The M.R.C.P.

SIR,—In the annotation "The M.R.C.P." (Aug. 6, p. 327) you ask a pertinent question, but do not suggest an answer. Thus you write, "When the College states that membership 'should signify a knowledge of general medicine that justifies further training as a consultant' the question must be asked, What further training is to be considered necessary, and who is to decide at the end of such training that the possessor of the M.R.C.P. is or is not 'a failed consultant'?" May I suggest several answers to your question?

First, it would be well if the M.R.C.P. were really considered to have the significance suggested by the Comitia of the R.C.P., because it would then be a qualification open to the general practitioner whose interests are mainly in general medicine, while it would also be a jumping-off place for the future consultant. If this were admitted there should then be a further examination for those who consider themselves fit to be consultants; and this examination should be adapted to the desires and capabilities of the individual candidates. Thus, for the men who wish to become general physicians (and let us hope that the race is not to become extinct), the higher examination would be one in general medicine; while for the aspiring specialist the examination would be, primarily at least, in his chosen subject. If the second suggestion were accepted there should be no limitation on the candidates in the matter of their "specialty," although if a man proposed a new subject he would have to justify his opinion that it deserved to be considered as a "specialty."

Such a plan would convert the present M.R.C.P. into a sort of primary examination for the Fellowship (for I suggest that those who passed the second examination should automatically become Fellows), while the whole machinery would be so flexible that there would be no difficulty in establishing new specialties so long as their exponents could convince the College that they were valuable. Details would, of course, have to be worked out. For instance, it might be wise for the regulations for the Fellowship to include a demand for a thesis or for submission of published work, while it would probably be wise to limit admission to the examination to those over the age of 30, or perhaps even over 34.

I am sure that some will ask how the member is to qualify himself for the Fellowship examination, and I feel strongly that he should have complete freedom in the matter, because, although the rudiments of a specialty can be taught, the task of really learning to be a specialist is a matter of personal initiative. Such a procedure would represent a real islet of freedom in our medical system, because each candidate could prepare himself as he thought best, although, of course, if he proposed to be examined in a "new" subject he would first have to convince the College that it was sufficiently important to be regarded as a specialty. I do no more than throw out these few suggestions, realizing that there may be some difficulties in carrying them into effect.—I am, etc.,

London, W.1. A. PINEY.

Mepacrine Dermatitis

SIR,—May I be permitted to suggest a small correction in your annotation (July 30, p. 275) on the above condition? The correction is in reference to the sentence, "It is now agreed that the ingestion of 0.1 g. or more daily of mepacrine for several months was the cause of this condition." I would point out that I stated in the article following that of Peterkin and Hair (*Brit. J. Derm. Syph.*, 1946, **58**, 263) quoted in the annotation that I had observed lesions of mepacrine dermatitis in troops newly arrived in India—i.e., who had been on suppressive mepacrine therapy for a few weeks only.

The subject of mepacrine dermatitis has been one of interest to the North of England Dermatological Society in the past year. I have shown a case producing identical lesions—a case of rheumatoid arthritis under gold treatment. Other members of the Society have described similar cases, and Dr. Twiston Davies has mentioned two cases of cardiac oedema taking Guy's pill, producing lesions similar to those of mepacrine dermatitis. It appears therefore that mepacrine is only one of a number of drugs capable of producing this type of skin manifestation.—I am, etc.,

Bradford. ALLAN BIGHAM.

Syringes

SIR,—I observe that Dr. Douglas Gairdner has made a plea (July 30, p. 282) for the standardization of the Luer nozzle or hub fitting on all hypodermic syringes. I would like to reinforce this plea, as these syringes (being of American manufacture) are now unobtainable here and, as I have previously indicated (*Proc. R. Soc. Med.*, 1946, **39**, 460), have particular advantages for ophthalmic work. This has been brought home to me with considerable force recently, as the few in my possession are wearing out and the contrast with the standard British fitting which I am compelled once again to use is very great.—I am, etc.,

Leeds. JOHN FOSTER.

Treatment of Stress Incontinence

SIR,—I join with my colleague Mr. Keith Vartan (July 9, p. 99) in admiring the technique of Mr. Wilfred Shaw's operation for the cure of stress incontinence. I do assert, however, that these arduous and technically difficult fascial sling operations are unnecessary. My operation[1] for the cure of this condition restores, underneath the urethra and particularly the neck of the bladder, those tissues which support these structures under stress, and is thus physiological in principle.

But it is results which count. In over 150 operations for the cure of stress incontinence (either for this condition alone, or combined with cystocele, or even vault prolapse) I have had two failures, one of course being in a "private" case. It has once been successful in "virginal" stress incontinence, and in another case where three attempts elsewhere had been made to cure this condition. These figures almost bring their own condemnation, for they show a success rate higher than in almost any constructive operation. They are, nevertheless, true. The fact remains, however, that, in my hands at least, the operation I have devised is so eminently successful that I can see no necessity for any form of sling operation. May I suggest that my operation be tried first, and if it be true that I am suffering from "the optimism which affects all inventors of operations for stress incontinence" I shall be only too glad to abandon my operation and join with Mr. Vartan in his enthusiasm for slings.—I am, etc.,

London, W.1. MORTIMER REDDINGTON.

REFERENCE

1 *Brit. J. Urol.*, 1948, **20**, 77.

Growth of Foetal Head

SIR,—In a recent paper by Blair Hartley[1] on the radiological detection of foetal abnormalities there occurs a very important paragraph which asks a question and carries a challenge demanding answer. He writes:

"A point to which further attention should be given is the statement which has been repeated in the past, that the foetal head continues to enlarge at the same rate during the later months of pregnancy. The late R. E. Roberts, for example, based his method of estimation of foetal maturity upon this assumption, but I have long had doubts regarding its correctness, and I have recently had the opportunity of examining the work of Dr. Sydney Josephs, who has already measured many foetal skulls by precision *x*-ray methods at 36 weeks and at birth, and he has been unable to show in the foetuses examined any increase in the diameter of the foetal head during the last four weeks of gestation. Indeed, is there any precise evidence to the contrary? It is important to emphasize the point that this applies only to normal-looking foetal skulls. It does not apply in hydrocephalus."

Now this appears to be a question to which a definite answer should be expected. Either the foetal skull increases its diameters by one-tenth of an inch (0.25 cm.) each week after