Indeed, the problem is analogous to that obtaining in the case of the congenital deformities of the limbs.

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[1]Penrose, L S, *Annals of Eugenics*, 1946, **13**, 145.

Asylums are still needed

SIR,—Your leading article (17 January, p 111) prompts me to suggest that, although still needed, asylums will be expected to play a more community-orientated role. Central to this role will be the "asylum" day hospital.

From a study of the records at this day hospital over a period of 14 years it appears that the day hospital may be assuming this community role. Over this period referrals from family doctors have increased from 16% to 39%; the remaining referrals in decreasing order of frequency have come from the parent hospital, social services departments, local employment offices, outpatient clinics, probation offices, and self-referrals.

Discharges from the day hospital to the parent hospital have decreased from 50% to 13% and discharges to hostels, sheltered workshops, and training centres have increased eight times. Patients readmitted from the day hospital to the parent hospital were almost invariably suffering from severe functional or organic psychoses.

It would appear that the day hospital and the mental hospital complement each other and it is hoped that over the next 20 or 30 years we shall see them evolve further until they become indistinguishable from present-day community facilities. It is evolution, not dissolution, that is needed.

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Thyroid cancer

SIR,—Your leading article on thyroid cancer (17 January, p 113) requires some clarification in order to restore balance. The types of thyroid cancer described are based on the clinicopathological classification of Wooner *et al*[1] and Hazard[2] which is now widely accepted as the best available. Their evidence[1 3] and that of others in the USA[4] and ours in the UK[5] on the behaviour of these tumours should lead us to recommend much less radical treatment for many patients than you advise.

Firstly, on diagnosis. You can hardly propose that a group of clinical signs is "highly suggestive of cancer" and then offer the option to classify it as "obviously benign"! In fact, the ways in which cancers present are: as a solitary thyroid nodule, which often feels soft; a thyroid nodule with lymph nodes or lymph nodes alone; a hard mass usually involving the whole thyroid; or, most rarely, as distant metastases. Some investigations you describe can be useful: needle biopsy can be diagnostic in anaplastic carcinoma and malignant lymphoma (which should be included in any description of these diseases) and can also show a benign condition where Hashimoto's disease occasionally mimics anaplastic carcinoma clinically.

The subclassification of papillary carcinoma describes occult (diameter less than 1·5 cm), intrathyroid, and extrathyroid types according to their morbid anatomy in the thyroid. The occult tumours (which may be a chance finding in a thyroid removed for another disease) and the intrathyroid type may both be accompanied by bulky metastases in local nodes but require no more than lobectomy, with perhaps contralateral subtotal lobectomy to control the primary. Near-total thyroidectomy may be necessary in extensive extrathyroid tumours where the risk of producing hypoparathyroidism may be acceptable. There is evidence that the modified neck dissection is preferable to radical dissection,[6] but it is doubtful if the former can be performed en bloc.

It must also be said that half follicular carcinomas are of the "microangioinvasive" type which, like occult and intrathyroid papillary carcinoma, have a prognosis which is equal to normal life expectancy as measured by an actuary.[3] Again, these are satisfactorily treated by lobectomy. The other half will be of the more malignant "angioinvasive" variety which you described.

Since the occult and intrathyroid papillary and microangioinvasive follicular carcinomas are satisfactorily treated by surgical excision it is nonsense to advocate using radioiodine for obliterating thyroid tissue and whole-body scanning. There is no evidence that this is necessary and the hazards and distress of inflicting these measures on patients who are often in their reproductive years are formidable.

Medullary carcinoma occurring sporadically is only rarely bilateral, so again total thyroidectomy is an unwarranted hazard when the disease is limited anatomically. In familial cases it is often bilateral, as it was in all four cases we reported.[7]

In what way is childhood cancer an entity? *All* types of tumour occur with increasing frequency in teenage children,[8] and they should be treated as in adults. One hazard, however, is that a child with benign dyshormonogenetic goitre may be diagnosed as having a carcinoma.[9] Hypoparathyroidism in children may be a more severe disability, but in our view this surgical penalty is to be avoided in all patients at all ages.

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[1] Woolner, L B, *American Journal of Surgery*, 1961, **102**, 354.
[2] Hazard, J B, in *The Thyroid*, ed J B Hazard and D E Smith, p 239. Baltimore, Williams and Wilkins, 1964.
[3] Woolner, L B, *et al*, in *Thyroid Neoplasia*, ed S Young and D R Inman, p 51. London and New York, Academic Press, 1968.
[4] Crile, G, jun, in *Thyroid Neoplasia*, ed S Young and D R Inman, p 39. London and New York, Academic Press, 1968.
[5] Beaugié, J M, *et al*, *British Journal of Surgery*, 1976, **63**, 173.
[6] Crile, G, jun, *American Journal of Surgery*, 1964, **108**, 862.
[7] Beaugié, J M, *et al*, *British Journal of Surgery*, 1975, **62**, 264.
[8] Campbell, H, *et al*, *British Medical Journal*, 1963, **2**, 1370.
[9] Richardson, J E, *et al*, *British Journal of Surgery*, 1974, **61**, 85.

SIR,—In your valuable and concise leading article on thyroid cancer (17 January, p 113) you draw attention to the need for earlier accurate diagnosis of these tumours. An important aid in this objective must be the joint head and neck tumour clinic or joint thyroid clinic within a head and neck unit. These clinics or units are gradually being established within larger hospital centres.

At this institution a consultant general surgeon, head and neck/ENT surgeon, and radiotherapist, with their senior registrars, see all patients referred together, plan their treatment, and jointly review their follow-up. This system has operated successfully since 1970 and has been of continuing practical benefit in the accurate diagnosis, selective treatment, and regular surveillance of these patients. The establishment of such clinics is now well known in the general field of cancer therapy but perhaps requires greater emphasis for the overlapping interests in the complex field of head and neck cancer.

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Multitudinous authorship

SIR,—Are we expected to believe that each of the 15 people named at the beginning of a recent article in the *BMJ* (7 February, p 318) actually contributed to the *writing* of the article? Surely this must be a notable feat of authorship by committee.

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Venous thromboembolism in pregnancy

SIR,—We have read your leading article (22 November, p 421) on thromboembolic problems during pregnancy with interest and would like to make a few comments.

As coumarin-like anticoagulants cross the placenta with the possibility of fetal malformations and fetal haemorrhage their use should be avoided, and as heparin treatment over longer periods is inconvenient for the patient, the diagnostic procedure is of great importance and must be correct. As clinical diagnosis of deep venous thrombosis is unreliable, the search for more objective diagnostic methods is an important task. We agree that the ^{125}I-fibrinogen test should be considered contraindicated in pregnancy but disagree that the diagnosis has to be based on clinical signs alone.[1] At least in the later part of the pregnancy ascending phlebography can be performed if the abdomen and pelvis are sheltered by lead.

Today there are, however, also non-invasive methods which can be used before therapy is instituted. Thermography, as originally described by Cooke and Pilcher,[2] has shown good diagnostic agreement with phlebography and is very simple to perform.[3] However, deep venous thromboses in pregnancy are often located in the proximal part of the venous system. Plethysmography gives a functional diagnosis and the reliability is highest in proximally located thrombi.[4] As modified by Hallböök *et al*,[5] using strain gauges, the method is fairly simple.

Recently we have had good diagnostic help from these methods in two pregnant women in whom deep venous thrombosis was suspected relatively early in the pregnancy. A 31-year-old woman, in the 13th week of pregnancy, was treated with heparin for a fortnight because of a