Correspondence

Letters to the Editor should not exceed 500 words.

Extended Family

SIR,—Your leading article (4 May, p. 253), like a similar one some years ago,[1] raises several points for which satisfying solutions appear endlessly evasive. None can doubt the sincerity of the Pro-Chancellor of Ibadan University in urging that "Mankind should be an extended family in which no nation should be an island of poverty and misery in a sea of affluence and surfeit." The stark realities of the situation are less exhilarating.

As regards opportunities overseas for retired practitioners, it will be recalled you reported that a deputation from the Association's Committee on Overseas Affairs visited the Ministry of Overseas Development on 1 November last year, the outcome of which was said to have been a "useful meeting" (11 November 1967, *Supplement*, p. 50). The proceedings were subsequently reported to the Committee on Overseas Affairs earlier this year (10 February, *Supplement*, p. 34). Inasmuch as the Committee "decided it was impossible to devise any scheme at the moment which would allow retired doctors to do the type of work suggested in the A.R.M. resolution," it is hard to believe any conclusion was reached that could fairly be described as "useful." As at present conceived the idea seems little more than fanciful.

Furthermore, while it may be appropriate that the Ministry of Overseas Development should continue, alluringly, to recruit on behalf of overseas Governments doctors who "should normally be nationals of the United Kingdom or the Republic of Ireland," this type of recruitment must surely be seen against the background of our own acute shortage of medical manpower, against the recent enticement of United Kingdom nationals back from the New World, and also against our deep dependence upon immigrant postgraduates from the Commonwealth. Indeed, an onlooker might be reminded of the ass in Aesop's fables who "blew hot and cold on the same dish of porridge." Your most recent leading article, like its predecessor, can do no more than define the needs and offer exhortative solutions. None could be more appealing than that "the work is surely the more worth while if it helps to ease the tensions that lead to racial conflict, a pressing evil of our time." The "hard facts" of these distressing reflections require a realistic approach. At local level in this country, on a regional basis, serious attempts to arrange more orderly secondment abroad seem merited. The Ministry of Overseas Development might well provide the necessary central administrative machinery and proper liaison with overseas Governments. Nor may it be overlooked that the supply of almost all forms of technical aid to emergent countries is largely dependent upon their willingness to receive it.—I am, etc.,

Liverpool 1. H. VINCENT CORBETT.

REFERENCE

1 *Brit. med. J.*, 1965, 1, 939.

Medical Examination of Immigrants

SIR,—In *The Times* of 6 May the Prime Minister is quoted as saying, "In 1967 over 20,000 Commonwealth immigrants were medically examined at our ports and airports, and only 58 had to be refused entry on medical grounds." I should like to ask what was the nature of the examination. A clinical examination is unlikely to discover helminths, amoebiasis, latent tuberculosis, or even early leprosy.

In 22 years' service in the R.A.M.C., and 14 years as a pathologist in the N.H.S., I have encountered a large amount of tropical disease, including some in this university town and seaport. It often takes a great deal of time and trouble to come to a diagnosis, including blood examinations and microscopy of urine and faeces, etc. Moreover, the incidence of disease varies greatly from one part of the tropics to another. Amoebiasis was very common in the soldiers in Assam and North Burma in 1944–5. In the Western Desert in 1942 there was a great deal of infectious hepatitis and cutaneous diphtheria. A friend who used to travel often to the East to examine final-year medical students said that if they did not mention tuberculosis as a cause of intestinal obstruction they were liable to be failed on that question. And so on.

I think that if the 20,000 were given thorough laboratory investigation more than 58 would be found to have evidence of disease; but who has time to do it? Possibly one of the hospitals or schools of tropical medicine might do a pilot scheme on a few hundred.—I am, etc.,

Beck Laboratory, Swansea Hospital. H. C. M. WALTON.

Hypothyroidism and ^{131}I Therapy

SIR,—In agreement with a number of centres we have found that about 30% of thyrotoxic patients treated with ^{131}I develop hypothyroidism after two years. Excessive radiation dosage has been blamed, and attempts have been made to reduce this by giving smaller amounts of ^{131}I spread over a longer period. It has even been suggested that there may be a case for returning to external *x*-ray therapy.[1] However, it may be that the increased incidence of hypothyroidism has nothing to do with excessive radiation dosage.

About 30% of thyrotoxic patients treated with carbimazole revert to the euthyroid state within two years. At the end of this time carbimazole can often be withdrawn. This "cure" has nothing to do with the drug itself but seems to be part of the natural history of the disease. Carbimazole exerts no permanent effect on the thyroid gland. It acts by blocking the synthesis of thyroid hormone, and this action persists only while the patient is taking the drug. Thus we have a group of patients who spontaneously revert to euthyroidism after two years. Presumably