keeping to our programme of inspections and our figures are much the same as those of last year. It seems that the number of defects remains at a steady fifteen per cent. despite all the advantages of state medicine.

As mentioned in the introduction, we have endeavoured to obtain some details of the defects 12b, 13c and 14b. These three defects form quite a large group and a break-down of the figures is given below:—

Number of pupils involved:

				12 b	13 c	14 b
Periodic inspections:						
Treatment	..	..	..	89	163	13
Observation	..	..	..	205	41	41
Special inspections:						
Treatment	.	..	..	15	46	6
Observation	..	..	..	216	83	33
Totals				525	333	93

Defect 12b—Development (Other):

By far the most numerous condition requiring treatment or observation under this heading was undescended testicles, accounting for 44% of the total of 525; a further 4% suffered from various other defects of the genitalia. 35% were obese and 9% were underweight.

Among the remaining 8% were such complaints as:—

Achondroplasia	Listlessness
Bladder and kidney troubles	Meningocele
Bleeding time prolongation	Oesophagus disorders
Chest deformities	Pancreas, fibrocystic
Coccygeal sinus	disease
Cysts	Scalp conditions
Hare lip and cleft palate	Thyroid trouble

Defect 13c—Orthopaedic (Other):

Various conditions of the legs, feet and toes accounted for 55% of the total of 333; these conditions included knock-knees, hallux valgus, valgus ankles and achilles tendon. Deformities of the shoulders, arms and hands represented 13%. Accidental breakages of arms and legs accounted for a further 12% and hip troubles—including congenital dislocations—6%.

Other conditions (14%) noted under this heading included:

Chest deformities	Osteomyelitis
Fibro-sarcoma	Paralysis—various types
Fractured skull	Post-poliomyelitis effects
Lumbar complaints	Rheumatoid arthritis
Muscular dystrophy	Spinal difficulties

Defect 14b—Nervous system (Other):

Of the 93 pupils noted under this heading, for treatment or observation, nervous paralysis accounted for 25% and spasticity 18%. Incontinence and enuresis (11%), nervousness (10%) and unsteady walk and clumsiness (10%) formed the other major groups.

Other conditions (26%) noted were:—

Claustrophobia	Fits
Encephalitis	Hydrocephalus
Fainting	Migraine
Febrile convulsions	Sleeplessness

Selective examinations at Clifton:

This is the first year in which we have been able to check our selective results, or should I say omissions, against the complete routine inspections of the "Leaver" group. The numbers of leavers examined are not very large but the defects found do give us some indication as to whether we are finding all the defects, which it is our business to note and for which treatment is to be arranged, by means other than that of routine medical inspection.

**CLIFTON "LEAVER" ROUTINE MEDICAL INSPECTION—
DEFECTS FOUND FOR THE FIRST TIME**

<i>Defect</i>		<i>Treatment*</i>	<i>Refer to Specialist†</i>	<i>Observation</i>
4	Skin	8	—	—
5a	Vision	21	11	2
5b	Squint	7	—	—
6b	Otitis Media	1	—	—
7	Nose and Throat	4	2	—
10	Heart	—	1	1
11	Lungs	4	—	—
13c	Orthopaedic (Other)	2	—	1
17	Other	2	—	—
		49	14	4

*These defects were in respect of children who were either already under treatment or were for children whose parents were advised to seek the advice of their general practitioner.

†These defects were in respect of children for whom the School Health Service arranged a Consultant's appointment.

COMMENT:

There were 557 children who were given the routine "Leaver" medical inspection. Of these, 306 had not been seen since they were seven or eight years of age. Of the 306 children 62, whose defects are given in the table, had defects which were unknown to us before the inspection. Only 20 children were not already under treatment or observation by hospitals, opticians or their general practitioner.

The two groups, vision and squint, make up the greatest proportion of the figures and these we feel would have been noted by the nurse in her "Survey" had the survey been carried out before the medical inspection.

Although the figures are not very large, they give the conclusion that we are missing few defects at the Entrant and Selective examinations that an extension of the Selective type of examination amongst intermediate groups is probably desirable, but that Entrant and Leaver examinations should continue on a routine basis. Again, making allowances for the smallness of the figures, the ratio does, however, approximate closely to those found at routine Leaver examinations in the remainder of the City where we have not been selective in our examinations.

The above views may be satisfactory from my own angle but what of the medical officer working in the field? I have included the opinion of Dr. Wroughton on page 11. Her thoughts are interestingly set down and she can speak with a thorough knowledge of the practical aspects of the work.

Medical Officer's Examinations:

The latest figures of the children seen by the medical officer in the selective procedure are as follows:—

	<i>Follow-ups</i>	<i>Supt. Nurse's list</i>	<i>Handicapped Pupils</i>	<i>H.T. Requests</i>
Spring, 1961	208	44	20	55
Summer, 1961	208	53	23	62
Autumn, 1961	100	23	8	77
Spring, 1962	128	32	15	76
Summer, 1962	31	11	4	50
Autumn, 1962	155	37	11	68
Spring, 1963	85	35	9	42
Summer, 1963	131	36	8	90
Autumn, 1963	137	30	10	83

ANALYSIS OF DEFECTS, 1963

<i>Defect Code Number</i>	<i>Referred for Treatment</i>	<i>Referred for Observation</i>
4	—	2
5a	25	36
5b	3	4
5c	—	1
6a	2	23
6b	—	2
6c	—	1
7	17	30
8	6	7
9	—	—
10	1	2
11	2	24
12a	—	—
12b	1	23
13a	1	1
13b	—	2
13c	—	10
14a	—	5
14b	1	3
15a	7	25
15b	9	25
16	—	3
17	6	91

Some thoughts on the Selective Examination of children in Junior Schools

by M. A. Wroughton, M.B., Ch.B.

I have tried to consider the merits and demerits of the selective examination in general, but bearing in mind that there may be some pressure to adopt the system regardless of these, I have also tried to see ways in which our present arrangements could be made to work more effectively. I feel, too, that the term-by-term working of the scheme depends so much on the School Nurses involved.

Advantages of Selective Medical Examinations:

1. Expenditure of time on normal, healthy children is avoided.
2. Effort is concentrated on children with problems.
3. There is very little need to put children on the Clinic Special Case list as they can be seen each term in school.
4. It is possible to get a complete picture of the child when parent, medical officer, class teacher, Head Teacher and child are all available at the same time.

Disadvantages of the Selective Examinations:

1. One never sees a normal junior. This is depressing and also tends to cloud one's image of the normal child. I consider that it is most important for school medical officers to have a very clear idea of what is normal.
2. Most parents do not understand the system. If the system were to be adopted throughout the City, I think they would have to be better informed about it, perhaps by a notice when their child entered Junior School.
3. Many parents do not attend the examination.
4. It is sometimes difficult to get hold of the Head Teacher, particularly as the schools where Selective Examinations are done at present are overcrowded, large and often scattered.
5. There is a slight possibility that defects missed at Entrant level or arising after the Entrant medical inspection may continue undetected.
6. There is a greater possibility that we are missing opportunities for giving advice and health education by not seeing those children who appear to be healthy. During this last term, about twenty children and parents were sent for to see the medical officer in error. They had been absent with some minor illness at the time of the Nurses' survey. In about seventy-five per cent. of these "normal" children, there was some difficulty about which the mother asked advice. Admittedly nature would have remedied most of these ills by the time of the "Leaver" examination but I should have thought we ought to help nature.
7. There is a heavy responsibility on the medical officer who examines the child at Entrant level, not only to avoid errors in his examination but to avoid slips and omissions in recording his findings. The latter is probably the easier mistake to make, and once the vital 'O' is left out of the column, the error could be irretrievable. The situation is made more difficult by the fact that five year olds are not always co-operative.
8. There is far too heavy a responsibility on lay-people (parents and teachers) in that without medical training, they should be expected to select the well from the not-so-well, the normal from the abnormal.
9. Because there is little gross physical illness in the Junior School, the Selective lists are hopelessly overloaded with social and behaviour problems, with which the medical officer cannot be a great deal of help. There is also a large number of dull children, not quite suitable for Special School. These are really an educational and social problem, rather than a medical one.
10. There is no place in the system for a comprehensive survey by medical officers of any particular condition or disease, as there is when the whole age group is being routinely examined.

The Present System at Nottingham:

(a) Nurses' Survey is arranged for all junior school children in their:

1. First Year as juniors, to test their visual acuity; and
2. Fourth Year as juniors, to test visual acuity and hearing; and to record their weight and height; and note general observations.

(b) Medical Officer's sessions are arranged every term:

1. Follow-up cases selected as in the rest of the City.

2. Superintendent School Nurse's list for observation of unsatisfactory cleanliness or home conditions.
3. Head Teachers' requests.
4. Nurses' referrals from their surveys.
5. Parent's requests.
6. Referrals by the medical officer.

Disadvantages of the Present System :

1. As the nature of each case is different, it is very difficult to assess the number of children to be included in a session. In my experience the time allotted is almost always inadequate, twice in the last fortnight by as much as forty minutes.
2. There is often duplication of effort. A child may be referred for some condition for which he is already having treatment. This may happen because the school or the School Health Service does not know about the treatment, or because the mother decides that she would like an opinion other than that of her own doctor, or occasionally that of a consultant. I feel that we must not encourage this sort of thing.
3. It is easy for a child to go right through a junior school without the staff knowing of significant facts in his medical history, because they are not severe enough for him to be officially handicapped. When the child is examined routinely at eight years, these things come to light and the Head Teacher can be made aware of any necessary point.
4. At the moment, the nurse often does not have the opportunity of picking up her survey absentees before the doctor's session. This means that either parents must all be sent for, many of them unnecessarily, or that if none is included, nurse must make a home visit for every visual or hearing defect found.

Conclusion :

My personal preference is for routine medical inspection. If we were short of staff, then the selective system would care adequately for those most in need. If, however, we are concerned with providing a comprehensive School Health Service, then I think this service should be offered to every child, whether he *appears to need it or not*.

9th December, 1963.

HANDICAPPED PUPILS :

Blind :

Residential Special Schools	..	..	..	5
-----------------------------	----	----	----	---

This figure is a reduction of one on 1962. One boy has left. Unfortunately he has not been able to settle into employment. His loss of vision was due to a cerebral tumour and he also had considerable intellectual deterioration. It was found impossible to help him vocationally at Birmingham, so that he had to be returned to his own home. This is a sad and unsatisfactory state of affairs and it is now very difficult to assist him.

Partially Sighted :

Residential Special Schools	..	..	..	3
Day Special Schools	..	..	..	5
Ordinary Schools	..	..	..	20

There is little change in these figures but we have co-operated closely with the City's Welfare Services Department and the Nottingham Eye Hospital in order to make quite certain that we are aware of all cases in this category. Where there has been any likelihood of the eye defect influencing adversely a child's choice of employment, we have suggested that they should be referred early to the department which will deal with their needs as handicapped adults.

There is one youngster whose case has been of considerable interest his brother now aged 20 had an eye condition which progressed so rapidly that he is now blind, the youngster has the same familial eye condition. At the moment it does not appear to be very progressive, and his vision is 6/18 in both eyes. We suggested, and his parents agreed, that he should receive vocational training in view of the outlook. However, in the meantime, the boy got himself a job and with this, and his mild fear of leaving home for training, he refused to accept vocational help and so we have been unable to give him the suggested training.

We have continued to make sure that the handicapped children of this category in ordinary schools are keeping pace with their colleagues or, at any rate, not falling very far behind. It should be noted that the three children in residential schools have also some associated learning difficulty which increases their handicap.

Deaf:

Residential Special Schools	..	..	..	4
Independent Residential Special School	..	..	..	1
Day Special Schools	..	..	..	29

There seem to be a few more youngsters whom we must consider as deaf. Indeed, I have seen several very young children quite recently who will not be included in the above figures until 1964 and who obviously have some severe loss of hearing. It is quite impossible to give a reason for their handicap other than it seems to be a congenital defect. Our day special school numbers are now above the accommodation available, with a nursery department full to overflowing.

Partially hearing:

Residential Special Schools	..	..	..	2
Day Special Schools	..	..	..	21
Ordinary Schools	..	..	..	57

One or two children who have been failing to keep pace in ordinary schools because of their handicap have been transferred to our Ewing Day Special School and we have been able to transfer back to ordinary school an odd one or two who have been able to grasp the need for lip-reading after the stimulation and encouragement which they have received in the special school.

With the help of the peripatetic teacher of the deaf, we have continued to keep in mind the desirability of returning from the school for the deaf those who would fit into ordinary school and, of course, this teachers' advice over transfers in the opposite direction is something which we find very valuable. I would like to pay tribute to the very good work she does.

Delicate:

Residential Special Schools	..	..	..	14
Hostel for Diabetics..	..	..	..	2
Day Special Schools	..	..	..	26
Ordinary Day Schools	..	..	..	154
Awaiting placement	..	..	..	1

This group is about the same size as last year. I suppose, as the general health of the population improves, so the number will decrease. As an example, there was a time when all rheumatic children were considered delicate, often for a considerable period after their acute attack, but now it is usually only necessary to restrict their activities for a matter of months and if their exercise tolerance is satisfactory, the hospital consultants remove all restrictions quite quickly.

Physically handicapped:

Residential Special Schools	..	..	..	11
Day Special Schools	..	..	..	63
Ordinary Day Schools	..	..	..	22
Home Tuition	..	..	..	4
Awaiting placement	..	..	..	1

There is little to add to the previous years' notes about this group. A few more children are able to travel between school and home with the help of special transport and in fact now, a total of 124 covering all handicaps are taken daily by car. This figure does not include children living in the administrative County of Nottinghamshire, some of whom attend our day special schools and because of distance and physical condition need transport.

The facilities for moving those who are chairbound have been under review. One difficulty is that many of the physically handicapped children are becoming quite big and too heavy to manhandle out of a car. Consideration is being given to the possibility of transporting these children complete with their chairs but an economical solution is not easy to find. We have looked at various vehicles with ramps and lifting devices but none of these meets our requirements.

Educationally sub-normal:

Residential Special Schools	..	..	..	5
Day Special Schools	..	..	..	445
Awaiting placement in Day Special Schools	..	..	..	74*

*8 of these were admitted to Day Special Schools in January, 1964.

This group of youngsters is causing us a great deal of concern. Despite the opening of the new special school at Clifton, we still find ourselves with a large waiting list.

During the year 127 have been admitted to our Day Special Schools. It might have been possible to admit another 20 at Clifton if the staffing position, like the staffing position elsewhere, had been less difficult.

The Youth Employment department have given me the following information about the educationally sub-normal school leavers:—

Boys:

15 left from Special Schools
3 left from Ordinary Schools
All settled in employment.

Girls:

*18 left from Special Schools
4 left from Ordinary Schools
*1 girl moved to Newark
1 girl has not applied for any employment—kept at home by father
1 girl temporarily unemployed but not unemployable and is likely to be placed shortly
The remainder have settled in employment.

It is gratifying to note how successful the Youth Employment Officers have been in placing these young people.

As I write and in co-operation with the Heads of our Special Schools, we are endeavouring to make an assessment of those who might return to ordinary school and who would not be too obvious there, or otherwise create teaching problems, even though they may not have received the full benefit of the special school education. At the other end of the scale, we have to consider most carefully the cases of those who are not benefiting by education at school so that they can go to the Health Committee's training centres for their future help.

Maladjusted:

Residential Special Schools	..	..	..	1
Residential Independent Schools	..	..	..	5
Residential Hostels	..	..	..	14
Day Special Schools	..	..	..	2
Ordinary Day Schools	..	..	..	17

The youngsters in this category are not large in number but they have all taken a considerable amount of the time of our Child Guidance team before decisions could be made about their placement. It is no easy matter to decide whether a child will benefit sufficiently—

(a) by treatment at the Child Guidance Centre as an out-patient, possibly with the help of medication, continuing to live in his own home, or

(b) whether he will be better catered for in one of our hostels, attending an ordinary school, where the main emphasis is on consistent handling and quiet, sensible discipline, or

(c) whether he would be better placed in a residential special school where he learns with others to live while he is being educated.

A long period of observation may be necessary before a decision can be made and at times this may also mean residence at Harper Villa, the Children's Unit at St. Ann's Hospital, and attendance at the Hospital Special School where teaching and nursing staffs can all contribute their share to the child's investigations.

Whatever decision may be made, it has to be borne in mind that eventually the child has to return to his own home and family and so continuing contact with the home must be maintained, so that the child knows he will return eventually to his parents. After care is, of course, essential and some of those now in ordinary schools have been treated in one or other of the ways mentioned. They continue to be reviewed from time to time either by the psychiatrist or psychiatric social worker.

Epileptic:

Residential Special Schools	..	..	..	11
Day Special Schools	..	..	..	10
Ordinary Day Schools	..	..	..	102

The figures for this category give one the impression that our numbers are increasing. Certainly there are more in Residential Schools and ordinary schools. I feel the explanation is that diagnosis, with the help of electroencephalograms, is becoming more accurate even in the milder types of epilepsy. The fact that those handicapped children in ordinary schools create little or no problem speaks well for the more enlightened attitude of everyone concerned with them and it is seldom that we are consulted about the action to take when a child has an attack. Actually it is rare for the known cases to have attacks at all when medication is regular and consistent, especially with the help of the newer anti-epileptic drugs.

Speech Defects:

Day Special School ..	..	..	..	..	1
Ordinary Day Schools ..	..	..	..	..	2

These figures do not convey any idea of the problem of speech difficulty. The subject is further discussed on page 23.

I was particularly interested to meet a youth whose defect was particularly persistent and who attended the Residential School for speech defects. At our meeting, two years after he had left school, when he was eighteen, his difficulty had resolved itself to such an extent that it did not show up at all, even in a television interview which, to most newcomers, must be a highly emotional episode.

Children with dual or multiple handicaps:

	<i>Other Handicap</i>						
	<i>Partially Sighted</i>	<i>Partially Hearing</i>	<i>Delicate</i>	<i>Physically Handicapped</i>	<i>Mal-adjusted</i>	<i>E.S.N.</i>	<i>Epileptic</i>
Blind ..				1			
Partially Sighted ..						4	
Deaf ..				1			
Partially Hearing ..	2		2		1	11	
Delicate ..		2				4	
Physically Handicapped ..	2	2				6	2
Maladjusted ..			1				
E.S.N. ..		3	1	2			
Epileptic ..			1			11	

Again, it is interesting to note how many handicapped pupils have educationally sub-normality as an additional handicap. One might expect the brain damaged, of course, to have epileptic attacks—any scar or loss of brain substance can act as a focus but it is difficult to see why partial hearing with E.S.N. should be so common, unless it can be blamed on poor health and inadequate diets resulting in a catarrhal tendency and middle ear damage. It is not easy to decide by how much a handicap is increased as a result of a secondary handicap, except by checking on progress against what is expected.

THE SCHOOL DENTAL SERVICE

Report of the Principal School Dental Officer for 1963.

Premises and Equipment :

The dental clinic at Bestwood was opened early this year and now fills a need in the North of the City. At present approximately 4,500 school children are based on this centre and this figure must surely increase as new schools are opened on the estate.

Further improvements and additions to existing equipment were again made during 1963 but unfortunately no improvements in existing premises could be attempted. The impending closure of Leenside Clinic in 1964 will be bound to cause a problem.

Staffing :

On 31st December, 1963, the dental staff consisted of:—

	<i>Full-time</i>	<i>Part-time</i>
Principal School Dental Officer	1	—
Orthodontist	.6	—
Dental Officers	3.4	1.3
Medical Officers	5.0	1.3
	—	1.1
	5.0	2.4
Dental Auxiliaries	NIL	
Dental Surgery Assistants ..	7.9	.5

There has been another slight improvement in the staffing position since last year. Medical officers, employed mainly for the administration of dental anaesthetics, replace dental officers in this work and the effective combined officer strength at the end of the year was 7.4, which is the highest figure in the history of the City's school dental service.

I have much pleasure in welcoming Mr. R. D. Beeley, who joined the full-time staff on 2nd December and I hope he will have a happy stay with us before he finds a suitable place for his general practice. I welcome too Mr. D. R. Davies, who since 12th August has been giving us six sessions of his time while building up his practice. I am glad that Mrs. Enid Durance has renewed her part-time appointment with us and I am sorry to report that Mr. D. M. Snapper has had to leave us owing to the increasing demands of his own practice.

Another part-time officer resigned during 1963, Mr. V. C. Carrington, Dental Officer, Senior Dental Officer and then Principal School Dental Officer in turn. He had worked part-time for the Authority since his retiral. An appreciation of his long service appears elsewhere in this Annual Report.

There would appear to be a pattern developing again of young graduates joining this local authority dental service for a time while they look around for a suitable place in which to enter general practice. I believe that this ought to be encouraged for, although it causes a lack of continuity in the service, it ensures an increase in general dental practitioners with experience in our work and who are willing to absorb at least some of our priority patients in their practices. I would, of course, welcome an increase in the number of dental officers who would be prepared to make the service a full-time career.

Miss Sharman, dental auxiliary who was with this Authority from 10th September, 1962, resigned her appointment on 29th September, 1963, on moving to Salford. Because of administrative difficulties, it was decided not to replace her for the time being.

Policy :

In May, 1963, a survey of dental inspection and treatment was made in five schools. This constituted a 3% sample of our school population. From this survey it can be said that far too many local children are still having difficulty in receiving emergency dental treatment and it must be policy to continue to make this provision at all reasonable times. There is a shortage of dental practitioners in Nottingham and because of the scale of fees in the general dental service and the time-consuming nature of children's dentistry, there is a natural reluctance on the part of practitioners to accept more than a small number of young children in their practices. Many parents complained of delay in receiving emergency treatment for their children. So far as treatment through our service is concerned, this can rarely be immediate. However, any complaints of unreasonable delay are investigated by the Principal School Dental Officer. It is unfortunate that some members of the public believe that the service is available only during school terms and when schools close they are at a loss to know how to apply for treatment. Direct applications (by telephone if urgent) by parents to the School Health Service Central Office (Dental Department) are always accepted during office hours and appointments given. More publicity given to this fact could reduce some parental frustration.

While emergency work rightly must take precedence, this is certainly not the whole of the function of the service and all forms of dentistry are undertaken, depending on the availability of staff and the length of the waiting lists.

Dental Inspection :

During the year 5,799 (or 11.3% of our school population) had a routine dental inspection and 21 dental officer sessions were devoted to this work. An additional 5,603 children (or 10.9%) were seen as casual or special inspections (mainly because of pain or sepsis). A total of 11,402 children (or 22.2%) therefore were inspected.

Of the 5,799 children *routinely* inspected during 1963, 5,447 (or 93.9%) were found to have some dental defect and treatment was offered to 4,149. 2,443 (or 58.9%) consented to treatment.

Dental Treatment :

During the year 2,163 dental sessions were devoted to treatment (including orthodontics) and of those sessions, 396 were reserved mainly for extractions under general anaesthesia. 20,109 attendances were made by school children and the following treatment was carried out:—

Fillings:	Permanent teeth	..	..	..	9,863
	Temporary teeth	..	..	..	43
					9,906
Extractions:	Permanent teeth	..	..	..	4,997
	Temporary teeth	..	..	..	11,798
					16,795

A general anaesthetic was given for extractions on 7,112 occasions and a local anaesthetic on 131 occasions. In contrast, a local anaesthetic was given for fillings on 851 occasions.

Other operations: Permanent teeth	..	..	2,375
Temporary teeth	..	..	16
			2,391
No. of diagnostic X-ray films taken	..	..	1,174

In the prosthetic and orthodontic section, 163 sessions were devoted to this work and 1,609 attendances were registered (included in the 20,019 above). 127 new dentures were supplied to children and 33 dentures were repaired.

Seventy-one orthodontic cases were completed during the year and 118 appliances (all removable) were fitted.

An innovation during 1963 is the acceptance by the Regional Hospital Board of one dental officer to work with the orthodontic consultant for one session each week. Twenty-five sessions were spent in this way during the year. As the patients treated on these sessions are City school children who are referred by us, nothing but good can come from this example of co-operation with the Hospital Service.

Summary of dental treatment carried out, under the Local Health Authority Maternal and Child Health Scheme, by the School Dental Service :

During 1963, arrangements were supervised by the Chief Dental Officer. Treatment for children of pre-school age continued to be available at all of the school dental clinics. Dental treatment of mothers was carried out at the school dental clinics at Bestwood, Clifton and Chaucer Street, in addition to the facilities already in operation at the General Dispensary.

<i>Dental Inspection and Treatment</i>	<i>Mothers</i>	<i>Children</i>
Number examined	403	361
Number needing treatment	403	340
Number treated	389	335
Number made dentally fit	187	64
Number of sessions	98	15
Number of attendances for inspection and treatment	1,267	412
Scalings and gum treatment	71	—
Number of fillings	112	3
Silver nitrate treatment only	7	—
Number of crowns and inlays	—	—
Number of teeth extracted under general anaesthetic	1,900	866
Number of teeth extracted under local anaesthetic	460	—
Number of general anaesthetics	439	375
Dentures provided:		
Full upper or lower	169	—
Partial upper or lower	16	—
Radiographs	31	1
Other operations	356	4
		(Temp. Teeth)

Dental care for the mentally sub-normal :

Following the Dental Inspection in 1962, 45 children in the City Occupation Centre, or on the waiting list, were treated during 1963. 53 attendances were made by the children and the following treatment was carried out. 87 temporary teeth and 79 permanent teeth were extracted, 48 general anaesthetics were given and one partial upper denture was fitted.

This service was much appreciated by parents.

We receive much support and encouragement from the Chairman and Committee and from all the departments of the Authority, whose co-operation is essential to us. We enjoy also the full co-operation and assistance from the Hospital Service. We are greatly appreciative of this and our gratitude is expressed to all concerned.

W. McKAY, L.D.S., R.C.S.(Edin.),

Principal School Dental Officer.

CHILD GUIDANCE:

Cases treated during the year:

By Psychiatrists	110
By Educational Psychologists	66
By Educational Therapist	271*
By Psychiatric Social Workers	25
In Boarding Homes	26

*Includes 169 new cases this year.

Examinations (New cases):

By Psychiatrists*	171
By Physician*	199
By Educational Psychologists	1,013
By Social Workers	234

*The same child could have been seen by either one or both of these (The actual number of new cases totalled 236).

Re-examination:

By Psychiatrists (excluding treatment interviews)	149
By Physician	23
By Educational Psychologists	67
By Social Workers	165

Attendance and Visits :

Attendances for treatment	6,744
Interviews with parents	1,003
Interviews with others	282
Home Visits by Social Workers	303
School Visits by Educational Psychologists	893
Hostel Visits by Social Workers	72

The Child Guidance staff has continued as last year, our main change being the loss of Dr. Rogers, who has gone to Lancashire. Dr. Benady has come in his place as Senior Registrar. Mr. Hughes came to us as an Educational Psychologist but as I write he is about to leave, feeling that teaching is his more natural bent. It seems to become more and more difficult to get people of the right calibre for this kind of work and it looks as though we shall have to arrange some inservice training, a suggestion which has the full backing of the Director of Education.

We have continued to work in close liaison with the Children's Unit in St. Ann's Hospital and it is surprising to note how often we find it necessary to get a better idea of a child's difficulties by admitting him to the unit for observation and investigation as well, of course, for continued education. (This is a Hospital Special School). The unit has been enlarged by the Regional Hospital Board and is now capable of dealing with 25 pupils (5 day pupils and 20 residents).

During the summer vacation, when there was an appreciable number of youngsters in residence, we were very grateful to have the services of several students from the Nottingham Training College. The students benefited, I hope, by enlarging their experience of maladjusted handicapped children and their associated psychological difficulties.

We are being increasingly embarrassed in the Child Guidance Service by the frequent requests for full reports from the Juvenile Courts. We do all possible to accede to these requests. There are many children from families which we know well, from which we can almost predict there will be social difficulties leading to court appearances, who need social or even material help.

The more one sees of Child Guidance cases, the more it is impressed on one that nowadays many parents have no idea of what their teenage youngsters do with their spare time, where they get to with modern, fast transport, how they spend their more than ample pocket money, or who their pals may be, until they find themselves in trouble. They are then prepared to blame everyone but themselves, or fall back on the expression "I never could do anything with him".

Educational Therapy :

We have continued with the summer holiday arrangements as last year. It is, however, becoming extremely difficult to cater for the many comparatively bright youngsters who are falling behind educationally for numerous reasons. The need for more help in remedial work has been accepted in principle but so far we have not been able to augment the staff working in this narrow orbit. In the meantime, those found by the Educational Psychologists to need intensive educational help are becoming steadily greater in number.

HOSTELS FOR MALADJUSTED CHILDREN :

Children in hostels of this Authority :

	<i>Orston House</i>		<i>The Gables</i>	
	<i>City cases</i>	<i>Notts. C.C. cases</i>	<i>City cases</i>	<i>Notts. C.C. cases</i>
At beginning of 1963 in residence..	6	1	7	1
Admitted during year	6	2	5	—
Discharged during year	6	1	5	1
At end of year in residence..	6	2	7	—

City children in hostels of other Authorities :

	<i>The Grove (Notts. C.C.)</i>
At beginning of 1963 in residence..	1
Admitted during year	1
Discharged during year	1
At end of year in residence..	1

There was a period early in the year when the Gables Hostel staffing was reduced to the Warden, Matron and part-time domestic staff and it was found necessary to employ a married woman with her husband

undertaking some duties in return for his board and lodging. This has worked reasonably well and it has been useful having another man in the hostel. It is surprising (or is it) how boys respond to the requirements of a man, whereas they will readily take advantage of a woman. As I write, the married couple have given notice to leave and we shall once again start on the long and tedious trail of trying to find some extra residential help to assist the Warden and Matron, to allow for their time off, and to undertake those extra duties all so necessary in the running of a residential establishment.

SPEECH THERAPY :

The following is a summary of the work carried out in 1963:—

Number of:					
Cases treated	..	..	..	..	411
Cases under supervision	..	..	..	..	825
Cases discharged	..	..	..	..	376*
School visits	..	..	..	..	112
Cases awaiting treatment at end of year	..	..	..	..	142
*Analysis of 376 cases discharged:					
Maximum benefit	..	..	..	..	261
Improved	..	..	..	..	36
No co-operation	..	..	..	..	17
Removed from waiting list	..	..	..	..	20
Left school or district	..	..	..	..	37
Referred to Child Guidance	..	..	..	..	3
Treated elsewhere	..	..	..	..	2
Visitors:					
2nd Year Students	..	..	..	..	4
Student from Portugal	..	..	..	..	1
Prospective Student	..	..	..	..	1

Last year I mentioned that a survey of a ten per cent. cross-section of the primary school population had been undertaken by the speech therapists. It was impossible to incorporate it in the Annual Report, chiefly because of the unfortunate accident which Dr. Daniels of the Institute of Education of the University of Nottingham suffered and which incapacitated him for a considerable time. He had agreed to give us the statistical results of the survey. These were held up but I am glad to say that we are now able to include them this year and the following is a summary of the results.

Speech Defect Survey

The suggestion for this survey came from Dr. Esther Simpson of the Special Services Branch of the Department of Education and Science. The aim of the survey was to get some idea of the current incidence of speech defects and to help in finding out how many speech therapists are required in proportion to the school population.

The Director of the Institute of Education, University of Nottingham, very kindly agreed to co-operate in the survey. This ensured that the survey would be carried out in a methodical and unbiased manner under the guidance of a statistician.

It was decided that the five Nottingham Speech Therapists (including the Senior) should test a 10% sample of the whole primary school population of the County Borough, (116 schools having 29,915 children on

rolls). Every tenth name on the school registers was listed by the Education Welfare Officers regardless of form or class dimensions. The aim of the survey was explained to the Head Teachers and their co-operation was asked for in a letter from the Director of Education.

The speech therapists were to find out how many children in the 10% sample used speech which deviated in some way from the norm, taking into consideration (1) the child's age, and (2) the dialectal speech of social groups. Pilot experiments were carried out to ascertain how reliable were the assessments of the speech therapists in making judgments of children's speech by means of only a short interview and what would be the best system of recording and classifying the speech therapists' observations.

Infant children were asked to count from 1 to 10 and then name seven familiar objects illustrated on a card—an orange, a dog, a spoon, a table, a leaf, a chair and a fish. Junior children were asked to count from 1 to 10 and then describe a picture which was shown to them.

The performances of the children were placed into three main categories:—

- (A) those with obvious speech defects who were clearly in need of treatment (including those with isolated 'r', 'l' and 's' defects if the child was six years of age or over),
- (B) this category had nine sub-divisions and was for those requiring: preliminary orthodontic or ear, nose and throat examinations, supervision until second dentition complete, observation for slight articulatory defects and occasional stammers etc., and
- (C) those who were Normal and required no treatment.

To check the reliability of the judgments made by the speech therapists, the children in the sample in six infant and six junior schools were tested twice by two different speech therapists (using four speech therapists in all). The positive correlation was 0.86 for the infant schools and 0.96 for the junior schools. It was evident from this result that following on the developments of the techniques of examining and recording the results in the pilot experiments and the consequent increase in skill that the trial runs had induced, a very high degree of reliability of the judgments was achieved. A considerable degree of confidence in the final estimates of the number of children who stand in need of speech therapy can, therefore, be claimed.

The table gives for each age group separately the percentage of boys and girls in the three main categories of speech performance. The nine sub-divisions have been amalgamated for this summary.

Percentage of Boys and Girls in each Category at the Various Age Levels.

Year of Birth and Age Range in Years and Months	CATEGORIES					
	"A" (in need of treatment)		"B"		"C" (Normal— No treatment)	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
1958 3y. 3m.—4y. 2m. ..	6.67	—	6.67	11.11	86.66	88.89
1957 4y. 3m.—5y. 2m. ..	3.85	4.26	11.53	9.56	84.62	86.18
1956 5y. 3m.—6y. 2m. ..	10.31	10.63	22.43	17.40	67.26	71.97
1955 6y. 3m.—7y. 2m. ..	14.65	9.31	13.13	13.75	72.23	85.94
1954 7y. 3m.—8y. 2m. ..	18.26	16.92	20.09	14.46	61.65	68.62
1953 8y. 3m.—9y. 2m. ..	19.35	9.33	23.95	11.11	56.70	79.56
1952 9y. 3m.—10y. 2m. ..	11.06	5.07	23.06	10.13	65.88	84.80
1951 10y. 3m.—11y. 2m. ..	10.91	4.98	17.69	8.47	71.40	86.55
1950 11y. 3m.—12y. 2m. ..	2.94	3.17	8.82	6.34	88.24	90.49
Age Groups combined	12.85	8.67	22.05	14.45	65.10	76.88

Conclusions and Comments:

1. There is some doubt at the present time about the proportion of primary school children who suffer from speech defect to such a degree that they need the attention of the speech therapy service. Previously, it was thought that there were between 1% and 3% who suffered to this degree but the results of this survey show that of a random sample totalling 2,867 children, 10.6% (boys 12.85%, girls 8.67%) were judged to be in category "A", i.e. those who were clearly in need of treatment.
2. A much larger proportion of children (boys 22.05%, girls 14.45%) were reported as having various minor defects of speech to a degree that it was felt they should be kept under some sort of continuous observation so that, if necessary, treatment could be provided at the appropriate time.
3. It is noticed that there is a gradual fall with age in the number of children judged by the speech therapists to be in need of treatment (**boys**—highest 19.35% in 8.3—9.2 years group—lowest 2.94% in 11.3—12.2 years group; **girls**—highest 16.92% in 7.3—8.2 years group—lowest 3.17% in 11.3—12.2 years group). The decline in the proportion of girls in need of treatment after nine years of age is much more rapid than for boys. It was found that the *th* defect is much less frequent among girls than among boys. However, it is impossible from our data to estimate to what extent speech therapy assists or accelerates this improvement. It is evident that speech defects in general were judged to be more common among boys than among girls.
4. Included in the sample of 2,867 children examined, only 77 children who were placed in category "A" and 21 children who were placed in

category "B" were found to be already on the record files of the speech therapy service. These 98 children constitute 3.4% of the sample, whereas we found in the survey that 10% of the children were judged to be in category "A". This ignores those who were placed in category "B".

Thus, we can say that only a third of the children needing the help of the speech therapy service were actually getting it.

5. Of the children who were judged to be in need of treatment, the majority were children with articulatory defects, that is, they had developmental disorders of speech and language. A smaller proportion had disorders arising from physiological or anatomical malfunction. No child was found, however, with a cleft palate that was unknown to a plastic surgeon nor was any grossly dysarthric child who had not been referred for treatment or investigation by the speech therapy service.

The results of the survey are to be published in full in the Autumn of 1964 (price 2s. 6d.) by the Institute of Education, University of Nottingham.

CLEANLINESS:

	1958	1959	1960	1961	1962	1963
On school rolls ..	52,242	52,089	51,691	51,694	50,846	50,382
Examinations	161,622	160,796	165,719	162,576	152,551	140,544
Number found unclean	5,326	4,848	4,424	4,458	3,745	3,500
Percentage of the number on rolls ..	10.2	9.3	8.5	8.6	7.4	6.9
Statutory notices to parents	51	73	79	61	69	55
Children cleansed ..	37	54	61	53	56	42

It is regrettable that it is still necessary to employ staff, whose main duty is to deal constantly with an unsatisfactory state of head cleanliness. It is essential not to let this side of the work slide, for although we do not think the spread occurs in the schools, an infected child could always be a source of spread. This can be noticed after the summer holidays when we invariably find not only our usual offenders but some of their playmates are also affected.

The above figures, I think, are in themselves a token of thanks to our nurses' assistants. The steady reduction in the numbers affected, the reduced need to send statutory notices to parents and the smaller number of children whose heads had to be cleansed, are all evidence of work well done.

OPHTHALMIC SERVICE:

The arrangements for the ophthalmic service continued unchanged.

	1958	1959	1960	1961	1962	1963
No. of pupils on rolls on 31st December	52,242	52,089	51,691	51,694	50,846	50,382
Pupils refracted	4,773	4,786	4,562	4,536	4,477	4,664
Percentage	9.1	9.2	8.8	8.8	8.8	9.2
Spectacles prescribed (pupils)	1,660	1,603	1,607	1,504	1,525	1,457
Percentage	3.2	3.1	3.1	2.9	3.0	2.8

It is surprising how steady the figures for prescribed glasses remain over the years. This service is run entirely by the Regional Hospital Board,

the Consultants being seconded to this department by the Sheffield Regional Hospital Board.

The school nurses held 190 sessions for dealing with broken or lost spectacles. Repairs for 618 broken spectacles were authorised and 113 replacement pairs were necessary.

Orthoptic Treatment at the Nottingham Eye Hospital:

	1958	1959	1960	1961	1962	1963
New cases treated	58	130	38	72	75	67
Total treated	159	291	164	165	153	146
Awaiting test or treatment at end of year	52	12	11	5	6	3

Operations for Squint at the Nottingham Eye Hospital:

	1958	1959	1960	1961	1962	1963
Number of operations ..	40	69	52	41	38	48
On waiting list at end of year	39	39	33	22	18	14

This work is done at the Nottingham Eye Hospital. All cases in need of either form of treatment are referred to the hospital from the School Health Service by the Regional Hospital Board Consultants concerned.

EAR NOSE AND THROAT DEPARTMENT:

Number of Operations for Tonsils and Adenoids	548
Number of Operations for Tonsils only	93
Number of Operations for Adenoids only	150

We have continued the arrangements in this department as usual. Unfortunately, we lost our Ear, Nose and Throat Consultant and Surgeon by sudden death in May, and although a locum took his place fairly quickly, nevertheless there was, of necessity, some change in the work of the department. It so happened that this coincided with an appreciable fall in the numbers on our waiting list and we have, therefore, been able to cope with this reduced list without difficulty.

Mr. J. F. Neil now undertakes one Consultant Out-Patient session and one operating session per week and Mr. E. Kaplan, pending the appointment of Mr. Marshall's successor, also does one of each. Both are seconded to us by the Sheffield Regional Hospital Board.

Visiting of the youngsters by parents has been allowed on the evening following the day of operation. It is only occasionally that this creates any emotional difficulty and it is working satisfactorily for all concerned. One has to bear in mind that these youngsters have rarely previously been separated from their parents and the children must, therefore, feel quite lost and strange. The knowledge that their "mum" or "dad" will be coming to see them before they go home is something to look forward to. Recently the youngsters admitted seem to have been among the younger age groups and these naturally are more inclined to need the presence of their parents for part of their in-patient sojourn.

AUDIOMETRY:

Mr. Ward, the Audiometrician, attended for 25 sessions during the year. He tested 235 selected children who made 254 attendances.

We have continued to be selective in our arrangements for audiometry. Only the following groups of children are tested, with a pure tone sweep audiometer:—

1. Those with speech defects or difficulties.
2. Those families at risk (hereditary deafness, old tuberculosis or other meningitis, maternal rubella or near miscarriage, etc.).
3. Those felt by parents, teachers, school nurses or medical officers to have possible hearing defects.

A random check on a hundred children who were tested gave the following results:—

Old otitis of catarrhal type	..	..	..	49
High frequency loss	..	..	..	1
Active Otitis Media Suppurative	..	..	..	6
Indefinite cause of hearing loss	..	..	..	12
(1 advised hearing aid but refused)				
No defect found	..	..	..	28
Wax	..	..	..	4

It will be noted that over a quarter of the youngsters had no deafness on test. Six were known to have active otitis media and an audiogram was arranged to give the present hearing so that it could be compared with previous or future readings to note deterioration or otherwise. The cases having catarrhal loss, if of more than 30 decibels, will be re-checked in the course of the next twelve months. All 49 have been, or will be, seen by the Ear, Nose and Throat Consultant so that treatment can be carried out if necessary.

EXAMINATION OF REMOVED TONSILS FOR HAEMOLYTIC STREPTOCOCCI:

Haemolytic Streptococcal Check on Tonsils:

1961

		<i>Positive</i>		<i>Negative</i>		<i>Total</i>
		<i>Number</i>	<i>Proportion of total</i>	<i>Number</i>	<i>Proportion of total</i>	
January	..	6	13%	39	87%	45
February	..	9	32%	19	68%	28
March	..	4	25%	12	75%	16
April	..	23	37%	39	63%	62
May	..	8	16%	42	84%	50
June	..	9	21%	32	78%	41
July	..	No operations		No operations		—
August	..	No operations		No operations		—
September	..	18	21%	64	79%	82
October	..	9	18%	40	82%	49
November	..	2	17%	10	83%	12
December	..	No operations		No operations		—
Totals	..	88	22.9%	297	77.1%	385 (100%)

1962

	<i>Positive</i>		<i>Negative</i>		<i>Total</i>
	<i>Number</i>	<i>Proportion of total</i>	<i>Number</i>	<i>Proportion of total</i>	
January ..	Nil	—	12	100%	12
February ..	12	25%	36	75%	48
March ..	7	16%	37	84%	44
April ..	4	9%	40	91%	44
May ..	15	29%	36	71%	51
June ..	10	28%	26	72%	36
July ..	22	34%	43	66%	65
August ..	No operations		No operations		—
September ..	49	53%	43	47%	92
October ..	47	51%	45	49%	92
November ..	41	44%	51	56%	92
December ..	19	40%	28	60%	47
Totals ..	226	36.3%	397	63.7%	623 (100%)

1963

	<i>Positive</i>		<i>Negative</i>		<i>Total</i>
	<i>Number</i>	<i>Proportion of total</i>	<i>Number</i>	<i>Proportion of total</i>	
January ..	38	49%	39	51%	77
February ..	29	51%	28	49%	57
March ..	31	69%	14	31%	45
April ..	40	77%	12	23%	52
May ..	22	63%	13	27%	35
June ..	29	52%	27	48%	56
July ..	34	56%	27	44%	61
August ..	No operations		No operations		—
September ..	25	66%	13	34%	38
October ..	46	61%	30	39%	76
November ..	34	56%	27	44%	61
December ..	16	57%	12	43%	28
Totals ..	344	59%	242	41%	586 (100%)

In the above three years, while our numbers have varied a little, there seems to be a general increase in the number of tonsils infected with streptococci (the organisms responsible for epidemic sore throats, rheumatic conditions and occasional nephritis). This is the first year in which more than 50% of tonsils were infected, and it looks as though there should be other evidence of this organisms presence.

OTITIS MEDIA SURVEY:

As mentioned in the introduction, we have endeavoured to get as much information as possible about ear conditions at the same time as we carried out the usual medical examinations.

The following is a summary of the results we obtained after seeing some six thousand youngsters. It will be seen that over five per cent. of the children examined have a history of otitis media.

Number of pupils seen	6,229
Less those with wax obscuring drums	201
Number of pupils examined for the survey ..	6,028

Number of instances found:

	<i>No. of instances</i>	<i>Percentage of the 6,028</i>
1. Any history of otitis media	351	5.8
2. Any active otitis media supp.	31	0.5
3. Granulations	6	0.1
4. Otorrhoea	28	0.5
5. Patent perforation present	25	0.4
6. Healed perforation	67	1.1
7. Scarring present	205	3.4
9. Any loss of hearing	72	1.2
9. Mastoid scar	9	0.15
10. Deformity of M.T.'s—any displacement of light reflex	157	2.6
11. Evidence of other upper respiratory tract infection	55	0.9
12. Nose unsatisfactory	55	0.9
13. Throat or nasal obstruction (? Adenoids) ..	40	0.7
14. Other		
(a) Hearing loss due to wax	10	0.2
(b) Not stated	6	0.1
TOTAL NUMBER OF PUPILS FOUND TO HAVE ONE OR MORE OF THE ABOVE DEFECTS		469
		7.8

ORTHOPAEDIC TREATMENT:**Children treated as out-patients:**

At Nottingham Orthopaedic Clinic	69
At Nottingham Children's Hospital	319

Children treated as in-patients:

At Harlow Wood Orthopaedic Hospital	95
At Nottingham Children's Hospital	281

Because of difficulties in attendance at our Central School Clinic, it was agreed with Mr. Waugh that he should see his patients at the Nottingham Orthopaedic Clinic. This has worked well and he has kept us up-to-date with information about them as well as letting their own doctor know the results of his examinations.

It is interesting to have some idea of the multitude of conditions dealt with as in-patients. I have, therefore, given below a list of these in some twenty-five children chosen at random from the 95 in-patients treated at Harlow Wood Orthopaedic Hospital:—

Nail off.	Ganglion.
Nerve suture.	Cartilage, knee (2).
Slipped epiphysis.	Cyst on knee joint.
Osteomyelitis.	Leg amputation for congenital deformity.
Osteochondritis—knee.	Flat feet.
Hallux rigidus.	Steindler for foot.
Overlapping toes.	Knock-knee (2).
Torticollis.	Perthe's hip.
Lumbar disc condition.	Tumour of foot.
Foot defect.	5th toes bent causing pressure from shoes (amputated).
Hallux valgus.	
Exostosis L. tibia (2)	

It is worth noting that the two youngsters who needed operation for knock-knees were both overweight.

It is interesting that although children's out-patient attendances have been reduced, there is actually an increase in the number of in-patients.

This means, of course, a better turn-over of beds, and as will be noted from the list of cases dealt with, more operations on conditions which relieve deformities and which can be dealt with only in a hospital.

ELECTRICAL AND OTHER TREATMENT:

Ultra-Violet Ray:

Number of children treated..	..	..	10
Number of attendances	..	..	128

This form of treatment becomes less and less fashionable as the past two years' figures show. Although it may give a superficial sunburnt and healthy look, this merely flatters to deceive. It can, however, be extremely effective for some skin conditions.

Ionisation:

Number of children treated..	..	..	77
Number of attendances	..	..	722

We still find this form of treatment with Magnesium Sulphate effective in many cases of warts, especially plantar warts. It is sometimes said that the effect is purely psychological and that the buying of the wart for sixpence, touching it frequently with the "milk" from a dandelion or casting a spell over it can have the same effect. I am sure, however, that these latter forms of "treatment" may be more picturesque but less certain.

Proetz:

Number of children treated..	..	..	59
Number of attendances	..	..	640

This suction treatment of infected sinuses is still very useful and effective. Figures are down on last year because of the reduced attendances of the Ear, Nose and Throat Consultants mentioned earlier.

COLOUR VISION:

	<i>Children with defective colour vision</i>		
	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
Secondary Modern Schools (Leaver)..	98	1	99
Grammar Schools (Leaver) ..	21	—	21
Junior Schools (Intermediate)..	61	4	65
TOTALS ..	180	5	185

Many Authorities have given up testing the colour vision of girls because of the small numbers involved, but nowadays when girls are employed in electronic work and wires covered with plastics of similar colour have to be used, it is important that their colour vision should be normal. I am told that girls do this exacting work more readily and quickly than boys.

ROAD ACCIDENTS AND HEARING DEFECTS:

In a Sunday paper in January, 1963, it was suggested that hearing difficulties might account for many of the accidents to children on our roads. In fact the article noted that more than half of the children concerned had a defect of hearing in one or both ears.

In an endeavour to check on this possibility here, the Chief Constable of Nottingham very kindly supplied me with a complete list of the names of all school children involved in road accidents during the

year 1962. The medical record cards of all the children concerned were scrutinised for possible ear, nose or throat defects. All those who in any way had had ear, nose and throat examinations were checked in school with the following results:—

Number of accidents to children in the City	303
Non-City children or no trace of medical inspection records	56
Number of cases investigated (medical inspection records perused)	247
Number of cases found with possible ear trouble	38
Number of cases left school	4
Number of cases for hearing test	34

Result of Hearing Tests

	25 words at 15 ft. Test				20 words at 10 ft. Test		Totals
	25-24 words	23-22 words	21-20 words	Below 20	20-19 words	18-17 words	
BOYS	6	6	4	2	2	—	20
GIRLS	6	4	3	—	—	1	14
TOTAL	12	10	7	2	2	1	34
Percentage of Number tested ..	35%	29%	21%	6%	6%	3%	100%

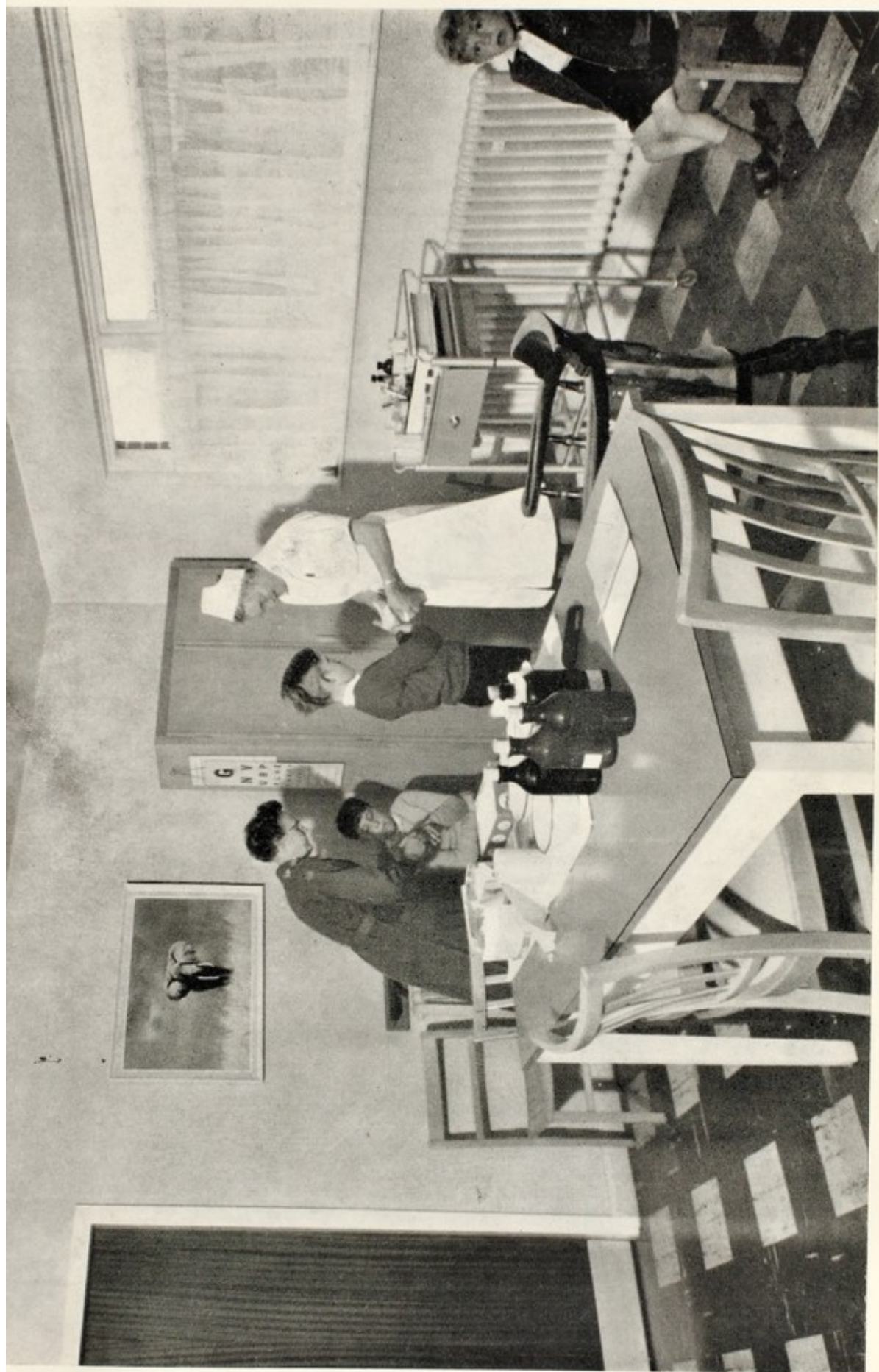
Conclusion:

It was impossible to lay the blame for road accidents on to loss of hearing.

SCHOOL ACCIDENTS:

The number of accidents to school children reported as occurring (in school) totalled 848 this year.

Dr. More has again analysed the accident reports and a table giving the comparison with last year is included below.



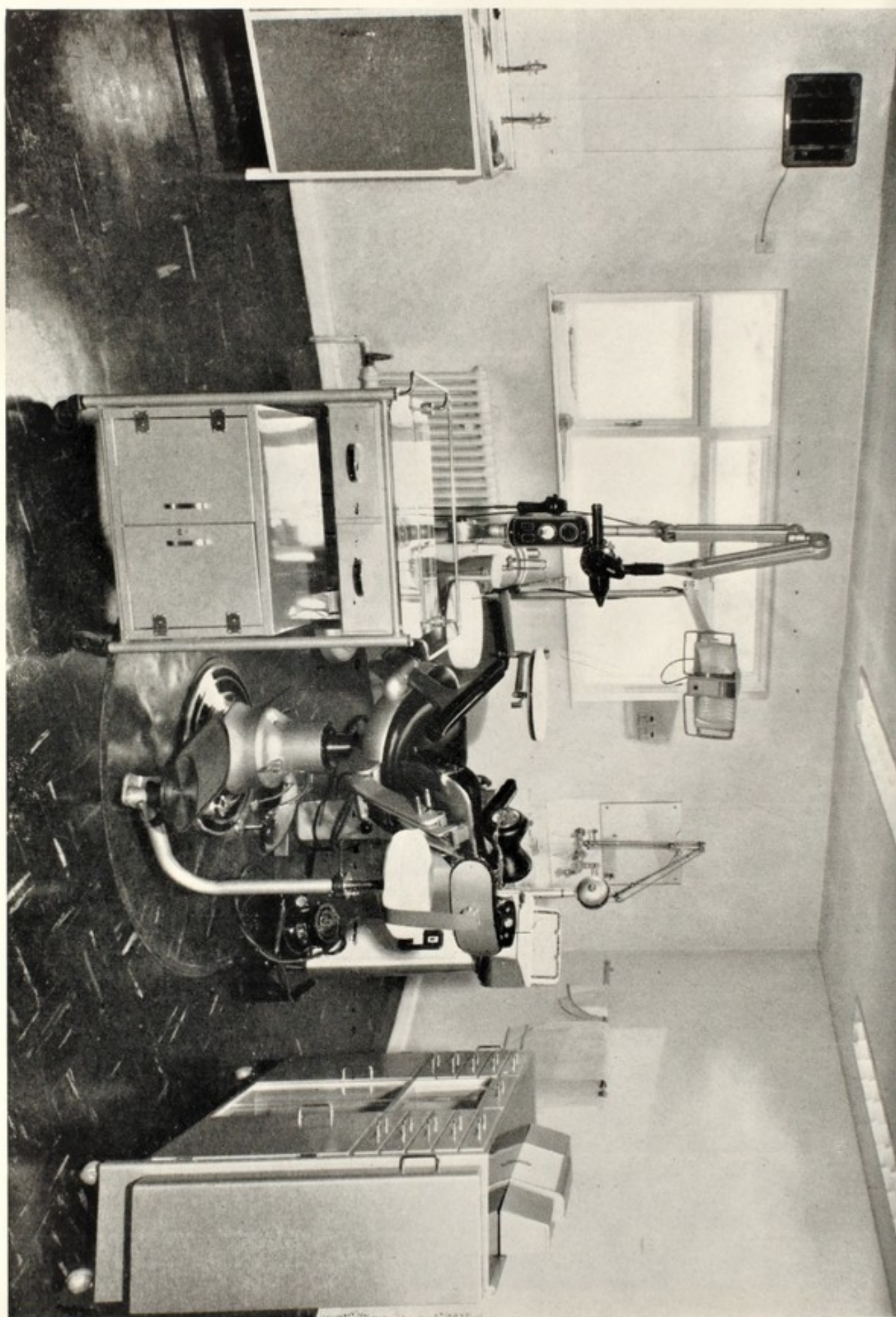
Children's minor ailments being treated at our newest Clinic



The Joinery Wor



Special School



SCHOOL ACCIDENTS **Analysis of Accidents occurring during Physical Education and Games**

	1962			1963		
	Number	Percentage	Percentage of School Population	Number	Percentage	Percentage of School Population
Total number of accidents reported—all causes ..	793	100		848	100	
1. Number reported occurring at P.E., dancing, swimming and games	268	33.8		286	33.7	
2. Sex:—						
(a) accidents to boys	164	61.2		185	64.7	
(b) accidents to girls	104	38.8		101	35.3	
3. (a) accidents occurring during P.E. and dancing	113	42.2		130	45.4	
(b) accidents occurring during games and swimming	155	57.8		156	54.6	
4. Accidents apparently serious	70	26.0		48	16.8	
5. Type of School:—						
(a) primary and special	B 50 G 17	25.0	Boys 0.15 Girls 0.05	B 52 G 15	23.4	Boys 0.17 Girls 0.05
(b) bilateral, secondary and comprehensive	67 78 73	56.3	0.2 0.48 0.45	67 96 66	56.7	0.2 0.59 0.41
(c) grammar and secondary technical ..	151 38 12	18.7	0.9 0.84 0.26	162 37 20	19.9	1.0 0.80 0.43
	50		1.1	57		1.2

PAEDIATRIC CONSULTATIVE CLINIC:

The following is a breakdown of the numbers of children who have attended Dr. Page's clinic during the year:—

	<i>Number of Cases</i>	<i>Number of attendances</i>
Heart conditions	54	75
Undescended testicles	37	53
Obesity, development, etc. ..	79	149

Dr. Page continues to take a considerable paediatric interest in other conditions apart from heart abnormalities. Obesity has become one of the subjects quite near to his heart and the numbers attending his clinic have once again increased. He only sees the real heavy-weights, not only because medical officers like to treat their own (if treatable), but because at times it needs his assurance to the parent that the condition is not due to some defect of the glands, and that diet, if really persisted in, can bring back the child to normal. Results are rarely spectacular, failures being probably more common than successes. Girls will more often stick to their diet than boys. The difficulty of getting attractive frocks to fit is one stimulus that may keep them to it. Perhaps there was something in the song of Ronald Frankau "No one ever loves a fat girl" which might be also an encouraging factor.

A survey of children having overweight conditions follows.

SURVEY OF OVERWEIGHT CHILDREN:

Once again, we have drawn up a graph of the numbers of our overweight children and a comparison with 1962 and 1960 is interesting. There seems no doubt that both amongst boys and girls, there are fewer really fat children. The secondary peak which previously had been around the fifteen year old level has moved forward to the thirteen year olds in both boys and girls.

In drawing conclusions from these figures, a number of questions occur to my mind—are we seeing a real reduction in our numbers of fatties, or is this merely a temporary fall? If the former, are children becoming more self-conscious about their overweight conditions and voluntarily cutting down their excessive intake of food? Are other factors at work, e.g. are parents and teachers encouraging the fatties to take more exercise? Would it be wise to give them some intensive physical exercise at the same time as they reduce their intake of calories? What is the attitude of this group to exercise? How many of them have become addicted to riding in motor cars?

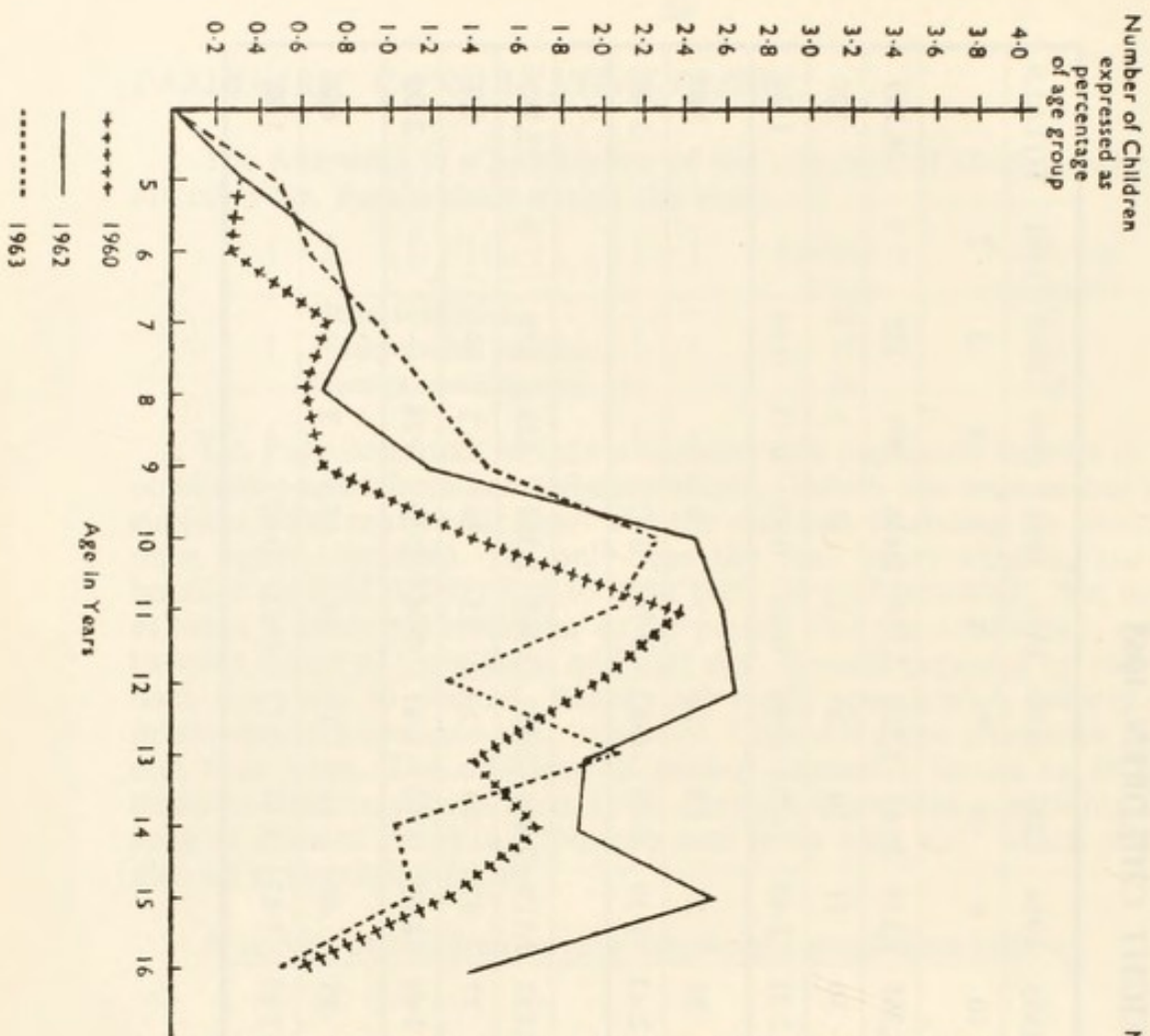
It can be said that fat children are often made to feel self-conscious when they are unable to take part in the usual, everyday physical activities of their school-fellows, or if they cannot take a fair share in the games of their contemporaries. This unpopularity may, on occasion, result in feelings of inadequacy, inferiority, moodiness and slipshod mental, as well as, physical attitudes.

NURSES' SURVEY OF OVERWEIGHT CHILDREN, 1963

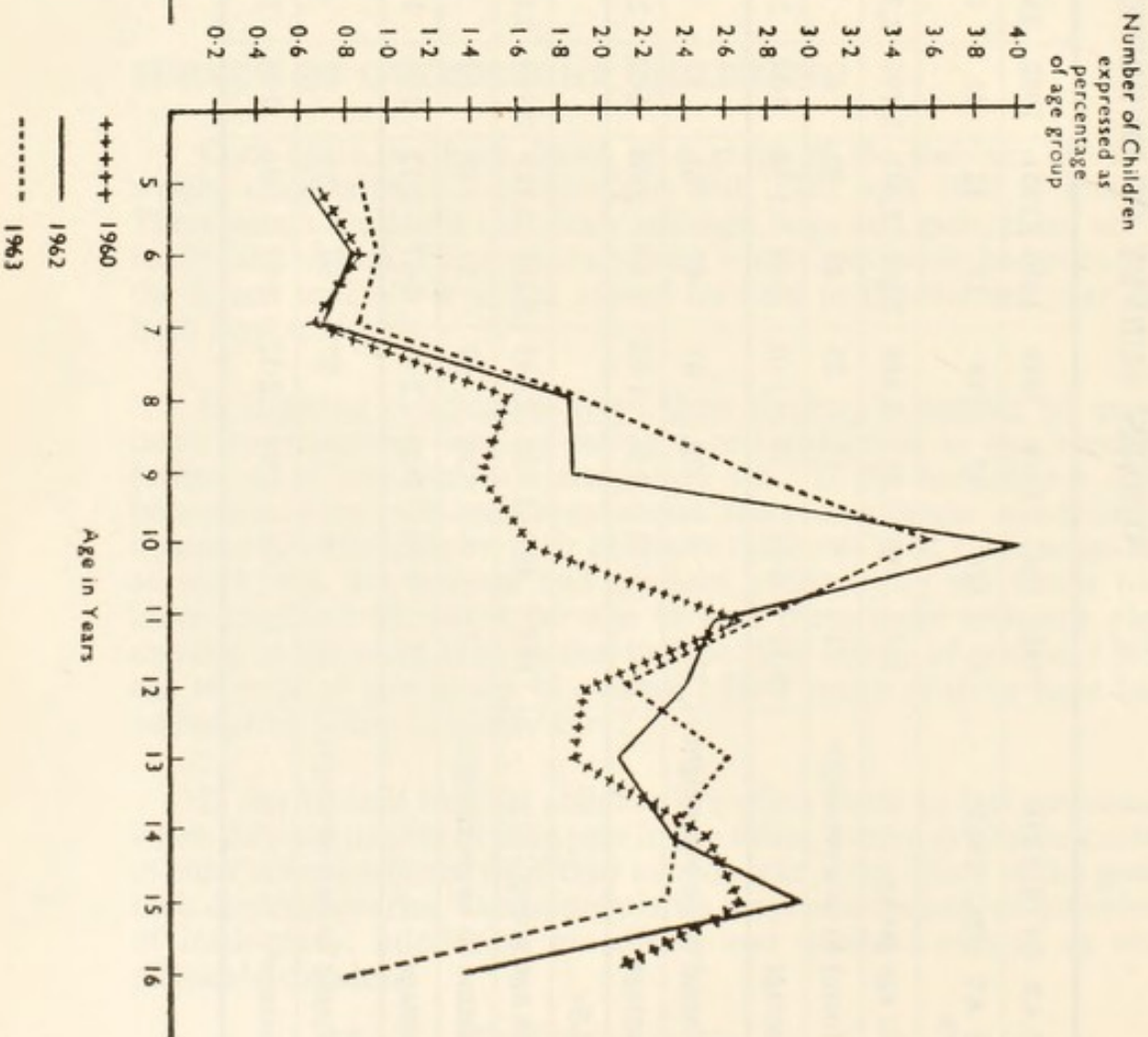
YEAR OF BIRTH	1946	1947	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	TOTALS
AGE AT DEC. 1963 BOYS	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	
No. in age group	324	560	1,315	2,468	2,401	2,247	2,195	2,265	2,135	2,161	2,222	2,379	2,466	901	225	5	26,269
No. found to be overweight	1	3	15	25	49	30	47	50	31	26	20	15	11	3	1	—	327
Percentage	0.31	0.54	1.14	1.01	2.04	1.34	2.14	2.21	1.45	1.20	0.90	0.63	0.45	0.33	0.44	—	1.24
1962: No. found to be overweight	1	6	29	47	47	63	57	54	27	15	18	17	9	—	—	—	390
Percentage	0.62	1.33	2.56	1.89	1.90	2.60	2.52	2.43	1.19	0.69	0.82	0.75	0.37	—	—	—	1.48
GIRLS:																	
No. in age group	173	497	1,420	2,493	2,211	2,113	2,169	2,132	2,119	2,096	2,187	2,392	2,313	829	210	8	25,362
No. found to be overweight	3	4	34	60	59	45	62	77	57	40	20	23	20	2	—	—	506
Percentage	1.75	0.80	2.39	2.41	2.67	2.13	2.86	3.61	2.69	1.90	0.91	0.96	0.86	0.24	—	—	2.00
1962: No. found to be overweight	1	4	33	57	50	52	52	85	40	41	16	18	15	2	—	—	466
Percentage	—	1.26	2.94	2.32	2.01	2.36	2.51	3.93	1.87	1.88	0.77	0.82	0.62	—	—	—	1.84

OVERWEIGHT CHILDREN

BOYS



GIRLS



SCHOOL NURSES:

The following is a summary of the work of the school nurses during 1963:—

Visits to schools	1,175
Visits to nursery schools and classes	631
Visits to schools for routine medical inspection	2,075
" " " " uncleanliness	71
" " " " investigation of infectious disease	3
" " " " other purposes	141
Visits to homes for uncleanliness	1,233
" " " " deafness and other ear conditions	98
" " " " absentees from ophthalmic clinic	796
" " " " absentees from T. and A. clinic	101
" " " " follow-up after T. and A. operation	29
" " " " miscellaneous reasons	1,900
Clinic sessions	5,262

Among the visits to schools noted above, we have asked our nurses to undertake the checking of both vision and hearing in the Clifton Schools. These are the two conditions which are not likely to be examined apart from at school. Any doubtful ones are referred to the medical officer who is in the school for selective examinations at least once a term. I feel that in this way, there is little likelihood of much being missed as a result of the change-over to selective examinations.

INFECTIOUS DISEASES:

The figures over the past seven years for the more common conditions are given below:—

	1957	1958	1959	1960	1961	1962	1963
Chicken Pox	1,617	1,412	2,560	2,662	784	2,286	1,039
Measles	2,005	1,401	1,388	2,128	1,589	855	1,749
German Measles	215	188	214	222	577	1,177	3,761
Mumps	2,080	266	879	3,965	318	416	2,292
Scarlet Fever	244	216	304	167	74	38	99
Whooping Cough	169	194	339	329	88	45	220

The number of known cases of whooping cough has been reduced until this year. It is doubtful if this year's increase is of any real significance. Whooping cough vaccination may not be completely effective but it does reduce the severity of the condition.

IMMUNISATION AND VACCINATION:

I am indebted to the Medical Officer of Health for the following statistics. Dr. Dodd points out that the figures for poliomyelitis and diphtheria refer to the whole child population of school age in the City, whereas the figures for B.C.G. vaccination apply only to those schools maintained by the Education Authority.

Poliomyelitis Vaccination:

The following table shows the number of school children who have received 3 injections at 31st December, 1963. In addition, 3,940 of these children were given their fourth dose against poliomyelitis.

<i>Year</i>	<i>No. of Children</i>	<i>Estimated Population Ages 5 to 15 years</i>	<i>Percentage</i>
1958	693	49,200	1.4
1959	32,166	49,300	65.2
1960	37,140	49,000	75.8
1961	38,028	48,400	78.6
1962	39,782	47,700	83.4
1963	41,533	46,500	89.3

Diphtheria Immunisation:

The table shows the number of children who have been immunised against diphtheria at 31st December, 1963.

<i>Year</i>	<i>No. of Children</i>	<i>Estimated Population Ages 5 to 15 years</i>	<i>Percentage</i>
1958	42,840	49,200	87.0
1959	40,658	49,300	82.4
1960	41,398	49,000	84.5
1961	40,724	48,400	84.1
1962	38,855	47,700	81.4
1963	38,602	46,500	83.0

B.C.G. Vaccination:

	1958	1959	1960	1961	1962	1963
Maintained Schools visited ..	44	50	43	45	47	47
No. of 13 year olds ..	4,165	5,197	6,149	4,938	4,768	4,695
No. of acceptances ..	2,791	3,455	4,235	3,606	3,631	3,482
No. of refusals ..	1,294	1,595	1,804	1,224	1,032	1,105
No. of others ..	80	147	110	108	105	108
No. tested ..	2,592	3,265	3,957	3,394	3,396	3,298
Negative reactors vaccinated ..	2,155	2,814	3,388	3,050	2,863	2,781
Positive reactors ..	371	372	498	285	454	424

The demand for smallpox vaccination, which had been so great last year, almost entirely disappeared in 1963. As I write, some cases of typhoid on the Continent are making T.A.B. vaccination desirable in those going for continental holidays.

TUBERCULOSIS IN SCHOOLS:

As noted in my preamble, there have been cases in schools or closely associated with schools which have warranted further investigation and it is interesting to note that during the last eight years, there have been investigations in schools as described below:—

1956 (Jan.)	A Secondary Modern Girls' School ..	..	..	Selective X-rays.
1957 (Mar.)	A Voluntary School ..	..	..	Skin tests and X-rays.
1957 (Apr.)	A Secondary Modern Girls' School ..	..	..	Selective X-rays.
1957 (Sept.)	A Junior School ..	..	..	Selective X-rays.
1957 (Sept.)	An Infant School ..	..	..	Selective skin tests.

1957 (Oct.)	A Voluntary Grammar School	.. ..	X-rays (whole school).
1957 (Dec.)	A Secondary Modern Boys' School	.. ..	Selective X-rays.
1958 (Apr.)	A Girls' Grammar School	.. ..	Selective X-rays.
1959 (Mar.)	A College of Further Education	.. ..	Selective X-rays.
1961 (Nov.)	A Secondary Modern Girls' School	.. ..	Selective skin tests.
1962 (Jan.)	A Voluntary School (same school as March, 1957)	.. ..	Skin tests (whole school).
1962 (Mar.)	A Mixed Grammar School	.. ..	Selective X-rays.
1962 (Dec.)	A Secondary Modern Girls' School	.. ..	Selective X-rays.
1962 (Dec.)	A Mixed Grammar School	.. ..	Selective X-rays.
1963 (Feb.)	A Secondary Modern Girls' School	.. ..	X-rays (Staff)
1963 (Dec.)	A Secondary Modern Boys' School	.. ..	Selective skin tests.
1963 (Dec.)	A Secondary Modern Boys' School	.. ..	X-rays (whole school)

We cannot be too grateful for the services so readily given by the Miniature Mass Radiography Unit and the Chest Centre.

CONVALESCENT HOME TREATMENT:

During the year, 51 children were sent to the following convalescent homes, compared with 26 in 1962:—

Charnwood Forest Convalescent Home, Woodhouse Eaves	.. ..	30 children
Roecliffe Manor Convalescent Home, Woodhouse Eaves	.. ..	18 children
Others	.. ..	3 children

Although the number of youngsters going to convalescent homes is not large, there does still seem to be some children who need a change from their homes, from the unimaginative food supplied there, and occasionally, from the highly emotional and upsetting atmosphere and also at times from the openly aggressive and physically hurtful attitude of their parents; or it may be that constant disharmony between the parents is upsetting a child's physical and emotional health.

CARDIAC REGISTER:

Details of our cardiac register as at 31st December, 1963, are as follows:—

1. Total number of children on the register:

1. Total number of children on the register 1.1.1963	.. ..	32
2. Number added to register during 1963	.. ..	8
3. Number removed from register during 1963	.. ..	*1
4. Total number of children on register 31.12.1963	.. ..	39

(One child included above came from Leicester; *this child died in March, 1963).

2. Diagnoses:

(a) Acyanotic heart defects:

1. Patent interventricular septal defect	.. ..	13
2. Aortic stenosis (uncomplicated)	.. ..	1
3. Mild pulmonary stenosis	.. ..	1
4. Mild aortic stenosis+another unidentified lesion	.. ..	1
5. Patent interventricular septal defect+pulmonary stenosis	.. ..	1
6. Patent interventricular septal defect with mild infundibular pulmonary stenosis and small left to right shunt	.. ..	1
7. Patent ductus arteriosus, successfully ligated	.. ..	2
8. Patent ductus arteriosus, ligated, subsequently developed ductus aneurysm, this now having been successfully ligated	.. ..	1
9. Patent ductus arteriosus awaiting operation	.. ..	1
10. Patent ductus arteriosus with congenital pulmonary stenosis	.. ..	1
11. Unidentified acyanotic heart lesion	.. ..	2
12. Unidentified acyanotic heart lesion with many other congenital defects	.. ..	1
13. Acyanotic form of Fallot's Tetralogy	.. ..	1
14. Congenital heart block, lesion unidentified	.. ..	2

(b) Cyanotic heart defects:

1. Tetralogy of Fallot	.. ..	2
(Both having had one operation—one awaiting further surgery).		
2. Tetralogy of Fallot complicated by other congenital heart defects	.. ..	5

As a result of investigations, 2 of the children listed in 1962's register as having Fallot's Tetralogy + 1 child with Fallot's Tetralogy and another lesion have been more accurately diagnosed.

(i) Tetralogy of Fallot + patent interventricular septal defect ..	1
(ii) Tetralogy of Fallot + patent interventricular septal defect and stenosed valve	1
(iii) Tetralogy of Fallot + R. sided aortic arch	1
(iv) Tetralogy of Fallot + pulmonary stenosis	1
3. Cyanotic lesion—persistent tunicus arteriosus	1
4. Cyanotic lesion, undiagnosed	1
(c) Rheumatic carditis	1

3. Alterations in diagnosis:

There were no changes in diagnosis but a closer diagnosis was made following investigations in the following cases:—

1. **Girl born 11.9.55:** Fallot's Tetralogy—was found to have in addition a large patent interventricular septal defect and a stenosed valve. She is awaiting surgery.
2. **Boy born 17.4.54:** Fallot's Tetralogy for which he had a Blalock's operation. He has remained cyanosed and dyspnoeic and is now also thought to have a patent interventricular septal defect.

4. Changes in condition:

One child died during 1963—**girl born 29.5.54.** Diagnosed as having Fallot's Tetralogy. She became increasingly dyspnoeic and cyanosed. In August, 1962, she was thought to have a bacterial endocarditis. This diagnosis was not proved but her condition later deteriorated and she died in March.

The other children maintained their condition. Those with acyanotic heart lesions remained in good condition with little disability, in most cases leading normal, active lives. Those with cyanotic heart defects all remained limited in activity with varying degrees of cyanosis and dyspnoea.

5. 34 children attend ordinary schools including 3 who need transport to enable them to go to ordinary schools.

5 children attend Special Day Schools for delicate children as follows:

1. **Girl born 11.9.55:** Fallot's Tetralogy + patent interventricular septal defect and stenosed valve.
2. **Boy born 31.8.56:** Fallot's Tetralogy + another unidentified lesion.
3. **Girl born 16.3.57:** Cyanotic heart defect—persistent tunicus arteriosus.
4. **Girl born 3.6.55:** Patent interventricular septal defect.
5. **Boy born 31.1.58:** Cyanotic heart disease—as yet undiagnosed.

6. No child in the age group covered has developed a rheumatic heart lesion during the past year.

7. Heart Surgery:

7 children (including one transferred from another Authority) have been subjected to heart surgery—only 1, however, in the past year:—

1. **Boy born 15.5.58:** Ligation of patent ductus arteriosus in 1963—with an excellent result. He has a normal heart and no disabilities.

2. **Boy born 17.4.54:** (transferred from another Authority): Fallot's Tetralogy for which he had a Blalock's operation in 1958. He was subsequently found to have a patent interventricular septal defect and is cyanosed and dyspnoeic. He is awaiting further surgery.

Details of the remaining five children appeared in last year's Annual Report.

Further comments:

Only one child has a history of maternal virus disease in early pregnancy:—

Girl born 31.1.57: Persistent ductus arteriosus and congenital pulmonary stenosis. Mother had rubella at seven weeks of pregnancy.

SURVEY OF DIABETES IN CHILDREN 1959 to 1963

A great interest is now being taken in the incidence of diabetes in children and adults, particularly from the viewpoint of prevention.

In Nottingham for the past year we have been testing the urine of school children, at the ages of 7 years, 11 years and 13-14 years, as part of the routine medical examination.

There appears to have been an increase in the incidence of diabetes in children in this area during 1963.

In view of these circumstances, it was thought that a survey of the cases of diabetes occurring among children between January, 1959 and December, 1963 might prove interesting. I have, therefore, examined the records of all children who developed diabetes during this period, and who have been treated at the Nottingham Children's Hospital and the Children's Ward of the Nottingham City Hospital. These hospitals draw patients from a wide area, including Nottingham and Nottinghamshire, parts of Derbyshire and parts of Lincolnshire.

Results:

No. of cases :	1959	..	..	2
	1960	..	..	6
	1961	..	..	9
	1962	..	..	7
	1963	..	..	13*
	Total	..	..	37 cases.

(*One case of 1963 is not included below because I could not get the notes).

Age of incidence:

Up to 1 year	..	..	..	1
1 to 2 years	..	..	..	2
2 to 3 "	..	..	..	3
3 to 4 "	..	..	..	6
4 to 5 "	..	..	..	1
5 to 6 "	..	..	..	4
6 to 7 "	..	..	..	4
7 to 8 "	..	..	..	4
8 to 9 "	..	..	..	3
9 to 10 "	..	..	..	2
10 to 11 "	..	..	..	1
11 to 12 "	..	..	..	2
12+	..	..	..	3

Length of history and symptoms:

1. In 31 out of 36 cases there had been a period of one to two months of anorexia and loss of weight with a rather sudden onset of polyuria and polydipsia varying from four days to four weeks prior to admission to hospital. In five cases the symptoms were preceded by a cold, in two cases by diarrhoea and vomiting, in one case by an ear infection, and in one case by septic skin lesions.
2. A baby aged six months had only a two-day history of apathy, restlessness and vomiting.
3. In three cases there was a slower onset and a longer history.
 - (a) Girl aged 7 years 3 months: History of septic skin lesions and pruritis vulvae over several months during which time the urine was tested on several occasions with negative results. She was later found to have diabetes.
 - (b) Boy aged 7 years 6 months: Frequency of micturition for months; urine tested several times and nil found. He subsequently developed nocturnal enuresis and was then found to have glycosuria.
 - (c) Boy aged 6 years 9 months: Two years history of bronchiectasis, and found to have diabetes on routine urine testing.
4. In two children diabetes was complicated by an already existing coeliac disease. In two children there was a history of bronchiectasis.
5. In one boy aged 10 years 4 months there was a two months history of loss of weight only. The parents later noticed a smell of acetone in his breath and tested his urine which showed the presence of glucose. This boy has an older sister who is diabetic; hence the urine check.

Heredity:

In 13 out of 36 cases there was a strong history of diabetes in the family.

Conclusions:

1. Diabetes in children is usually an acute illness with a sudden onset of symptoms and a short history. Urine testing at intervals does not appear to help in diagnosis or in picking up early symptomless pre-diabetic conditions. In fact four children had had their urine tested on several occasions in the year preceding the development of diabetes. Two were on account of other unrelated conditions, one by a diabetic father who tested his daughter's urine regularly, and one in the course of investigation for recurrent skin infections. None of these tests showed glycosuria during the year preceding the development of diabetes. Also no case of diabetes occurring in children has been revealed as a result of routine urine testing in the school examinations.
2. Heredity appears to play an important part in the development of diabetes. It might be more useful to test at more frequent intervals the urine of children in families with a history of the disease.
3. There appears to be a considerable rise in the number of cases of diabetes occurring during 1963 as compared with previous years.

December, 1963

BARBARA WARD,
M.B., B.S., D.A., D.C.H.

SEX EDUCATION:

It is indeed a strange world in which we live. All kinds of people, of associations and of religious bodies, are prepared to rush into print to give their version of what young people ought to know, or not know, about sex. They try to give some idea of the emotional attitude which should be observed. Unfortunately, few of them give any practical help to young people who may be thrown together in situations in which instinct rules their actions, when preferably—as the song has it—they should “let conscience be their guide”. One must bear in mind that the sexual act is largely instinctive, that it is pleasurable, and that however many questionable and dirty jokes may be made about it, the purpose of it is for procreation, and for that alone.

The young of the human race are faced with very strong, compulsive desires like the young of any species. Consequently, in these days when there is so much freedom of action in everything and a lack of willingness to wait until tomorrow for consummation of all sorts of desires, it is understandable but regrettable that the young take their pleasures without thought for tomorrow or of the consequences. The fact that contraceptives are advertised with an air of secrecy in every barber's shop and are readily available to all and sundry, may produce a spirit of daring and adventure in the young but physically mature male—at times to his own as well as his girl's consternation.

One cannot also help but feel that modern music is to some extent to blame for some of the increased sexual activities of the “Teenage Group”. Popular beat music is obviously erotogenic in its effect as one can note in any gathering of girls when one of the many beat groups is in full session, and mass hysteria affects many to the stage of loss of consciousness, and of lack of thought for immediate welfare, etc. It is especially noticeable that a change to a slower tempo can almost immediately quieten and return a bunch of screaming young females to their former thoughtful and less emotional attitude. It is hardly to be wondered at that these beat groups are taking full economic advantage of a situation, the like of which has not been seen in Western civilisation since the days of “St. Vitus”. I suppose we can expect something from the young males of similar age but as yet they seem happy to allow their girl contemporaries to shriek and make, what we “old squares” think, fools of themselves.

One may ask quite rightly what is to be done about it and this is a difficult question to answer. There is still a large proportion of the young men in this country who prefer their fiancées to be virgins until they marry them. The girl who is anybody's solace will, if she remains in her own home neighbourhood, find in the end that she is “nobody's”. The stories of the well-to-do prostitute may be true of odd ones but there can be many more sordid, more dangerous and more uninteresting stories told of the girl who went astray.

At the risk of repeating what has been said before, I am including a statement which the Earl of Dundee, Minister of State for Foreign Affairs, is reported to have made in the House of Lords debate on the Newsom Report on Education on 29th January, 1964—

“We have all heard reports of sex instruction in schools which have made us seriously wonder whether the teachers ought not to be instructed by the pupils, rather than the other way round . . . In most cases it is preferable that this should be done by parents at home rather than in a public class”.

I agree that this is not a job for teachers direct to the youngsters but at the same time, I am sure many parents are quite unable or incapable of imparting even the most elementary facts of sex to their teenage offspring. I wonder what response there would be if parents were invited to discussion groups in Evening Institutes in which the whole subject could be discussed in an emotionless way.

HERNIA SURVEY:

Dr. Ward has again analysed the figures we have collected this year and these are given below:—

	1962	1963
Girls :		
Number having had successful operation ..	5	6
Number already awaiting operation ..	3	1
Number under observation	1	1
Number unaware of the condition	—	—
Totals ..	9	8
Boys :		
Number having had one successful operation	30	26
Number awaiting operation	6	2
Number having had an unsuccessful operation	1	—
Number who had had more than one operation before being successful	1	1
Number of cases already under observation by General Practitioner	3	3
Number of cases where treatment was refused	—	—
Number unaware of defect and referred for treatment	18	12
Totals ..	59	44

The hernias occurring in the eight girls can be divided into 1 bilateral inguinal, 1 left inguinal and 6 right inguinal. The figures for boys are 3 bilateral inguinal, 21 left inguinal and 20 right inguinal.

It will be observed that this condition occurs more frequently in boys and that whilst the proportions of left and right hernias are about equal in boys, there is a large preponderance of right hernias in girls.

SPINAL MOVEMENTS SURVEY:

Doctors More and Ward have given me the following report—our figures are given in the table.

This year we continued our follow-up of the spinal movements of a group of children as they moved up through school. The survey began in 1958 when these children were aged between seven and nine years.

We measure their ability to toe touch from both a standing and a sitting position, and note any changes from year to year.

1,156 children were examined this year. Again, the majority were able to toe touch, and it is interesting that a larger percentage of the girls can do this, than the boys. This coincides with the findings of Mr. Waugh's spinal survey reported on in last years' report.

Another interesting point is that 5.5% of the boys and 4.2% of the girls, who were previously unable to toe touch, now can do so, and that this number is greater than those who have lost their ability to toe touch.

SPINAL MOVEMENTS SURVEY

	BOYS				GIRLS			
	1962		1963		1962		1963	
	Number	Percentage of number seen	Number	Percentage of number seen	Number	Percentage of number seen	Number	Percentage of number seen
1. Total seen	613	100	579	100	589	100	577	100
2. Able to toe touch	477	77.8	482	83.2	497	84.4	503	87.2
3. Unable to toe touch	136	22.2	97	16.8	92	15.6	74	12.8
4. Unchanged:—								
(a) able to toe touch previously.. ..	436	71.1	450	77.7	475	80.7	479	83.0
(b) unable to toe touch previously ..	74	12.1	72	12.5	35	5.9	63	10.9
5. Changed:—								
(a) able to toe touch last examination now unable	65	10.6	25	4.3	56	9.5	11	1.9
(b) unable to toe touch last examination, now able	38	6.2	32	5.5	23	3.9	24	4.2

SURVEY OF THE INCIDENCE AND DISTRIBUTION OF ACNE VULGARIS IN NOTTINGHAM SCHOOL CHILDREN, SEPTEMBER, 1962—JULY, 1963

The following is a report by Dr. Wroughton on the survey carried out earlier in the year:—

"Acne vulgaris is a common disease of the skin, affecting mainly the adolescent population. Little is known about its aetiology, except that it appears to be connected with puberty, although it sometimes persists into adult life. A survey was undertaken amongst secondary school children in Nottingham in the academic year 1962-1963, in an attempt to find out in what type of child acne develops, and also how the affected child reacts to the condition.

Material:

All secondary school children submitted to routine medical examination were included. These were mainly boys and girls aged 14+, but there were also children of 12, 15 and 18, who were seen in the Grammar Schools. A questionnaire was completed by the Medical Officer for each child found to have acne.

Incidence:

2,945 boys and 3,163 girls were inspected. Of these, 15 boys (0.5%) and 247 girls (7.8%) were found to have acne. The lower incidence in boys is to be expected, owing to the later onset of puberty in the male.

Boys:

The number of boys found to have acne is insufficient to give significant data, but a quick résumé of the questionnaires reveals the following points. The average age of onset was 13 years, with a range of 12 to 14 years. 5 cases were rated as severe, 8 as moderate and 2 as mild. The face was affected, together with other areas, (e.g. back and chest) in 13 cases, and was unaffected in 2 more. The skin of 8 boys was described by the observers as oily, that of 4 boys as average and 3 as dry. 12 boys were of average build and 3 were considered to be thin. None was rated as obese.

Most of the boys (10) were sallow in colouring, 1 of a fresh complexion, and 5 medium. There were no Asians or Negroes amongst them. There was only 1 blond and 1 fair-headed boy, 4 were of medium hair colour and 9 were dark. Only one boy was thought to eat excessively of carbohydrates, the others taking a mixed diet. The attitude to cleanliness was good in 14 cases, and indifferent in 1, who also had only indifferent washing facilities at home. All the others were described as having good facilities.

14 of the boys with acne were fully mature, and puberty was commencing in 1. 6 boys said that other members of their families suffered, or had suffered from the same trouble. 7 were touchy about their condition, 1 was ashamed and 2 were slap-happy about it. The remainder were described as stable in their attitude. 1 boy had received no treatment for his skin, 1 boy had attended a consultant, 7 had treated themselves at home and 6 had visited their family doctor. 6 appeared to be keen on having treatment, 6 were half-hearted about it and 3 were not interested.

Girls:

The numbers here are much greater, and are detailed in the accompanying table. It will be noticed that the numbers under each heading

SURVEY OF THE INCIDENCE AND DISTRIBUTION OF ACNE VULGARIS — GIRLS

Severity :				
<i>Severe</i>		<i>Moderate</i>		<i>Mild</i>
19		66		162
Site :				
<i>Face only</i>		<i>Other areas only</i>		<i>Face and other areas</i>
73		42		132
Type of skin :				
<i>Dry</i>		<i>Average</i>		<i>Oily</i>
7		99		141
Body build :				
<i>Thin</i>		<i>Average</i>		<i>Fat</i>
65		164		18
Skin Colouring :				
<i>Fresh</i>	<i>Medium</i>	<i>Sallow</i>	<i>Asian (Eurasian)</i>	<i>Negress</i>
53	124	67	1	2
Hair Colouring :				
<i>Blonde</i>	<i>Fair</i>	<i>Medium</i>	<i>Dark</i>	<i>Red</i>
6	49	121	60	8
				<i>Asian (Eurasian)</i>
				1
				<i>Negress</i>
				2
Diet :				
<i>Mixed</i>	<i>Excessive carbohydrate</i>	<i>Excessive fats</i>		<i>Vegetarian</i>
182	50	8		—
Attitude to cleanliness :				
<i>Good</i>		<i>Bad</i>		<i>Indifferent</i>
220		1		26
Facilities for washing :				
<i>Good</i>		<i>Bad</i>		<i>Indifferent</i>
218		—		29
Family history :				
	<i>Positive</i>	<i>Negative</i>		
	102	113		
Stage of puberty :				
<i>Not present</i>	<i>Just commencing</i>	<i>Fully mature</i>		
—	10	237		
Mental attitude :				
<i>Ashamed</i>	<i>Touchy</i>	<i>Stable</i>	<i>Slaphappy</i>	<i>Not stated</i>
9	31	178	13	16
Treatment received :				
<i>Home</i>	<i>General Practitioner</i>	<i>*Consultant (included in G.P.)</i>	<i>None</i>	
107	69*	9	71	
Desire for treatment :				
<i>Keen</i>	<i>Half-hearted</i>	<i>Not interested</i>	<i>Not stated</i>	
94	109	31	13	

do not always add up to a total of 247. This is owing to the fact that sections of some of the questionnaires were incomplete, e.g. absence of parents, adopted and foster children are often unable to give a family history.

The average age of onset was 12.6 years, ranging from 9 to 16 years. At the time of the examination, puberty had commenced in 10 of the affected girls and was complete in the remainder. This tends to support the theory that the development of acne is associated with the onset of puberty.

Most of the cases were mild, and only 19 were described as severe. For the most part, however, the disease did affect the face, with or without the involvement of other areas. In connection with this, it should be noted that only 94 girls were keenly interested in having treatment, and only 69 had consulted their general practitioners. Of these, 9 had been referred to a consultant for further advice. In talking with the girls, I found that some of them were unaware that their doctor could do anything to help them, whilst others felt that they should not take up his time with a complaint they feared he would regard as trivial. Most of the girls had a sensible attitude towards their "spots", but a few appeared to be ashamed or touchy on the subject.

The traditional picture of the adolescent acne subject, with dark, greasy hair, and a sallow, greasy skin, was not altogether borne out by our survey. Most of the girls were assessed as having an oily skin, but there were almost as many fair-headed, fresh-complexioned girls as dark, sallow ones. The majority were considered to have both hair and skin of a medium hue. Only 2 Negresses and 1 Eurasian girl were found to be suffering from the disease.

Exacerbations of acne have been ascribed, by some authorities, to the consumption of excessive amounts of carbohydrates and fats, and chocolates in particular. 50 girls admitted to eating large amounts of carbohydrates, 8 had a diet which was high in fat content, and 18 (a higher proportion than in an ordinary school population) were considered to be obese. The majority were of average build.

Another factor in the production of acne is thought to be increased activity of the sebaceous glands at puberty, and this is supported by our finding of a large number of greasy skins. However, regular de-greasing of the skin with soap and water appeared to be taking place in most of the girls we saw, almost all of whom had a good attitude to cleanliness, and ample facilities for washing.

Family history appeared to play little part in influencing the disease, although information was unavoidably incomplete in many cases, particularly as a large percentage of parents do not attend the medical inspection of their children in this age group.

Conclusion:

It would seem, then, that most of the secondary school girls of Nottingham take their acne in their stride, as neither the physical nor the psychological problem appears to be of any magnitude. Most of the girls are of average build and colouring, and have a high standard of personal cleanliness. In view of the permanent scarring which can be the end-result of the acne process, and the temporary disfigurement which it produces, I feel that we should take a more active part in encouraging the sufferers to obtain, and in promoting in them a keener desire for treatment".

M. A. WROUGHTON, M.B., Ch.B.

ENURESIS CLINIC :

We have continued to use a pad and alarm bell apparatus for our enuretics. This still proves to be the most useful means of helping these unfortunate youngsters and their parents. I mention parents because hope of a cure for their child not only gives them immediate relief from the need to be constantly on the watch for soiled and odorous beds, but allows them to make long-term arrangements for visits to friends or holidays without the constant fear of "mishaps" on the part of their offspring.

At times one hears of humorous reasons for wetting—to quote one example, the boy whose bedroom was on the top floor, who was not provided with a chamber pot and whose W.C. was in the back yard two flights down. One can almost understand his accepting that it was simpler and less troublesome to all concerned if he wet his bed especially when we realised that his mother went to work and did not inspect his room more than once a week.

Treatment on occasion cannot be judged completely successful but parents are extremely grateful to have an improvement when there never has been a dry night.

The main reason for apparent failure still seems to be lack of co-operation from parents. I do not mean that there is any lack of co-operation in dealing with the apparatus itself but rather a lack of sympathy, understanding and encouragement of the youngster. The children themselves, even if given a little understanding and encouragement, are usually only too prepared to co-operate.

During the year, 34 boys and 32 girls have been treated and it is rather unusual that boys have shown better results this year than the girls.

It has unfortunately not been possible to treat several youngsters because their home conditions were unsatisfactory in that they had to share a bed with a brother or sister and at times there seems to have been some uncertainty as to which was the incontinent one. It was amusing to find one parent who asserted that the apparatus would be too noisy and refused to use it. I have a feeling she was really a little afraid of it.

It is pleasing to note that seven children on our waiting list stopped wetting the bed after discussion with the school medical officer and the nurse's home visit. No other treatment was given. The waiting list has now assumed reasonable proportions. As a result, we have been able to reduce the waiting time to a few weeks.

Taking advantage of the fact that we admit children to our Tonsil and Adenoid Ward at the Central School Clinic for operation, we have kept a record during the past six months of the cases of enuresis known to us during the time while they were in-patients for tonsil and adenoid operation. These children were all aged between 4 and 11 years. The numbers are:—

Total admissions (4-11 years)	..	..	..	456
Total of known cases of enuresis	..	..	..	26 (5.7%)

During the stay in the Ward :

(a) Number of known enuretics found to be wet	..	11	(42.3% of Enuretic Group)
			(2.4% of Admissions Group)

- (b) Number of known enuretics who remained completely dry 15 (57.7% of Enuretic Group)
(3.3% of Admissions Group)
- (c) Number of children not previously reported as enuretic but who were found to be wet 14 (3.1% of all Admissions)
- (d) Total number of children found to be enuretic .. 25 (5.5% of all Admissions)

It should be noted that many children (15) reported to be bed wetters showed no signs of this while they were in-patients and that many whose parents did not report them as such were incontinent. It is realised that admission and its attendant surgical upset does create an unusual emotional atmosphere and this may, of course, explain these somewhat anomalous figures. On the other hand, parents are often ashamed to admit that their youngster is so affected and are unwilling to report their difficulty. I cannot imagine, however, that the reverse applies.

SURVEY OF CHILDREN WHO DO NOT DRINK SCHOOL MILK :

Thinking of possible reasons for the earlier maturity of children and wondering whether there was any one factor which might give a clue to this comparatively new phenomenon, I wondered if the addition of milk to the diet might be implicated. There is a fairly large number of children in our schools who do not drink their milk for various reasons, some reasonable, others silly or frivolous, but for the most part the youngsters concerned never do drink milk. It seemed, therefore, that a comparison of their heights and weights in Junior Schools (where, as a rule, differences are really considerable) with the normal might tell us something. The tables below show the results we obtained:—

	AGE GROUP				
	7 yrs.	8 yrs.	9 yrs.	10 yrs.	11 yrs.
BOYS :					
Average height (ins.)	50	51	53	54½	56
National average height—1959 (ins.) (+ or — 10%)	49	51½	53½	55½	56½
Average weight (lbs.)	54½	60½	67	71½	82
National average weight—1959 (lbs.) (+ or — 10%)	54	60	66	72	76½
GIRLS :					
Average height (ins.)	48½	50½	52½	55	55½
National average height—1959 (ins.) (+ or — 10%)	48	50½	52½	54½	57
Average weight (lbs.)	51½	59	65½	73½	76
National average weight—1959 (lbs.) (+ or — 10%)	52½	58	63½	70½	78½

The numbers of non-milk drinkers involved were 1,062
 Numbers in the Junior Schools in the survey .. 16,891
 Expressed as a percentage 6.28

There appears to be no statistically significant difference between the height and weight of the average and those who do not drink milk.

The results do not confirm the hypothesis that those who do not drink milk are retarded in general growth and maturity. We cannot attribute the so obvious earlier maturity to this one article of diet. On the other hand, in our present ideas of diets, there seems to be no need for school milk from a nutritional angle. I suggest that school milk, while being a pleasant and acceptable mid-morning "cocktail" for the young, is as essential and necessary as the mid-morning "cocktail" often partaken of by their elders!

There may, of course, be children who are dependent on school milk for the vitamin portion of their diet. (I cannot imagine that the 100 or so calories in one-third of a pint are essential for their energy value). One can instance some whose main energy supply is derived from chips and who may be short of vitamins but even amongst poor and large families, mothers seem to realise the need for some fresh food in the diet, although the general quality may be unsatisfactory. For these, milk with its considerable vitamin content may be essential.

Recent criticism, in the medical press, of milk as a possible cause of dental caries seems to me to be misplaced in these days when refined carbo-hydrate is almost certainly the proved culprit.

TATTOOING :

Last year, a brief mention of this was made in the Annual Report. It is of interest to note that a prosecution in the Courts has since taken place. The charge being one of technical assault, but it was impossible to sustain this on the evidence provided, and no case could be made out against the defendant. It may be, however, that in future the tattooist will ask for parental permission before decorating an obvious youngster and I cannot see that being often given.

SCHOOL MEALS :

Whilst perusing List 71 (1963)—"Selected Statistics relating to Local Education Authorities in England and Wales", I noticed that my own County Borough supplied only 36.6 per cent. of its day pupils with a school dinner, whereas the average for English County Boroughs is 47.2 per cent. In fact, there are only twelve County Boroughs in England showing a lower percentage than Nottingham.

I asked Miss Beard, our School Meals Organiser, if she thought our children had such a good evening meal that parents considered a mid-day meal was unnecessary, or were the schools here so well distributed that children could easily get home for their meal.

Miss Beard replied stating that on one normal day recently, excluding special schools, 18,393 children were served with a school dinner 38% of these were secondary, 36% junior, 24% infant and 2% nursery school children. She went on to say that it would seem that many parents prefer their younger children to go home for their meal. Parents of junior and secondary age children tend either to go out to work as their family grows up, or allow their children to please themselves whether they have a school dinner. Another factor which might have a greater influence than might at first be expected is the tradition of the school and the attitude of the Head

Teacher as to whether or not the eating of sandwiches on the premises is frowned upon. A choice of meal to children in secondary schools would, it is certain, increase the number of dinners served to that section of the school population but though desirable and not impracticable, the strict budget to which we are subject does not allow for such "refinements".

It would appear that in Nottingham a large number of workers go home at mid-day—this fact is supported by the Industrial Caterers—but many husbands and grown up sons and daughters still expect a "cooked tea" on their return home in the evening. No doubt the younger members of the family enjoy this meal too.

PHYSICAL EDUCATION :

Some of my colleagues in the School Health Service in other areas raised the question of the suitability of weight-lifting and training as a form of athletic exercise for girls. I raised this with the Committee's Inspector of Physical Education and she replied as follows:—

"Weight-lifting is not allowed in City schools. Therefore the question of weight-lifting being part of general practice in the girls' Physical Education time-table does not arise.

Circuit training in a few cases does arise. This is for a muscle build-up in the girl who has shown athletic prowess. These exercises performed at the individual's own speed and endurance, are done in after-school club time. The only weight involved here is their own body weight, e.g. press-ups from the floor or feet slightly raised and body off the floor. In adult clubs, weight-training may well be being used in women's training. Here some girls may be introduced to weights.

The woman physical educationalist should not lose sight of the aim of femininity coming through in a physical education lesson. I would not be happy to find in general practice teachers allowing school girls to use weights in strength build-up. Even in circuit training, I hope the teacher has the sensitivity and fully realises the dangers of over developing the girls. However, one cannot be too certain on this score.

New ideas have to be accepted if facts prove that one's own opinions are wrong. Weight training I would not like to see in general practice in the schools, weight-lifting as a sport, never. If any of your colleagues know of any school club allowing weight-training for girls I would be most grateful if I could have information about it.

Another disturbing fact is that male lecturers are being appointed to the women's colleges so we may have women coming along wishing to use weights, as part of general strength build-up.

It looks as though this form of training is not to be encouraged amongst girls. I must raise the question with the Boys' Inspector.

I also raised the question of how the child whose parents live in one of the new, tall, skyscraper-flats was going to get his exercise, and if there was any difficulty in getting young girls to play hockey, etc. Her reply was quite illuminating. She suggested a variety of individual activities. I wonder whether those children who do not show a special aptitude or inclination for team games should not have encouragement to play golf? There is usually plenty of room on the golf courses in the mornings and I am sure there would be no difficulty in finding teachers to supervise and demonstrate the finer points of the game. Any suggestion that it has a high snob value is now weakening; it certainly does not apply to Scotland.

DEATHS OF CHILDREN OF SCHOOL AGE :

Analysis of causes :

Malignant growths and Leukaemia	..	..	4
Haemophilia and injuries (brothers)	..	..	2
Road accidents	..	..	4
Acute chest infection following severe general condition	..	..	2
Drowning	..	..	1
Burns	..	..	1
Heart failure (congenital heart disease)	..	..	1
Cerebral haemorrhage	..	..	1
Total	..	..	16

On this occasion, again some form of violent death has occurred in six cases and if we include the two haemophiliacs who had injuries, half of our deaths had some form of accident associated with them. Except in one case, these eight deaths had occurred to children in the age groups 7—8 years, i.e. when parental watchfulness had been reduced but experience was not yet wide enough to keep the youngsters out of danger.

It so happens that the numbers are exactly the same as in 1962.

CONCLUSION :

As usual, I have endeavoured to bring to notice some of the work of your School Health Service. There is much routine work that goes on behind the scenes as it were, but as long as the Service runs smoothly, it receives the minimum of notice. I have to thank many, not only at Chaucer Street and Clarendon Street, but also in the clinics and schools, for the quiet and efficient way in which the work of the department is performed. The fact that we have the full support of the Special Services Sub-Committee in our work makes it worthwhile, and I am grateful to many agencies for their help and encouragement and to the Director for the confidence he places in me and my staff.

I am, Ladies and Gentlemen,

Your obedient Servant,

R. G. SPRENGER,

Principal School Medical Officer.

APPENDIX A.
MEDICAL INSPECTION AND TREATMENT RETURN
Year ended 31st December, 1963

**Part I—Medical Inspection of Pupils attending Maintained
Primary and Secondary Schools
(including Nursery and Special Schools)**

TABLE A.—PERIODIC MEDICAL INSPECTIONS

Age Groups Inspected (By Year of Birth)	Number of Pupils Inspected	Physical Condition of Pupils Inspected			Pupils found to require treatment (excluding Dental Diseases and Infestation with Vermin)			
		Satisfactory		Unsatisfactory	For defective vision (excluding squint)	For any of the other conditions recorded in Part II	Total individual pupils	
		No.	% of Col. 2					
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1959 and later	837	837	100	—	—	7	111	117
1958 ..	1,617	1,617	100	—	—	47	221	260
1957 ..	2,715	2,715	100	—	—	107	475	540
1956 ..	295	295	100	—	—	20	64	79
1955 ..	2,278	2,277	99.96	1	0.04	156	290	423
1954 ..	1,142	1,142	100	—	—	95	68	148
1953 ..	2,407	2,406	99.96	1	0.04	217	291	479
1952 ..	1,636	1,636	100	—	—	193	214	384
1951 ..	444	444	100	—	—	61	48	101
1950 ..	430	430	100	—	—	82	45	120
1949 ..	2,975	2,975	100	—	—	418	306	682
1948 and earlier	2,286	2,285	99.96	1	0.04	470	225	660
Total ..	19,062	19,059	99.98	3	0.02	1,873	2,358	3,993

TABLE B.—OTHER INSPECTIONS

Number of Special Inspections	..	..	..	..	..	..	..	12,435
Number of Re-inspections	..	..	..	..	..	..	..	9,613
						Total	..	<u>22,048</u>

TABLE C.—INFESTATION WITH VERMIN

(a) Total number of individual examinations of pupils in schools by school nurses or other authorised persons	..	..	..	..	..	140,544
(b) Total number of individual pupils found to be infested	..	..	..	..	..	3,500
(c) Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	..	..	..	..	..	55
(d) Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	..	..	..	..	..	42

Part II—Defects found by Medical Inspection during the year
TABLE A.—PERIODIC INSPECTIONS

Defect Code No. (1)	Defect or Disease (2)	Periodic Inspections				
		Entrants		Leavers	Others	Total
		(3)	(4)	(5)	(6)	(7)
4	Skin	T	85	104	186	375
		O	12	2	9	23
5	Eyes—					
	(a) Vision	T	178	747	948	1,873
		O	252	72	249	573
	(b) Squint	T	146	127	331	604
		O	18	—	21	39
	(c) Other	T	19	14	35	68
		O	3	—	1	4
6	Ears—					
	(a) Hearing	T	40	11	46	97
		O	32	8	56	96
	(b) Otitis Media ..	T	27	19	27	73
		O	7	2	8	17
	(c) Other	T	10	7	22	39
		O	7	—	5	12
7	Nose and Throat ..	T	286	50	203	539
		O	172	8	89	269
8	Speech	T	42	3	44	89
		O	36	1	23	60
9	Lymphatic Glands ..	T	5	2	2	9
		O	14	—	5	19
10	Heart	T	18	6	20	44
		O	14	6	26	46
11	Lungs	T	50	41	53	144
		O	58	5	33	96
12	Developmental—					
	(a) Hernia	T	8	—	7	15
		O	18	—	12	30
	(b) Other	T	26	23	40	89
		O	57	19	129	205
13	Orthopaedic—					
	(a) Posture	T	—	2	1	3
		O	—	1	8	9
	(b) Feet	T	30	9	42	81
		O	12	1	9	22
	(c) Other	T	41	58	64	163
		O	11	9	21	41
14	Nervous System—					
	(a) Epilepsy	T	12	7	13	32
		O	5	2	23	30
	(b) Other	T	5	—	8	13
		O	5	—	36	41
15	Psychological—					
	(a) Development ..	T	7	3	24	34
		O	43	1	43	87
	(b) Stability	T	9	5	27	41
		O	15	2	32	49
16	Abdomen	T	7	1	8	16
		O	2	—	4	6
17	Other	T	4	—	4	8
		O	26	3	34	63

TABLE B.—SPECIAL INSPECTIONS

Defect Code No. (1)	Defect or Disease (2)	Special Inspections	
		Pupils Requiring Treatment (3)	Pupils Requiring Observation (4)
4	Skin	150	40
5	Eyes—(a) Vision	908	2,481
	(b) Squint	244	479
	(c) Other	35	7
6	Ears—(a) Hearing	39	279
	(b) Otitis Media	34	18
	(c) Other	80	18
7	Nose and Throat	601	349
8	Speech	30	66
9	Lymphatic Glands	—	5
10	Heart	7	90
11	Lungs	3	172
12	Developmental—		
	(a) Hernia	4	25
	(b) Other	15	216
13	Orthopaedic—		
	(a) Posture	2	9
	(b) Feet	25	42
	(c) Other	46	83
14	Nervous System—		
	(a) Epilepsy	4	89
	(b) Other	6	33
15	Psychological—		
	(a) Development	163	132
	(b) Stability	137	157
16	Abdomen	4	11
17	Other	176	528

**Part III.—Treatment of Pupils attending Maintained Primary and
Secondary Schools (including Nursery and Special Schools)**

TABLE A.—EYE DISEASES, DEFECTIVE VISION AND SQUINT

	<i>Number of cases known to have been dealt with</i>
External and other, excluding errors of refraction and squint	623
Errors of refraction (including squint)	5,436
Total ..	6,059
Number of pupils for whom spectacles were prescribed	2,052

TABLE B.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	<i>Number of cases known to have been dealt with</i>
Received operative treatment—	
(a) for diseases of the ear	112
(b) for adenoids and chronic tonsilitis	1,446
(c) for other nose and throat conditions	67
Received other forms of treatment	848
Total	2,473
Total number of pupils in schools who are known to have been provided with hearing aids:—	
(a) in 1963	11*
(b) in previous years	72†

- * Includes three pupils living in the Nottinghamshire County Council Area.
 † Includes one pupil living in the Derbyshire County Council Area.
 † Includes fifteen pupils living in the Nottinghamshire County Council Area.
 † Includes one pupil living in the Derbyshire County Council Area.

TABLE C.—ORTHOPAEDIC AND POSTURAL DEFECTS

	<i>Number of cases known to have been treated</i>
(a) Pupils treated at clinics or out-patients departments	388
(b) Pupils treated at school for postural defects	—
Total	388

TABLE D.—DISEASES OF THE SKIN (excluding uncleanliness, for which see TABLE C of Part I)

	<i>Number of cases known to have been treated</i>
Ringworm—(a) Scalp	—
(b) Body	—
Scabies	44
Impetigo	97
Other Skin Diseases	2,235
Total	2,376

TABLE E.—CHILD GUIDANCE TREATMENT

	<i>Number of cases known to have been treated</i>
Pupils treated at Child Guidance Clinic	498

TABLE F.—SPEECH THERAPY

	<i>Number of cases known to have been treated</i>
Pupils treated by speech therapists	411

TABLE G.—OTHER TREATMENT GIVEN

	<i>Number of cases known to have been dealt with</i>
(a) Pupils with minor ailments	4,160
(b) Pupils who received convalescent treatment under School Health Service arrangements	51
(c) Pupils who received B.C.G. Vaccination	2,781
(d) Other than (a), (b) and (c) above:	
1.—by the Authority: U.V.R.	10
2.—by the Authority: paediatrics	116
3.—by the Authority: heart cases	54
4.—at hospital: paediatrics and general medicine	374
5.—at hospital: general surgery	519
Totals (a)—(d)	8,065

Handicapped Pupils requiring Education at Special Schools or Boarding Homes

	Blind (1)	Partially Sighted (2)	Deaf (3)	Partial Hearing (4)	Physically Handi- capped (5)	Delicate (6)	Mal- adjusted (7)	E.S.N. (8)	Epileptic (9)	Speech Defects (10)	Total Cols. (1)-(10) (11)
A. During the calendar year ended 31st December, 1963, number of handicapped pupils newly assessed as needing special educational treatment at special schools or in boarding homes ..	—	1	3	5	16	14	12	133	3	—	187
B. (i) of the children included at A, number newly placed in special schools (other than hospital special schools) or boarding homes ..	—	1	2	5	14	12	12	64	3	—	113
(ii) of the children assessed prior to 1st January, 1963, number newly placed in special schools (other than hospital special schools) or boarding homes ..	—	—	—	1	4	3	4	63	1	—	76
Total (B(i) and B (ii)) ..	—	1	2	6	18	15	16	127	4	—	189
C. At 23rd January, 1964, number of handicapped pupils:—											
(i) requiring places in special schools—											
(a) day ..	—	—	—	—	—	—	—	70	—	—	70
(b) boarding ..	—	1	—	—	1	4	—	—	—	—	6
(ii) included at (i) had not reached the age of 5 and were awaiting:—											
(a) day places ..	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places ..	—	—	—	—	—	—	—	—	—	—	—
(iii) included at (i) who had reached the age of 5, but whose parents had refused consent to their admission to a special school, were awaiting:—											
(a) day places ..	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places ..	—	—	—	—	—	1	—	—	—	—	1

Dental Inspection and Treatment carried out by the Authority during the year ended 31st December, 1963.

(a) Dental and orthodontic work:

I	Number of pupils inspected by the Authority's Dental Officers:							
	i At Periodic Inspections	..	..	..	5,799	} Total I	11,402	
	ii As Specials	..	..	..	5,603			
II	Number found to require treatment	..	..	..	..	..	10,691	
III	Number offered treatment	..	..	..	..	..	9,279	
IV	Number actually treated	..	..	..	..	..	8,419	

(b) Dental work (other than orthodontics):

I	Number of attendances made by pupils for treatment, excluding those recorded at (c) i below..	..	..	..	..	..	18,984	
II	Half-days devoted to:							
	i Periodic School Inspections	..	..		21	} Total II	2,071	
	ii Treatment	..	..	..	2,050			
III	Fillings:							
	i Permanent Teeth	..	..	..	9,863	} Total III	9,906	
	ii Temporary Teeth	..	..	..	43			
IV	Number of teeth filled:							
	i Permanent Teeth	..	..	..	8,977	} Total IV	*9,015	
	ii Temporary Teeth	..	..	..	38			
V	Extractions:							
	i Permanent Teeth	..	..	..	4,997	} Total V	16,795	
	ii Temporary Teeth	..	..	..	11,798			
VI	(i) Administration of general anaesthetics for extractions	..	..	..	..	..	†7,112	
	(ii) Number of half-days devoted to administration of general anaesthetics by:							
	A. Dentists	..	..	..	3	} Total VI	396	
	B. Medical Practitioners	..	..	..	393			
VII	Number of pupils supplied with artificial teeth	..	..	..	..	..	151	
VIII	Other Operations:							
	i Crowns	} Not recorded				} Total VIII	2,391	
	ii Inlays							
	iii Other Treatment	..	..	..	2,391			

(c) Orthodontics:

i	Number of attendances made by pupils for orthodontic treatment	1,125	
ii	Half-days devoted to orthodontic treatment	..	113
iii	Cases commenced during the year	..	75
iv	Cases brought forward from previous year	..	55
v	Cases completed during the year	..	71
vi	Cases discontinued during the year	..	26
vii	Number of pupils treated by means of appliances	..	101
viii	Number of removable appliances fitted	..	118
ix	Number of fixed appliances fitted	..	—
	1,174 X-ray films were also taken		

* 851 local anaesthetics were given for fillings

† In addition 131 local anaesthetics were given for extractions

APPENDIX B. TREATMENT ARRANGEMENTS

<i>Clinic</i>	<i>Treatment carried out</i>	<i>Consultant Sessions</i>	<i>School Medical Officer attended</i>	<i>Children's attendances during 1963 for minor ailments</i>
Central— 28 Chaucer Street	Minor Ailments, .. Electrical .. Paediatrics .. Refractions .. E.N.T. .. Dental ..	Weekly 5 sessions weekly 2 sessions weekly	Tuesday and Friday a.m.	7,791*
Bulwell— Main Street, & Springfield School	Minor Ailments .. Refractions .. Speech Therapy .. Dental ..	Monthly	Monday and Thursday a.m.	6,680
Clifton— Southchurch Drive	Minor Ailments .. Refractions .. Speech Therapy .. Dental ..	Weekly	Wednesday p.m.	6,361
Leenside— Canal Street	Minor Ailments .. Dental ..	—	Thursday p.m.	5,283
Bestwood— Beckhampton Road	Minor Ailments, .. Refractions .. Speech Therapy .. Dental ..	Monthly	Monday a.m.	7,227
Player— Beechdale Road	Minor Ailments, .. Refractions .. Speech Therapy .. Dental ..	Weekly	Monday and Thursday a.m.	13,671
Portland— Westwick Road	Minor Ailments	—	—	2,064
Rosehill— St. Matthias' Road	Minor Ailments .. Refractions .. Speech Therapy .. Dental ..	Weekly	Thursday p.m.	8,967
Scotholme— Beaconsfield Street	Minor Ailments ..	—	Tuesday a.m.	3,557
William Crane— Aspley Estate	Minor Ailments .. Speech Therapy ..	—	Monday a.m.	8,396
Child Guidance— 34 Clarendon Street	Psychiatric .. Speech Therapy ..	4 sessions weekly	Tuesday p.m. and Wednesday a.m.	—
Orthodontic— 36 Clarendon Street	Orthodontic ..	—	—	—

* Including U.V.R., Ionisation and Proetz cases.

† Opened February, 1963, to replace Padstow and Burford School Clinics.

