be tedious, especially as most of them have already been ably answered in your columns by Pertinax and others. The conclusions to be drawn from Dr. Cardew's letter, to my mind, are inescapable. If "Blueprint for the Future" is the anvil of the M.P.U. it is difficult to see their hammer—the rarely to be used but indispensable hammer—as anything better than a toy with a rubber head and a plastic handle. They are nice fellows in the M.P.U.—earnest, conscientious, methodical, and dedicated—a decent enough debating forum for a lean year, but a body totally unsuited for the harsh world of power.

I challenge Dr. Cardew, though I'm quite aware he is no longer general secretary, to tell us just how many M.P.U. members are actually opposed to some form of prescription charge at present. I fear he may face further surprises.—I am, etc.,

Dinnington, Near Sheffield. JOHN R. BATTY.

SIR,—Our inland colleagues understandably envy us for the hordes of temporary residents we treat each summer. Certainly the boost to our pay packets on 1 January is most acceptable.

They do, however, provide an argument in favour of the patient's making some payment to the doctor for his services, on the grounds that "nothing is appreciated unless paid for" (Dr. J. G. Goundry, 8 August, p. 385). So often T.R.s show the worst traits of the welfare-state mind. Knowing that they are unlikely to have any other dealings with their temporary doctor, some (a minority, I would agree) are much less reasonable with him than they would be with their own. They tend to look upon any ailment as an emergency, and come to the house at any time of day or night, often without regard to surgery hours.

I am not really complaining. We do well from our T.R.s. But they do provide evidence for the necessity of a financial "barrier" (call it what you will) between doctor and patient. And evidence too (unless it is simply that I am getting older and less patient) of the increasing flabbiness and irresponsibility of the citizens of our welfare state.—I am, etc.,

Ramsgate, Kent. W. G. BENSON.

SIR,—Pertinax is getting soft-hearted (15 August, p. 441). He suggests absolving children and the elderly from direct patient–doctor payments. Who is he to deny these classes the privilege and pleasure of a financial link with their doctors? And where, Sir, will the rot stop? Logically, not with children and the aged. This diabolical suggestion gives a perfect opening to those members of the profession who will seek to add further classes of patient to the list of the privileged, for instance the chronic sick—those on anticoagulants who need to see their doctor regularly, the hypertensives, those with varicose ulcers, with peptic ulcers, the chronic bronchitics, the anxiety neurotics, the depressives, the socially inadequate.

Before long we will find ourselves accepting payment from about one in ten patients only—i.e., the busy working man who wouldn't be seen dead in the surgery, unless he really was ill, because of the waste of time involved.

It was very rash of Pertinax to admit exceptions, but reason will prevail even in small quantities. The snag is that once permitted it leads on to dangerous conclusions—dangerous that is for his type of reactionary—i.e., free access to one's G.P. for everybody.—I am, etc.,

Norwich, Norfolk. J. F. YOUNG.

Itching and Diabetes

SIR,—In your leading article on elderly diabetics (15 August, p. 400) you say many of them have symptoms, especially thirst and itching. If this refers to localized itching of the vulva or penis I would agree, but I would like to ask my general medical colleagues who deal with large numbers of diabetics how often they see patients with generalized itching due to diabetes. I have investigated many patients sent to me with generalized pruritus and it is a long time since I found one with sugar in the urine. This is always given in the textbooks as a cause of generalized itching, but in my experience it is a very rare cause, and in fact I wonder whether such itching is really more common in diabetics than in a comparable group of elderly patients. This impression may be the result of selection in the patients whom I see, but I would welcome the opinion of the experts on diabetes.

Localized itching is a different story, though even here I wonder if the itching is due to the glycosuria or whether it may not really be caused by a secondary candida infection. Many women with sugar in the urine never complain of irritation. One patient of mine after years of symptomless glycosuria suddenly developed severe pruritus vulvae which disappeared again when her candida infection was successfully treated. As as result of this and similar experiences I believe that diabetic patients with pruritus vulvae or penis should be treated empirically with nystatin ointment or pessaries as appropriate.—I am, etc.,

Leeds 2. F. F. HELLIER.

Visual Standards for Driving

SIR,—It is commendable that the N.O.T.B. Association (8 August, p. 385) has shown concern at the increasing incidence of road accidents. At the same time I cannot concede that there is necessarily a relationship between visual function and the incidence of driving accidents, and I would very much like to know what evidence they have accumulated to support their view.

Many of us know patients who have one eye, or patients who have grossly contracted fields of vision, and even central vision below the present standard, all of whom appear to drive without difficulty. I can recall a trolleybus driver with telescopic vision who drove for more than 40 years without a single accident. Further, I cannot recall a single road traffic accident with which I have been associated where defective vision has been a factor in the accident. If defects of vision are to be excluded before a driving licence is issued then why not defects of hearing, and neurological and cardiovascular disease? And why has the N.O.T.B. not considered the question of colour vision?

To come to the detailed standards suggested, a visual acuity of 6/9 is said to be necessary, but why not 6/4 or 6/60? What is the evidence for 6/9? And should drivers be allowed to drive with spectacles? The second requirement with regard to fields is too vague and would lead to uneven standards. The same applies to the vague third paragraph which refers to the absence of any defects of ocular function likely in the opinion of the examiner to be of significance with regard to road safety.

It is then suggested that in the event of failure to reach the prescribed standard a full report by an ophthalmologist must be obtained, but to whom is he to report and what is the object of his report? Is he the final arbiter as to whether a person drives or not?

To summarize, while appreciating the concern of the N.O.T.B. Association, I doubt whether they have evidence to correlate visual defects with driving accidents, and, secondly, I think the proposals are far too vague and would lead to uneven standards. Courtesy and good manners must surely be the most important factors in determining whether individual drivers are involved in accidents. It would be interesting to hear the views of our psychiatric colleagues on this aspect of the problem.—I am, etc.,

London W.1. H. JACKSON.

Rough Voice

SIR,—We were most interested in "Rough Voice," your leading article (11 July, p. 74). While there is little doubt about most of the views expressed there are three points which we feel merit further discussion.

(1) It has not been our experience that the majority of patients who complain to their doctors of "a rough voice" are "almost certainly referred to a laryngologist at once."[1] Indeed in our study of 101 cases of chronic laryngitis only 33 were seen by a laryngologist within three months of the onset of symptoms. Twenty-four patients had symptoms for more than a year before attending the out-patient department. We feel that it cannot be emphasized too often or too strongly that patients who remain hoarse for two weeks should be referred at once to a laryngologist.

(2) There was no mention of nasal or paranasal infection as a cause of changes in the laryngeal epithelium.

(3) Although Norris and Peale[2] in their histological studies found that their patients with cell atypia were more likely to progress to carcinoma, this was not so in our series.[3]—We are, etc.,

C. E. GABRIEL.
D. GLYN JONES.

Ear, Nose, and Throat Hospital, Glasgow.

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2 Norris, C. M., and Peale, A. R., ibid., 1963, **77**, 635.
3 Gabriel, C. E., and Jones, D. G., ibid., 1962, **76**, 947.

Resuscitation of the Newborn

SIR,—I would agree with Dr. A. L. Hodgson (15 August, p. 446) that a neonatal

laryngoscope and sterilized disposable endotracheal tubes, such as described by Tunstall and Hodges,[1] should be available in every obstetric bag. I am astonished that there should still be labour rooms without this essential and inexpensive equipment that make necessary the manœuvres described by Dr. A. F. Doss (15 August, p. 446).

A word of advice and a word of warning, however. First, direct-vision intubation should be learnt from one accustomed to this technique, and an anaesthetist is the obvious choice. Anyone practising obstetrics should, I believe, have this instruction. Second, never, as implied in Dr. Doss's letter, attach an oxygen supply to any endotracheal tube without a means of controlling the pressure, and in the case of the newborn a means, manometric or otherwise, of preventing this pressure exceeding a maximum of 30 cm. of water. Disaster will otherwise surely follow.

Referring to the use of intragastric oxygen advocated by Mr. Wallace Barr (30 May, p. 1427), this method of oxygen administration to the newborn was shown to be valueless by Cooper, Smith, and Pask in 1960,[2] and its continued practice wastes the vital time that can be occupied by the administration of intermittent positive-pressure respiration through an endotracheal tube.—I am, etc.,

R. H. BLAZEBY.

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The Hydrocephalus Association

SIR,—The problems of spinal palsy and hydrocephalus are with us, and there is no doubt that these children need the help and support of a strong parents' association—but must we have yet another group with a special cause to plead? Already the mentally handicapped children have their group and the spastics theirs in this field alone. As Dr. J. Lorber points out (25 July, p. 250) at least one-third of the spinal-palsied children are mentally retarded, and in addition hydrocephalus is a common and potent cause of cerebral palsy. There is already enough confusion in the minds of patients, doctors, and the money-providing public; what will happen when there is yet another group for children who might easily belong to either of the already existing societies?

The continual splitting of voluntary effort for very special causes can in the end lead only to the defeat of its own objects. As these spinal-palsied children are primarily physically handicapped, I must make a special plea that the Spastics Society should take the bold step of accepting this problem as a condition closely allied to cerebral palsy, and opening wide their facilities on all levels to the children affected.

I do not believe that the country can afford another group to compete for funds, sympathy, and skill, and this is made even more difficult when the affected children often have both spinal and cerebral palsy in a manner which makes clinical distinction impossible.

The time is ripe for a bold and imaginative gesture by the Spastics Society (who must already accept hydrocephalic children with cerebral palsy). I do not believe that mere terminology or legal difficulties should be allowed to stand in the way of a step which will be humane, practical, logical, and will have immeasurable consequences for good.—I am, etc.,

Wigan, Lancs. R. M. FORRESTER.

Success at University

SIR,—These are rather obvious observations on the findings of J. R. Anderson and colleagues and F. Brockington and Z. Stein which are discussed in your leading article (15 August, p. 401). Students entering university at 17 are highly selected, because they were able to pass all their necessary examinations—O levels, 3 A levels with a high pass mark—and a university interview at that early age. There is also an easy explanation to the question why boys from social classes IV and V do better at university than at grammar school. These boys again are highly selected. Children of the middle and professional classes expect to go to university as a matter of course if they should be lucky enough to obtain a place. All through their school career they have the full backing of their home to facilitate their studies. They have a room of their own for their homework, they are often sent abroad to learn languages, there are books at home, and stimulating conversation.

The boy from social classes IV and V might have to fight antagonism at home, he has to create his own intellectual atmosphere. If with all these handicaps he has secured a place at a university against fierce competition he must be a first-class person, not only of high intelligence but showing perseverance, initiative, and often moral courage.—I am, etc.,

London N.W.3. S. COLLETT.

Oral Contraceptives and Breast Cancer

SIR,—Recently one of my former registrars, Mr. A. E. J. Mullins, described in a letter to me a young lady with a rapidly growing carcinoma of the breast who was taking oral contraceptives. I recently had a young patient aged 34 with a small carcinoma which appeared to be implicating the deep fascia although it was small in size. She was taking oral contraceptives, and asked me if they had caused the growth, or should she continue taking them.

I do feel that these drugs should be discontinued if carcinoma is thought or known to be present. Quite a proportion of the carcinomas of the breast are known to be hormone-sensitive and may be influenced adversely if the hormone is continued. Whether or not these hormones favour the origin of the growth or the viability and persistence of secondaries is open to question, but at this stage I feel that as they are known to cause occasionally an increased blood flow to the breasts in the premenstrual phase it might be advisable to discontinue their use in suspected or proved carcinoma of the breast.—I am, etc.,

The Lister Hospital, Hitchin, Herts. J. J. SHIPMAN.

Magnesium for Atherosclerosis

SIR,—Impressive results in coronary disease have been reported by Parsons[1 2] using intramuscular magnesium sulphate; he has since treated 200 cases of advanced coronary atherosclerosis for three and a half years with one death and one reinfarction (personal communication). Parsons attributed the benefits of magnesium therapy mainly to its action in preventing further atherosclerosis by reducing cholesterol and other lipid serum levels.

Professor J. H. Burn and Mr. W. R. Gibbons (6 June, p. 1482) have now contributed evidence which helps to clarify this effect of magnesium therapy; they report that the effect of sympathetic stimulation in releasing catecholamines depends on the concentration of calcium ions present and that the increased inhibitory response produced by additional calcium was antagonized by magnesium. Douglas and Rubin[3 4] found that the amount of catecholamines liberated from the adrenal medulla depended on the amount of calcium in the perfusing fluid and also reported that the addition of magnesium to this solution reduced the effect of raising the calcium content.

In a study of the influence of smoking on blood lipids Kershbaum and Bellet[5] found that smoking in humans and nicotine infusion in dogs caused a rapid and consistent rise in serum levels of free fatty acids. Accompanying this rise in human subjects was an increase in urinary catecholamine excretion; sympathetic ganglionic blockade prevented or inhibited the rise in free fatty acids, and adrenalectomized patients showed either a negligible or no rise. The rise in free fatty acid levels appeared to be due to the effect on adipose tissue of catecholamines released from the adrenal glands, extra-adrenal chromaffin tissue, and postganglionic sympathetic nerve endings by nicotine.

Now that a theoretical basis for the anti-atherosclerotic action of magnesium has emerged, I hope that more clinical workers will interest themselves in magnesium therapy, which I have found in my own practice[6] to be invaluable in many types of arterial disease.—I am, etc.,

Hornchurch, Essex. S. E. BROWNE.

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[4] —— —— ibid., 1963, 167, 288.

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Transfusion Services in Africa

SIR,—The development and interpretation of much scientific work depend upon the study of samples of blood collected from populations which differ in race or geographical distribution. Transfusion services are the ideal source for these samples, and many already assist in this work by providing large numbers of random samples from their donors or by collecting samples from individuals who may live in their area.

The valuable material available in Africa is not fully exploited, due to lack of knowledge about the existence of some of these services. In the rapid population move-