The regimen being evaluated in our study is based on the two-day cyclical treatment shown to be effective in late breast cancer.[1] A dose reduction of one-third has been made as a further safeguard and this modified regimen is being evaluated on a multicentre basis in histologically established stage 2 breast cancer.

Recruitment of cases began in the summer of 1975, and although we have had over 80 registrations so far it is hoped that more clinicians will participate in the trial in the near future. Detailed information is available on request.

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[1] Edelstyn, G A, *et al*, *Lancet*, 1975, **2**, 209.

Early diagnosis of cancer in the head and neck

SIR,—May I take this opportunity of supporting Mr H J Shaw (14 February, p 379) in his plea for centralisation in the management of head and neck tumours. Such a philosophy is never popular of course since it implies that not every ear, nose, and throat surgeon is competent to care for these patients; nor for acoustic tumours, the more sophisticated middle ear techniques, or many other problems. Since we all remain limited by personal preference, past experience, and present facilities it is sensible to accept our limitations with a brave face and ensure our patients' welfare by referral to those with particular interests and opportunities. This particularly applies to cancers affecting the head and neck region, where, as Mr Shaw has so ably shown, treatment requires a plethora of skills and experience. Let us ensure that those that should be cured have their chance, although I still adhere to my belief that every team must have a clinically experienced leader—and in this field it is usually a surgeon. "Surgery by committee" leads to confusion.

With regard to Mr Shaw's slightly optimistic figures for cure rates in these cancers—40-45%—it must be appreciated that all-embracing figures mean little in this region unless they are broken down to reveal the numbers at different sites and stages of disease. Early tumours in some sites such as the maxillary antrum remain extremely rare and overall cure rates consequently remain low. Alternatively, the larynx is a relatively good site. If a centre's experience is biased towards the larynx, oral cavity, or paranasal sinuses obviously a generalised figure could be unusually good or bad. Such a comment of course in no way contradicts the author's plea for early diagnosis and early referral. Only a few experienced specialised units exist for the care of such patients, and there is as yet little evidence that trained personnel exist for more. Many patients are still unwilling to travel and it therefore remains the responsibility of general practitioners to ensure that their patients do find themselves under the care of skilled and experienced individuals in adequately equipped units.

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Shortage of organs for transplantation

SIR,—Shortage of cadaver kidneys constitutes the main bottle-neck in renal transplantation, as pointed out repeatedly and again recently by Professor R Y Calne and others on behalf of the British Transplantation Society (20 December, p 704).

However helpful the Department of Health may be in launching surveys and registers and whatever legal changes are made, close liaison between each renal transplant unit and the medical and nursing staffs of its own and adjacent groups of hospitals will always remain of critical importance. This relationship cannot be built up overnight and will be achieved only by painstaking and continued contact, essentially on a personal basis. Members of the renal transplant unit, and particularly its director, should attend seminars to present cases and give talks on transplantation, not only to members of the medical and nursing and ancillary staffs but also to clergy and to lay societies, which are always delighted to have speakers on this subject. All these activities would generate an interest in transplantation and would allow people outside the unit to assess at first hand the type of persons responsible for this relatively new, possibly still somewhat mysterious, and even "suspect' surgery.

A specially appointed "liaison officer" does not possess the necessary knowledge or authority to fulfil these tasks adequately. They are essentially the duty of the director of the unit and of his trained staff, whose time, however, is fully committed to routine work and to emergency calls to remove and to transplant kidneys. How can all this be carried out in the centres without increase in staff? The transplant activities of a major centre such as the one in Sheffield were, on opening six years ago, added to the duties of existing fully committed urology and nephrology staff, and no amount of representation has made any difference to central policy on regional attitudes to organisation and treatment which has now become no less successful, and in some cases more so, than that of accepted major cancer surgery.

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Reticuloendothelial phagocytosis in patients with nephritis

SIR,—I read with interest the short report by Dr G Drivas and others (7 February, p 321) on the use of ^{125}I-labelled aggregated albumin as a test of reticuloendothelial system function in patients with nephritis. They suggest that rapid clearance of this substance from the blood of patients with certain types of nephritis could reflect the presence of circulating immune complexes in these patients.

One obvious drawback in the interpretation of in-vivo tests of macrophage function such as the one that they describe is the fact that it is difficult to be very sure what one is measuring. Uptake by Kupffer cells is markedly influenced by hepatic blood flow, while metabolism of the injected substance with consequent release of the radioactive label can give false results. This is particularly true of albumin, except where appropriate corrections are made. In this context the recently described polyvinyl pyrrolidone (PVP) test[1] may be considered an advantage. Besides, uptake of aggregated albumin, unlike that of immune complexes, is essentially a non-specific process. It is therefore not surprising that colloidal carbon has been shown to inhibit clearance of intravenously injected ^{125}I-labelled aggregated albumin.[2] In contrast, we were unable to demonstrate inhibition by this substance, in vitro, of uptake by guinea-pig macrophages of ^{125}I-labelled HSA/anti-HSA complexes which are phagocytosed through specific receptors. It is possible that specific phagocytosis of some immune complexes could lead to stimulation of the non-specific process.

The finding by Dr Drivas and his colleagues of increased clearance of ^{125}I-labelled aggregated albumin in patients with proliferative and membranous glomerulonephritis, as well as in Henoch-Schönlein nephritis, is therefore of interest because it suggests the possibility of a "switch-on" effect on macrophage function produced by certain soluble complexes. This is in keeping with our observed in-vitro enhancing action on uptake of radio-labelled aggregated human IgG by guinea-pig macrophages in the presence of sera from rheumatoid patients with cutaneous vasculitis.[3] We showed that such enhancing action was related to the presence of IgM rheumatoid factor complexes. Their results may well represent the in-vivo expression of our enhancing phenomenon. It will thus be interesting if they can show that sera from patients in whom the clearance half time of injected ^{125}I-labelled aggregated albumin was significantly reduced also contained soluble immune complexes, presumably of the IgM type.

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[1] Morgan, A G, and Soothill, J F, *Clinical and Experimental Immunology*, 1975, **20**, 489.
[2] Iio, M, and Wagner, H, *Journal of Clinical Investigation*, 1963, **42**, 417.
[3] Onyewotu, I I, *et al*, *Clinical and Experimental Immunology*, 1975, **19**, 267.

Rebound effect of hyoscine butylbromide on postoperative bowel contractions

SIR,—Atropine antagonises the muscarine actions of neostigmine except for intestinal contractions,[1] which have been known to tear open recent bowel suture lines.[2] It seemed that the addition of hyoscine butylbromide to the neostigmine and atropine given to reverse the residual muscular paralysis after operation under muscle relaxant drugs might reduce the strength of consequent bowel contractions.

One hundred consecutive patients anaesthetised for laparotomy with the addition of muscle relaxant drugs were placed randomly by an electronically derived numerical series into two groups. To reverse muscle paralysis the patients in group A (13 male, average age 57·7, and 37 female, average age 41·6) were given neostigmine 2·5 mg and atropine 0·6 mg intravenously while those in group B (17 male, average age 46, and 33 female, average age 45·9) also received hyoscine butylbromide 40 mg intravenously a few minutes before the other two drugs. As soon as a dressing had been applied to the wound the abdomen was auscultated for 20 seconds by a doctor who did not know which drugs had been injected and the presence or absence of bowel sounds noted.