

Failure to control the tachycardia is usually explained by inadequate dosage. Practitioners are apt to be unduly frightened of digitalis intoxication, which, in my experience, more often results from an excessive maintenance dose given over a prolonged period than from overdosage during the initial stage of digitalization. Patients vary greatly in their tolerance for digitalis, and it is therefore undesirable to use massive doses except in emergency: 3 gr. (0.2 g.) of the powdered leaf given eight-hourly will usually suffice to control the ventricular rate within 24 hours, and thereafter a maintenance dose of 1 to 2 gr. (0.065 to 0.13 g.) generally proves adequate; sometimes even smaller doses suffice. In an emergency 1 mg. of digoxin may be given intravenously.

The most obvious signs of digitalis intoxication are excessive slowing of the heart, nausea, vomiting, and bigeminal heart action, in which every normal beat is followed by an extrasystole. It is important to distinguish between the nausea due to overdosage with digitalis and that due to congestion of the gastric mucous membrane resulting from circulatory stasis in cases of heart failure, since the latter condition is attributable to inadequate control of the tachycardia, which can be relieved only by increasing the dose of digitalis. Likewise, bigeminal heart action is by no means always due to digitalis intoxication, and is not an indication for withdrawing the drug unless it is associated with bradycardia or other toxic manifestations.

When fibrillation is of recent origin, or persists after subtotal thyroidectomy, an attempt should be made to restore normal rhythm with quinidine, 6 gr. (0.4 g.) two-hourly for five doses, repeated if necessary. It is, however, only in those cases in which the disability is attributable to the abnormal rhythm rather than to the associated myocardial or valvular disease that quinidine therapy is indicated. In cases of old-standing heart disease there is a risk of embolism, and the patient is likely to derive more benefit from control of the tachycardia with digitalis.

Auricular Flutter

Flutter is closely related to fibrillation and, like fibrillation, may occur either in paroxysms or as an established condition. It is most often associated with either rheumatic or degenerative heart disease. In this disorder the auricle beats regularly at a rate of about 300 per minute and the ventricle usually responds at half that rate.

Clinically, therefore, auricular flutter may be suspected in cases of regular tachycardia when the pulse rate is in the neighbourhood of 150 per minute, and confirmation may be obtained by noting venous pulsation in the neck at double this rate or slowing of the pulse when pressure is applied to the carotid sinus; but the diagnosis can be established with certainty only by the electrocardiogram, which is distinctive.

Under the influence of digitalis the ventricular rate may be reduced to a quarter of the auricular rate or the heart's action may become irregular, the ventricle responding to every second, third, or fourth auricular impulse. Provided 4:1 heart block is maintained auricular flutter will *per se* cause no appreciable disability, but occasionally a 1:1 ventricular response develops, either spontaneously in untreated cases or in the course of treatment with quinidine, and unless promptly controlled may lead to acute cardiac dilatation.

If a patient with auricular flutter is fully digitalized the flutter will often be converted to fibrillation, and subsequently normal rhythm may supervene. Similarly a transient stage of auricular flutter may be observed before normal rhythm is restored when a patient with auricular fibrillation is treated with quinidine.

Next Refresher Course Article.—"Medical Aspects of Air Travel," by Sir Harold E. Whittingham.

COLLEGE OF GENERAL PRACTITIONERS

Eleven additional general practitioners from different parts of the British Isles have been elected to the Foundation Council of the College. Until the first annual general meeting, to be held in the autumn, the Foundation Council will consist of:

G. F. Abercrombie (London), <i>Chairman.</i>	R. M. S. McConaghey (Devon).
G. O. Barber (Essex).	J. G. Ollerenshaw (Yorkshire).
J. Cottrell (Lincolnshire).	R. J. F. H. Pinsent (Birmingham).
D. G. French (Staffordshire).	F. M. Rose (Lancashire), <i>Deputy Chairman.</i>
Annis C. Gillie (London).	Richard Scott (Edinburgh).
H. K. Glyn Hughes (London).	J. D. Simpson (Cambridge).
I. D. Grant (Glasgow).	G. Swift (Hampshire).
J. M. Henderson (Perthshire).	A. Talbot Rogers (Kent).
W. V. Howells (Glamorgan).	G. I. Watson (Surrey).
D. M. Hughes (Carmarthen).	J. C. Young (Belfast).
J. H. Hunt (London), <i>Honorary Secretary.</i>	

Foundation Membership.—By February 12 1,600 general practitioners had joined the College.

Reprints of Steering Committee's Report.—These will be sent to anyone on request.

Plans of Surgeries.—The College is collecting plans and photographs of up-to-date surgeries, consulting-rooms, dispensaries, waiting-rooms, etc. During the past few years many doctors have spent much time and thought in adapting, or building anew, such premises for single or group practices. It is hoped to provide a centre where plans, and perhaps scale-models, of these projects can be collected and studied, so that young doctors may benefit from the experience of others. As this collection grows it will be freely available to any doctors, architects, or builders who may wish to consult it. Will general practitioners who have recently adapted old houses to their practice needs, or who have built new premises, please send to the Secretary (at 14, Black Friars Lane, London, E.C.4) plans and photographs, with a note to indicate the special features of the buildings and of the practices concerned?

CANCER EDUCATION IN CHELSEA

The Borough of Chelsea's Cancer Education Committee held a public meeting on February 17 at Chelsea Town Hall. The meeting was attended by the Mayor of Chelsea, representatives of various interested bodies, and some 200 members of the public. Alderman G. L. TUNBRIDGE presided. He said that the Chelsea Cancer Education Committee had been formed in 1949 when the Borough Council was asked what it was doing about cancer education. Since then the Committee had produced 12 informative leaflets for lay people.

Mr. R. W. RAVEN, F.R.C.S., then gave a brief address in which he described an investigation carried out by the Chelsea Committee with the aid of a questionnaire. Of the people questioned, 17% believed that cancer is infectious, 27% that it is incurable, and another 20% that it is of doubtful curability; nearly all thought that a careful programme of education would be useful. The object of cancer education, said Mr. Raven, was to substitute knowledge and confidence for ignorance and fear. There were already about 15 cancer education committees at work in Britain, and these should be increased. The population would have to be covered in stages: special attention should be given to teaching district nurses and health visitors—their combined number being nearly 20,000—student nurses, welfare and social workers, who could then disseminate information among lay people. Later a more direct approach by leaflets, lectures, films, and carefully written newspaper articles would be possible. Mr. Raven ended his address by outlining a five-point programme for cancer control.

There then followed a film entitled "Time is Life," and a period for questions. Dr. J. BROWNING ALEXANDER moved the vote of thanks.