pustular eruption follows, which tempts the patient once more to resume treatment.

Three patients with this syndrome have been referred to me within the last few months. The most severely affected had suffered from rosacea for five years and for the last four had applied betamethasone-17-valerate ointment daily. This had controlled the papulo-pustular eruption but her face had become more and more red. On examination she showed severe telangiectasia not only over the cheeks and central part of the face but strikingly over the whole face up to the hair line, where she had applied the ointment. The skin was soft, velvety smooth, and atrophic and showed subcutaneous ecchymoses similar to senile purpura. Another less severely affected patient had used betamethasone-17-valerate ointment daily for six months for rosacea. Within two days of stopping the ointment an angry eruption of pustules appeared over her whole face, which became much swollen. Having been taken by surprise with this rebound pustulation in the first of the three patients, the second patient had been warned what to expect and her eruption slowly improved with oral tetracycline and a bland lotion. A month later the telangiectasia was less prominent.

Telangiectasis may also become visible in skin conditions other than rosacea. A fourth patient used betamethasone-17-valerate ointment daily for a year for the treatment of a mild dermatitis of her eyelids. The skin of the upper eyelids became plum-coloured with numerous telangiectases, but the condition had almost recovered six months after ung. aquosum had been substituted for the betamethasone-17-valerate ointment.

While these patients have used potent corticosteroid creams for an excessive time, it is probably unwise to apply fluorine-containing corticosteroid applications with great penetrating properties to rosacea.—I am, etc.,

I. B. SNEDDON.

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Screening for Anaemia

SIR,—The results of the screening survey for anaemia reported by Dr. P. C. Elwood and others (23 December, p. 714) are most interesting and show many features in common with other surveys.

During the course of a study of anaemia in a working-class industrial general practice[1] a 10% random sample was examined, with the aim of getting as complete a sample as possible. It was felt that a general practitioner is in a unique position and may be able to get a more complete sample than other less personal approaches. This was done, 99.6% of the random sample of 347 patients being examined. The results were examined to see if those who do not co-operate in a survey were more or less anaemic than those who do co-operate.

The patients in the sample, considering adult non-pregnant women only, were placed in three groups:

(1) Those patients who attended surgery for any reason. Most of these were presumably ill to some extent.

(2) Those who came up with a relative or were sent for through a relative who had attended at surgery. With this group were included those who came in response to a written invitation.

(3) The last group consists of those who failed to respond to a written request and required visiting in order to obtain samples. Owing to varying hours of shift work some members of this group required several visits in order to find them at home. This group would probably not be included in any survey conducted by an outside person or unit.

Age	Group 1		Group 2		Group 3	
	Anaemic	Normal	Anaemic	Normal	Anaemic	Normal
14	0	6	1	15	0	2
24	1	7	0	9	1	2
34	1	1	0	10	1	0
39	3	3	1	6	2	2
44	4	2	1	10	0	4
54	2	12	0	6	0	4
64	1	5	0	8	2	3
Total	12	36	3	64	6	17
Mean Hb in g./100 ml.	10·4 S.D. ± 0·9				11·0 S.D. ± 0·6	

In this particular survey the greatest number of anaemic patients and the more severely affected were found among those already attending the surgery. Further searching did uncover a few more cases of anaemia, but this was hardly worth while in view of the effort involved. Moreover, of those patients in group 3 who were anaemic two failed to attend for treatment and one defaulted before her haemoglobin level had returned to normal.

Although the discovery of anaemia in two patients was an important factor in the early diagnosis of carcinoma of the colon, there were no cases of serious organic disease discovered as a result of screening the random sample. This was also the experience of the authors of the M.R.C. Survey[2] of 1945: "No obvious cause for the anaemia was found in any instance as a result of routine physical examination."

Every encouragement should be given to doctors to obtain accurate haemoglobin estimations on those patients who come to them. Anaemia is a common cause of poor health, and is often an important clue in the diagnosis of more serious disease, but there appears to be no need to go to great lengths to discover new cases.—I am, etc.,

Cambridge. R. H. MORGAN.

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Mycoplasma in Leukaemia

SIR,—In 1964 one of us (Negroni[1]) reported the isolation of infectious agents from patients with leukaemia; on the basis of some biological characteristics the infectious agents were classified as viruses. This conclusion was refuted by Grist and Fallon,[2] and by Girardi and others,[3] who showed that the infectious agents were mycoplasmas. Negroni[1 4 5] had also found that sera from leukaemic patients neutralized, at a low titre, the infectious agents more frequently than sera from non-leukaemic individuals. This was not confirmed by Grist[6] or by Fallon.[7] Because of these conflicting results a series of sera previously tested by Negroni, and stored since then at −20° C. were retested at Glaxo Laboratories. The results of these tests are reported here.

Twelve samples of sera from leukaemic and non-leukaemic individuals were coded so that their origin was unknown to the workers at Glaxo Laboratories. For each serum two different serological techniques, the neutralization test in tissue culture (Negroni[2]) and the metabolic inhibition test in broth (Taylor-Robinson *et al.*[8]), were used. Only when the results of these tests were known was the identity of the serum revealed and the Glaxo results compared with those obtained previously by Negroni. The tissue culture neutralization tests were carried out in both laboratories in the same way. Tenfold serial dilutions of Negroni's mycoplasma were titrated in the presence and absence of 1/10 dilution of serum using two tubes per dilution. At Glaxo, in addition, serial twofold dilutions of serum were tested against a fixed dose of mycoplasma in the metabolic inhibition (colour) test.

The results are shown in the Table. There was general agreement between the results obtained in the two laboratories; thus all three samples from healthy individuals were negative in both laboratories. There was also agreement between laboratories for five of the remaining positive sera, but it is clear that low levels of inhibition of mycoplasma growth in the tissue culture may be detected in one laboratory and not in another (sera 5, 8, 10, and 11). These results show that

Serological Tests with Human Sera

No.	Diagnosis	Glaxo		I.C.R.F. Mill Hill T.C. Infectious Doses Neutralized by 1/10 Diln. Serum	Agreement
		Metabolic Inhib.	TC Infectious Doses Neutralized by 1/10 Diln. of Serum		
		Serum Diln. Endpt.	100 TCD_{50}		
1	Healthy	<0	<0	0	+
2	„	<0	<0	0	+
3	„	<0	<0	<10	+
4	Acute monocytic	1/40	½ at a 100*	100	+
5	Unspecified leukaemia	<0	<0	10 (in 2 tests)	−
6	Chronic lymphocytic	1/20	10	10 (in 3 tests)	+
7	„ „	1/10	10	>100	+
8	Acute „	<0	<0	10 100 (in 2 tests)	−
9	Chronic myeloid	<0	<0	0	+
10	„ lymphocytic	<0	10	0	−
11	Unspecified	<0	<0	10 ½ at 100* (2 tests)	−
12	Acute myelo-monocytic	1/40	10	10	+
13	Immune rabbit antiserum	1/80	100	1,000	+

* ½–1 tube out of 2.

sera from some leukaemic patients do neutralize growth of mycoplasma first isolated by Negroni, though the inhibitor has not been shown to be antibody, and these results do not solve the problem of the role of this mycoplasma in aetiology of leukaemia, but they make it more likely that it, or an antigenically related organism, does infect man.

Our thanks are due to Dr. R. J. C. Harris, who aranged for the tests and coded the samples.

—We are, etc.,

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St. Wolfgang and Gout

SIR,—I enjoyed the Christmas Quiz (23 December, p. 740), but have a question concerning the listing of St. Wolfgang as patron saint of sufferers from gout. Investigating this matter some years ago, we found no fewer than a dozen saints and holy persons who were credited with cures of the gout.[1] These include Andrew the Apostle, St. Julian of Alexandria, St. Sebastian, St. Tranquillanus, Bl. Autriclinian of Limoges, St. Maurice, St. Placidus, St. Maurus, St. Stapinus of Dourgne, St. Gallus, Hildegard of Bingen, and St. Albert of Messina. Somehow we missed St. Wolfgang, however, and would appreciate more information concerning his dates and activities.—I am, etc.,

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Department of Medicine,
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REFERENCE

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Hospital Attachments

SIR,—Last November all items of work in my practice were noted, as had already been done during two previous Novembers.[1 2] No great difference from the figures of two years ago appeared, but on further investigation it turned out that much of the routine work in the practice could equally well have been performed by a district nurse or health visitor. One hundred and twenty-one visits, or about a quarter of the 441 home visits made in the month, could have been dealt with in this way. The general practitioner could therefore be freed to make fuller use of his special skills, but how can he achieve this in the present state of evolution of our health services ?

One way would be to allow general practitioners to have access to hospital beds as described in your General Practice Observed article (17 February, p. 436). Should the general practitioner be able to follow into hospital selected cases within the scope of his professional skill, several advantages immediately follow.

The practitioner is enabled to make full use of his knowledge, and is not, because of the rigid barrier between hospital and general practice, debarred from this.

The hospital medical staff would be relieved of a good deal of the routine work and would be able to devote more time to the more difficult and complicated cases.

The removal of some of the routine work of the hospital would lessen the present strain on, and difficulty in obtaining, junior hospital staff.

The increased contact with the hospital would be of inestimable benefit to the general practitioner and perhaps also to the hospital staff.

The problem is how to bring about this desirable state of affairs when the integration of such patients into the traditional hospital ward presents so many difficulties. Could not facilities be provided in district hospitals such as are enjoyed by our colleagues who have access to cottage hospitals, and a male and female ward set aside for such a purpose in each new district hospital ? These wards would be run entirely by general practitioners, who would provide a 24-hour-day cover for their patients. The resident hospital staff would have no duties in connexion with the unit, though the consultant staff would be available for consultation. The administration of these wards would be by the hospital secretary and matron, while the laboratory and diagnostic facilities would be, as at present, available for use by the general practitioners.

A difficult scheme to work, you may say, but those general practitioners and their patients who use the facilities of a cottage hospital can point out with justification that these units, where they already exist, function to the benefit of all, and the rigid barriers between the hospital doctor and the general practitioner are lowered.—I am, etc.,

JOHN WILSON.
Lockerbie,
Dumfriesshire.

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Trainee Anaesthetists

SIR,—The Associates in Training Committee of the Association of Anaesthetists of Great Britain and Ireland represents the views of trainee anaesthetists to the Council of the Association of Anaesthetists.

I would draw attention to the Ministry of Health Memoranda H.M.(67)26 or S.H.M. 30/1967 (Minimum Time Off-duty for Junior and Intermediate Grades of Hospital Medical and Dental Staff) and H.M.(67)27 or S.H.M. 29/1967 (Professional and Study Leave for Medical and Dental Staff in the Hospital Service). The committee would like to hear from any trainee anaesthetist (up to and including the grade of senior registrar) who has found that the recommendations in these memoranda are not being implemented.—I am, etc.,

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St. Marylebone Division

SIR,—The St. Marylebone Division of the B.M.A. has been bereaved recently by the loss of Dr. E. C. Warner (obituary, 20 January, p. 187), Miss Gladys Sandes (obituary, 27 January, p. 255), and Dr. D. C. Norris (obituary, 3 February, p. 322). They were all senior members of the Division who had devoted much of their time over the years to the services of the Division and its members, and to the British Medical Association itself.

Dr. Warner was a courteous and able chairman at a time when the Division was passing through a rather difficult phase. Miss Sandes had also been its chairman and was, prior to her death, still an active member of the executive. Dr. Norris had been treasurer for many years.

The Executive of the Division wish to place on record their sincere appreciation of these three colleagues, and of their devoted help and work during their lifetime, and to extend deep sympathy to their families.—We are, etc.,

W. A. H. STEVENSON, Chairman.
P. PATON-PHILIP, Secretary.
P. L. BACHUS, Treasurer.
A. LAWRENCE ABEL.
R. COVE-SMITH.
H. E. A. CARSON.
E. HOROWITZ.
J. HUNT.
MAURICE LEE.
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London W.1.

Points from Letters

Royal Malady

Mr. W. B. MCKELVIE, Ch.M., F.R.C.S.Ed. (Isle of Man) writes: In your leading article entitled "Royal Malady" (6 January, p. 2) you mention that it would be worth while seeking evidence of porphyria in the Old Pretender and his offspring, which, if it occurred, would dispose of the story of substitution at his birth.

One trouble James II had in common with his grandson, Prince Charles Edward, was epistaxis. The former was severely affected by nose bleeding during the Boyne campaign, and Prince Charles Edward was similarly troubled during his West Highland wanderings after Culloden. I have not been able to find out whether the Old Pretender, or the many descendants of Charles II, suffered from epistaxis.

Dangers of Birth-control Pill

Dr GUY BOUSFIELD (Broadbridge Heath, Sussex) writes: The pill will not kill the gonococcus or the dreaded *T. pallidum* of syphilis. The more primitive, but safer, sheath at least afforded some protection against these and other infections. People with free ideas on sexual intercourse, whether they rely on the pill or not as a contraceptive, are very likely to contract venereal disease and communicate it to their existing paramour. Shall we ultimately be faced with a resurgence of venereal disease ?