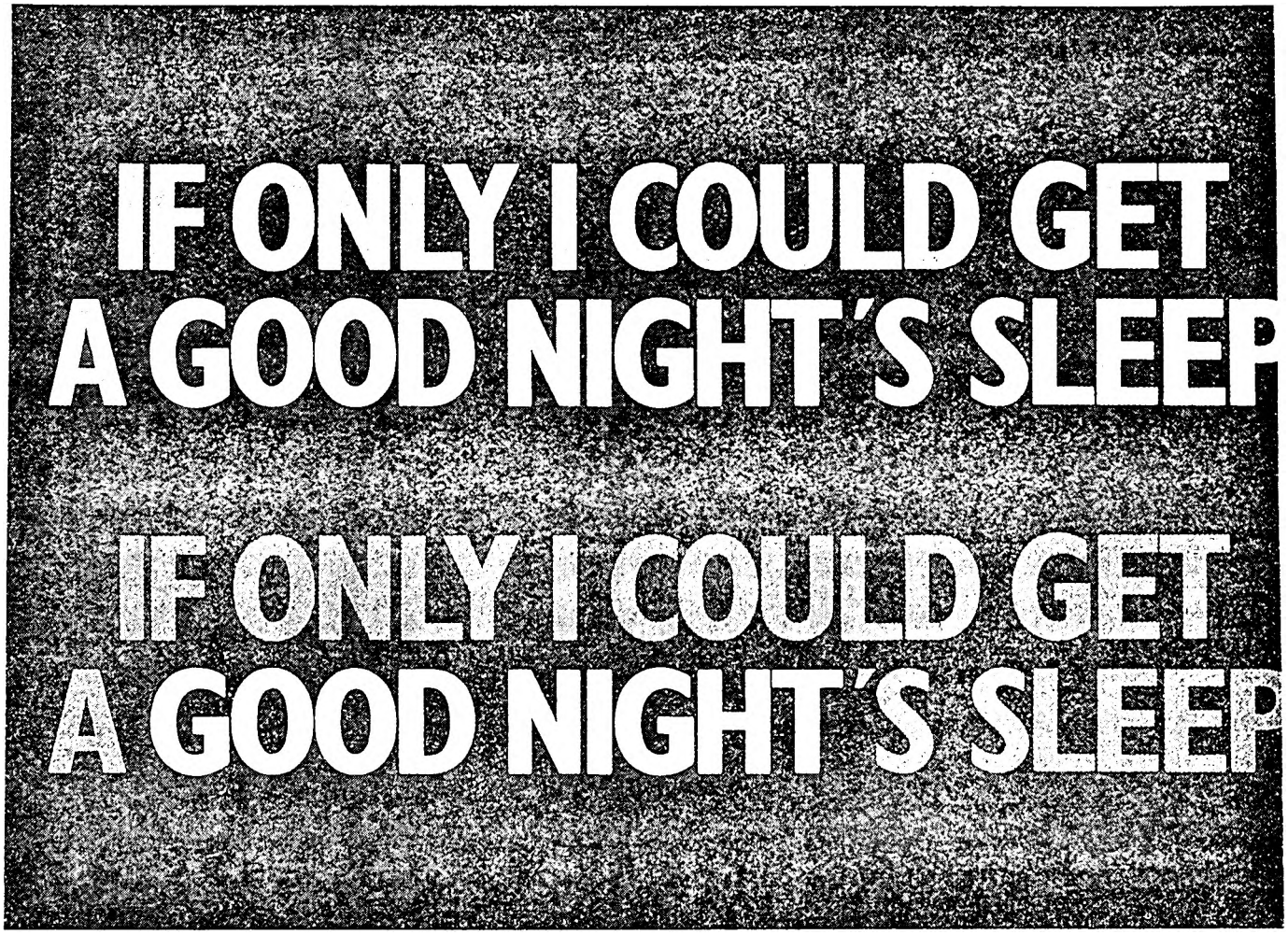

To the Editor: Dr Edge[1] presented a well-written article, but I must take issue with him over one point — teething. During 20 years in dental family practice I too often saw the effects of teething, both on the sufferer and on the immediate family.

I have often seen cases in which infants exhibited pyrexia, diarrhoea, irritability and general malaise, and let us not forget the pain. Those of us who have had problems with semi-erupted third molars (wisdom teeth) will know of some of the agony of tooth eruption. Imagine the discomfort amplified tenfold and then, to add insult to injury, not being able to tell anyone about it! In most of the abovementioned cases no cause could be found other than a tooth having difficulty in erupting.

My usual advice to the distraught parents was to take a cotton wool swab about the size of a large grape, wrap it in gauze, and soak it in an antihistamine solution such as diphenhydramine (Benadryl Elixir). This should be patted gently onto the gums, and the baby should be allowed to suck on it. The local topical effect will reduce the swelling, and whatever is swallowed will help the child to sleep.

It appears to the clinical observer that teething is relatively innocuous, and so it is in terms of long-term effects, but during that time the baby might undergo the tortures of the damned. Anything we can do to help should be done.

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1. Edge WEB. Some paediatric fables, foibles and sheer bad habits. *S Afr Med J* 1985; 67: 1010-1012.

Social class classification in the RSA — a comparison of four ethnic groups

To the Editor: In the RSA an upward shift in occupational status in the urban black population has made it increasingly important to have accurate assessments of social and socio-economic class in health-related research. A rising middle class is apparent among black urban South Africans, who now have similar numbers in social classes III, IV and V. Previously in our surveys among preschool children, socio-economic groupings were based on residence in upper-, middle- or lower-income areas. Although this provides a measure of socio-economic comparison within any group it is not appropriate for across-group comparisons. In 1979 Schlemmer and Stopforth[1] published a guide for coding occupations in South Africa broadly based on British and American models. This is similar to the system used in the Registrar-General's classification of occupations throughout Britain.[2]

Since 1979 in nutritional and dental health surveys on interethnic groups of Transvaal preschool children[3-5] we have noted the father's and mother's occupation. From 1979 to 1981, in all but black rural groups (from a general population), children attended nursery schools; numbers in each group comprised 559 black rural, 825 black urban, 130 coloured, 594 Indian and 897 white families. In 1984, 668 black rural, 836 black urban, 558 Indian and 699 white children aged 4 - 5 years were studied, randomly drawn from the general population. Proportions falling into each social class and ethnic group are shown in the histogram (Fig. 1) for both 1978-1981 and 1984. The similarity of proportions for both nursery school and general population groups indicates that little if any bias existed in the selection of these two groups.

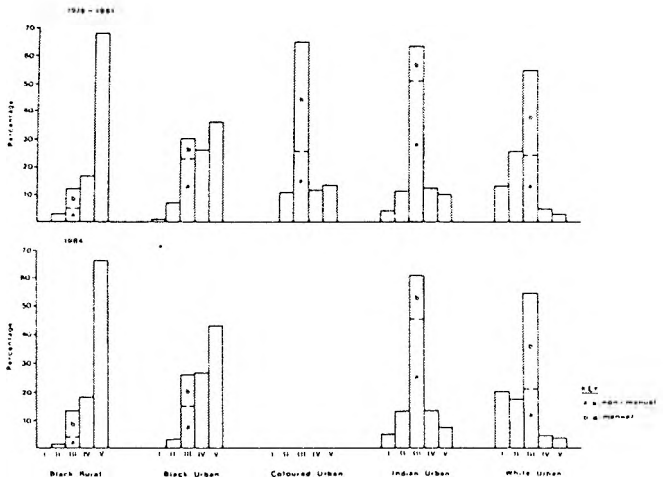

Fig. 1. Histogram depicting proportions of four South African preschool populations by social class and ethnic group; 1978 - 1981 and 1984.

The black rural group falls mainly into social class V. In the black urban group many fall into social classes IV and V, but surprisingly similar numbers are now found in social class III. The coloured group falls largely into social class III, as do the majority of Indian and also white families. In the latter group, there are greater proportions in social classes I and II; a similar smaller distribution is present for Indians.

Even though these patterns may not be representative of the country as a whole, they present a profile of social class not described previously in South African communities, nor indeed in any African country. There is now a sound basis of comparison for South African groups with published figures for other countries.

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1. Schlemmer L, Stopforth P. *A Guide to the Coding of Occupations in South Africa* (Fact Paper No. 4, 1979). Centre for Applied Social Sciences, University of Natal, 1979.
2. Office of Population Censuses and Surveys. *Classification of Occupations*. London: HMSO, 1970.
3. Richardson BD, Rantsho JM, Pieters L, Cleaton-Jones PE. Total sucrose intake and dental caries in black and white South African children of 1 - 6 years: Part 1. Sucrose intake. *J Dent Assoc S Afr* 1978; 33: 533-537.
4. Cleaton-Jones P, Richardson BD, McInnes PM, Fatti LP. Dental caries in South African white children aged 1 to 5 years. *Community Dent Oral Epidemiol* 1978; 6: 78-81.
5. Cleaton-Jones PE, Richardson BD, Rantsho JM. Dental caries in rural and urban black preschool children. *Community Dent Oral Epidemiol* 1978; 6: 135-138.

Radiological diagnosis of traumatic hernia of the left diaphragm

To the Editor: Schulman *et al.*[1] make a plea for radiologists and clinicians to be aware of the possibility of traumatic hernia of the left diaphragm as a cause of acute abdominal symptoms, and draw to our attention the many pitfalls in its radiological diagnosis.

I do not know the incidence in our community of traumatic left diaphragmatic hernia in relation to the incidence of high but intact left diaphragm (eventration, paralysis, etc.). In my experience, nearly all radiologists reporting on the radiograph (Fig. 2, p. 41) displayed in Schulman *et al.*'s article would make a diagnosis of 'eventration'. Comparison of this plate with Fig. 1 on p. 49 of the article in the same issue of the *SAMJ* by Sharma *et al.*[2] makes one understand why it is very often impossible to distinguish between the two conditions (even with the help of contrast studies of whatever sort).

A patient with an as yet uncomplicated traumatic hernia of the diaphragm is in grave danger, particularly if he lives far from a major hospital, because of the possibility of strangulation which, if not treated early, can rapidly be fatal. Even if such a patient has easy access to a major hospital the correct diagnosis is frequently missed, with fatal results, as Schulman *et al.* have shown.

My plea is that a radiograph showing a 'high left diaphragm' in any patient who has a history of trauma, and particularly of penetrating trauma of the left chest, should be reported as probably demonstrating a hernia, and only possibly an eventration. Such a report will at least alert the clinician to the possibility that his patient is walking about with a time-bomb inside his chest, and should result in appropriate action to defuse this threat if it should be confirmed.

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1. Schulman A, Fataar S, Alheit B. Obstruction-strangulation of post-traumatic diaphragmatic hernia — delayed diagnosis and fatal outcome: report of 9 cases. *S Afr Med J* 1985; **68**: 39-44.
2. Sharma BC, Kapalanga NJB, Ahmed SR. Volvulus of the stomach: a case report. *S Afr Med J* 1985; **68**: 48-49.

Erratum

In the article entitled 'Changes in infant mortality rates among whites, coloureds and urban blacks in the RSA over the period 1970 - 1983' by Herman and Wyndham, which appeared on pp. 215 - 218 of the *SAMJ* of 17 August 1985, the regression line in Fig. 3 given as ENMR is in fact that for PNMR, and the regression line given as PNMR is in fact that for ENMR.