would like to make a few more points. Professor Witts neglects to mention an important situation, not nowadays obvious, which caused much anxiety at the time when the Medical Act of 1950 became law. Many of the men and women to whom he refers committed themselves to lengthy periods of study for combined degrees in science and medicine before the 1950 Act received its first reading. Thus a year of pre-registration experience was added to an already long course by legislation which could not reasonably have been expected at the time study began. This situation applied equally to those studying medicine alone, but here the hardship was felt most among another minority —namely, the married, the ex-Service, and those urgently needed in a family practice.

Professor Witts's suggestion that accredited teaching or research posts should count as pre-registration experience seems sound. It is supported by the fact that "medicine" or "surgery" in practice can mean "psychiatry" or "ophthalmology" respectively; hence the argument that the purpose of the 1950 Act is to produce better "basic doctors" falls down. The exclusion of research and teaching experience from acceptable pre-registration posts merely denotes that a poorly represented minority has once more been hit. In this respect it is interesting to reflect upon the inevitable indignation of the majority had a period of research experience been regarded as a *sine qua non* of full registration.

It is of interest to note that the pre-registration year makes a relevant contribution to the N.H.S. clinician's seniority, while little attention is paid to it among candidates for academic positions. Thus during the pre-registration year the future research worker is uprooted from the literature of his subject and loses contact with his university department and his former colleagues. This is aggravated by the absence of any remuneration for relevant extra qualifications, so that not even monetary compensation is made for the disrupting effect of pre-registration appointments on what must be regarded as the foundations of an academic or research career. It would therefore seem that the clinically inclined graduate has much to gain and his scientifically inclined colleague much to lose at present; and the sooner a fairer system is instituted, the better for all concerned.—I am, etc.,

Glasgow, W.2. STEWART FLETCHER.

Hypoglycaemia and the Mind

SIR,—Your leader on this subject is timely (*Journal*, January 18, p. 150). Undoubtedly functional hypoglycaemia is commoner than is suspected; the reason why it is not more frequently diagnosed is that it is seldom possible to do blood-sugar estimations at the time of occurrence of the symptoms, which, as in most functional disorders, are transient. Nevertheless, glucose in tablet and parenteral form can be carried in every medical bag: if from the history of poor diet it seems likely that hypoglycaemia is present there is a rapid improvement in symptoms after glucose administration.

In the course of seeing patients with headache, it is not uncommon to see cases of hypoglycaemic headache, either simple or acting as precipitants of tension headaches or true migraine. Some cases of very severe migraine are precipitated by hypoglycaemia, and the attacks are reduced in severity and number with simple dietary measures such as a high protein, low carbohydrate diet. Attempts at studying these cases with glucose tolerance curves have given results difficult to interpret, but in general two classes are found: one in which the curves are low and flat; and another in which there is a rapid rise of the blood-sugar level followed by a rapid fall, symptoms occurring during the rapid fall in blood-sugar level. The low, flat curves have been found in cases of fatigue and also associated with premenstrual tension.

It is highly probable that functional hypoglycaemia accounts for some road accidents. One of my patients presented himself with typical functional hypoglycaemic headaches, and did well on simple dietary measures. Three years later he came again in great distress, having had his driving licence taken away by the police (very properly), having had what the policeman diagnosed as an epileptic fit by the side of his car. He had driven for many hours throughout the night on his way to his holiday resort, and had only attempted to eat one sandwich, which was rejected as it was bad. An E.E.G. was done and reported on by Dr. E. Jacoby as being normal except for some theta activity when the test was done after fasting and the blood sugar was 50 mg.%.

Among other patients, I can recall reviving an unconscious patient with glucose in a ladies' hairdressing establishment. She subsequently said that she was fasting for the sake of her figure. In her case too she had had a long journey the previous day.

A boy of 12 was prone to attacks of violence and destructiveness. A careful record of the times of his outbursts suggested that he might be getting functional hypoglycaemia. With him dietary measures had a good effect, and only recently the mother said how well he had done since this simple treatment was begun.

Finally, I think that the prevalent habit of going to work without breakfast is the cause of a good deal of the fainting at work and in the office in the middle of the morning, especially in young girls. The motto must be "Eat and be sweet-tempered," especially before driving long distances.—I am, etc.,

Birmingham, 27. K. M. HAY.

Unusual Transmission of the Haemophilic Gene

SIR,—Since the publication of our article on this subject (*Journal*, December 28, 1957, p. 1528), patient Mrs. E. R. (V 4) has been delivered of a male child (S. R.) whose blood we have found to be deficient in anti-haemophilic globulin. The mother received one pint (0.6 l.) of fresh blood at the onset of the first stage of labour; no abnormal bleeding was encountered before, during, or after the birth of the baby, who weighed 8 lb. 5 oz. (3.8 kg.). That this boy is a haemophiliac is still in conformity with the usual recessive sex-linked character, but this does not favour or rule out any of the possible explanations we have offered for the occurrence of this disease in his sister and female cousin.—We are, etc.,

JOHN F. WILKINSON. F. NOUR-ELDIN.
Manchester, 13. M. C. G. ISRAËLS. R. L. TURNER.

Early Separation of Handicapped Children from Parents

SIR,—Mrs. B. I. Ingall (*Journal*, December 28, 1957, p. 1545) is indignant at my suggestion that deaf children should not go away to school at an early age. It is impossible not to generalize, as I was thinking of all handicapped children. Undoubtedly there are some cases where it will be essential for the child to be removed from home, but weekly boarding would be preferable to termly boarding, and where possible local transport or a peripatetic teacher should be used.—I am, etc.,

White Colne, Essex. J. VINCENZI.

Anxious Patient and Worried Doctor

SIR,—I have followed with interest the correspondence (*Journal*, January 4, p. 40) following on your annotation (*Journal*, December 21, 1957, p. 1483) under the above title, and I have wondered how often "cancer apprehension" is considered as a differential diagnosis to neurosis, hypochondriasis, etc. Patients suffering from "cancer apprehension" go to their family doctor complaining of some ill-defined symptoms. When they are given a bottle of medicine they are *not* reassured, and return "to live on the doctor's doorstep."

During a long experience in the out-patients department of my hospital, I saw very many such cases, and the principle I adopted was, after careful examination, to state, "I am glad to say that there is nothing serious and no evidence of cancer," taking care to emphasize the word cancer. On a great many occasions the patients have replied in some such words as, "Thank God, that was what was really worrying me." Some of these patients are brave enough to mention the word cancer to their doctor, and he, with the best of intentions, tries to "laugh it out of them." The

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