level. At present, therefore, it would seem that the issue has yet to be settled and is not resolved by an ex cathedra statement.

Apart from the question of whether clinical procedures are effective or not, one must still face the fact that resources are limited. Presumably it will always be necessary to choose between competing projects or forms of expenditure, and the demonstration of the clinical effectiveness of a technique is thus only a necessary (but not sufficient) condition for it to be recommended for implementation. Doctors working in the specialty may not be content about this state of affairs, but the ultimate objective must surely be the optimum allocation of resources throughout the whole NHS and indeed the entire economy.

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[1] Allan, R, and Dykes, P, *Gastrointestinal Endoscopy*, 1974, **20**, 154.
[2] Morris, D W, *et al*, *American Journal of Digestive Diseases*, 1975, **20**, 1103.
[3] Sandlow, L J, *et al*, *American Journal of Gastroenterology*, 1974, **61**, 282.
[4] Hoare, A M, *British Medical Journal*, 1975, **1**, 27.

Craniopharyngiomas

SIR,—We would like to comment upon one point in your leading article (3 July, p 5).

In referring to our paper[1] you rightly state that in craniopharyngioma concomitant strabismus may occur as a presenting feature, a fact recorded also by Wybar.[2] It is, however, misleading to imply that the onset of such squints is characteristically sudden. Any form of non-paralytic squint can present suddenly, but an unobtrusive onset is much more common. This holds good in craniopharyngioma.

The possibility that direct involvement of the visual path may be providing a visual obstacle to binocularity and so initiating a concomitant deviation should be remembered in every case of squint in a small child. The presence of optic atrophy or of a sluggish pupil should be excluded.

HUGH B KENNEDY
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[1] Kennedy, H B, and Smith, R J S, *British Journal of Ophthalmology*, 1975, **59**, 689.
[2] Wybar, K, *Annals of Ophthalmology*, 1971, **3**, 6, 645.

Sexual problems clinic

SIR,—As one who dealt tremulously with a few of the patients with sexual problems not treated by our Oxford sexual problems clinic in 1974-5, I must express relief at the modesty of the results claimed by my colleague, Dr John Bancroft, and Mrs Lesley Coles (26 June, p 1575).

This modesty may not be apparent either in the tables provided or in the claim, valid in itself, for "substantial benefits for two-thirds of those receiving treatment"—presumably based on table IV, which shows 53 (68%) in successful outcome or worthwhile improvement. But this 68% is of a total of only 78, while the sample studied was of 200. How comes this? For a start table IV omits altogether 19 patients (2 women, 17 men) whose problem is stated in table III as "others" and whose outcome is as undisclosed as their exact problem. We need to know more about them and about the two given advice only: what advice and why only advice? Then there are a further 15 (9 women, 6 men) still receiving treatment or on the waiting list. To them must be added the 86 (43% of the whole sample) who, for reasons given in the text, refused or were refused treatment. Of the total sample, the outcome was successful in only 14·5% and with improvement worthwhile in 12%, making a total ameliorated cohort of 53 (26·5%), a quarter of all.

Successful outcome	Worthwhile improvement	No worthwhile improvement	Dropped out	Given advice only	Not yet completed	Undisclosed "others"	Refused or inappropriate
29(14·5%)	24(12%)	10(5%)	15(7·5%)	2(1%)	15(7·5%)	19(9·5%)	86(43%)

All this could have been seen at a glance in the accompanying table if it had been included in the paper. May not this more modest presentation conduce to clear understanding?

SEYMOUR SPENCER

Oxford

**We sent a copy of this letter to Dr Bancroft and Mrs Coles, whose reply is printed below.—ED, *BMJ*

SIR,—Dr Seymour Spencer is, of course, free to interpret our results in whatever way he chooses, but it is not clear to us what point he is trying to make. The issue is not whether we should be awarded a prize for the best results but whether the time and effort put into therapy is justified by the outcome.

When estimating outcome we can see no purpose in including those who were not treated, any more than those who were referred but did not attend. The reporting of outcome, as we noted, is in any case a difficult matter and our estimates must be regarded as crude. For this reason we confined the reporting of outcome to those patients with common types of sexual dysfunction. We are not concealing information which would alter the message we are hoping to convey, which, briefly stated, is that: (*a*) nearly half the patients seen in such a clinic reject or are not considered suitable for our methods of treatment; (*b*) of those who are treated, a sufficient number, in our opinion, benefit to justify the expenditure of time and the use of these treatment methods; (*c*) considering the extent to which treatment was carried out by inexperienced therapists, better results could be expected with more therapeutic experience; (*d*) the work load generated by such a service is relatively small and for a comparable area would probably require no more than six or seven sessions of therapist time per week.

JOHN BANCROFT
LESLEY COLES

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Hazards of modern competitive tennis

SIR,—The recent matches at Wembley have suggested two points of medical interest.

Firstly, with the advent of high-speed service there are risks of serious injury to people on the server's side of the net, especially the server's partner, spectators at the courtside, and the net monitor. The latter—often elderly—sits with bowed head on his hands folded on the post top.

It has been estimated that in expert hands a service ball attains 140 mph (225 kph). A direct hit at this speed on the right target could produce instant death; death following intracranial haemorrhage; ruptured ear drum or eyeball; or detached retina. As there is no reason to believe otherwise, speeds will increase. Protection of side seats by wire screen is obvious. The umpire and net judge could be protected by wearing motorcycle helmets. An electronics expert could easily arrange a visual or audible signal to show that the ball has hit the net cord; it seems odd that in this age the game can depend on a man laying his skull on a net post. I suppose expert players carry insurance for third-party trouble; there could be some hefty claims.

Secondly, during the games we were frequently annoyed by the insanitary habit of a very prominent foreign competitor who filled his mouth with liquid and then spat it out in a stream at the feet of his opponent. And this in a club where permission to remove jackets in a heat wave has to be requested!

E M R FRAZER

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Extrinsic allergic alveolitis

SIR,—It is indeed disappointing that our two papers[1 2] are not mentioned in your leading article on this subject (3 April, p 791). Two points are unsatisfactory in your article. The first one relates to the simple test of detection of precipitating antibodies. Although indeed this may provide evidence of exposure to antigen, this can usually be obtained by taking the history. The point is that precipitating antibodies do not distinguish between asymptomatic exposed individuals suffering from other respiratory disease and symptomatic patients with extrinsic allergic alveolitis.

You then go on to refer to the not fully understood immunological mechanisms. In our publication[1] we were able to show clearly that although precipitins were in fact present in symptomatic individuals with pigeon breeders' disease, lymphocyte transformation in vitro was clearly a valuable test in the distinction of those patients with allergic alveolitis. This implied therefore that cellular mechanisms may be more important than the classic Arthus reaction as previously suspected. This relatively simple laboratory technique, we feel, becomes an important diagnostic test in allergic alveolitis.

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[1] Hansen, P, and Penny, R, *International Archives of Allergy and Applied Immunology*, 1974, **47**, 498.
[2] Penny, R, *Medical Journal of Australia*, 1974, **1**, 979.

**We agree, as we pointed out, that the presence of precipitins does not necessarily

indicate disease. The distinction between subjects with precipitins who have disease and those who have not must be made by clinical, radiological, and physiological means, but the presence of precipitins in a subject with a clinical picture consistent with allergic alveolitis is an important guide to the diagnosis.

The scope of our leading article did not allow full discussion of the immunological mechanisms of extrinsic allergic alveolitis, though, as we pointed out, the Arthus concept is insufficient to explain all the features of the disease. Dr Penny and his colleagues have shown lymphocyte transformation in patients already selected on clinical and radiological grounds but none in asymptomatic subjects with precipitins. Alternative approaches have been to look for immunological abnormalities in subjects without precipitins[1] or to measure complement (C3) consumption[2] in order to detect disease at an earlier stage. Moreover patients have been described in whom precipitins and a positive response to challenge with pigeon serum are present, but lymphocyte reactivity to the serum is absent.[3] For the moment the clinician must still make the diagnosis on clinical and histological criteria, supported but not overinfluenced by those immunological tests that are available to him.
—ED, *BMJ*.

[1] Boyd, G, and Parratt, D, *Thorax*, 1974, **29**, 417.
[2] Berrens, L, and Guikers, C L H, *International Archives of Allergy and Applied Immunology*, 1972, **43**, 347.
[3] Moore, V L, *et al*, *Journal of Allergy and Clinical Immunology*, 1974, **53**, 319.

Doctors, contraception, and sterilisation

SIR,—In these days when so much time is expended through the media of broadcasting and publications on the subject of the reproduction of the human species and its control it is not unreasonable to pause for thought and review the situation.

Our vocation as doctors is to the prevention and treatment of disease and injury; a full-time occupation and one not adaptable to regular hours. We are therefore responsible people and as such should be applying ourselves to administering drugs to control infections and correct deficiencies or deviations from the norm in those who need them. Similarly, when the case requires surgical intervention, operation is undertaken with a view to cure or alleviation.

What justification, therefore, have we in prescribing "the pill" to disrupt the normal hormone rhythm in the female and what right to mutilate the male to the end that he be rendered sterile?

ARTHUR R HILL

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Suffolk

Dosage of neomycin sulphate

SIR,—We have noticed a discrepancy in the dosage of neomycin sulphate quoted for use as an intestinal antiseptic between the *British Pharmacopoeia* and the *British Pharmaceutical Codex*.

The dosage range suggested in the *BP* is 2-8 MU, whereas that in the *BPC* is 2-8 g. Since there is 1·5 g of neomycin sulphate in each megaunit the *BP* dose is 3-12 g, half as much again as that suggested in the *BPC*. To complicate the matter further, the *Extra Pharmacopoeia* (Martindale)[1] and Goodman and Gilman,[2] both respected texts, follow the *BPC* and suggest a dosage of 2-8 g while the *British National Formulary* follows the *BP* in giving a dosage of 2-8 MU.

Since neomycin sulphate is available as a standard preparation of the *European Pharmacopoeia*, monographed as containing not less than 650 international units of activity per milligram, it must be accepted as a substance that can be determined by weight alone. It would therefore seem that dosage ranges should be given by weight rather than in units.

The discrepancy between the various respected authorities should, perhaps, be explained.

M G THUSE
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[1] *Martindale: The Extra Pharmacopoeia*, ed N W Blacow, 26th edn. London, Pharmaceutical Press, 1972.
[2] Goodman, L S, and Gilman, A, *The Pharmacological Basis of Therapeutics*, 5th edn. New York, Macmillan, 1975.

Measles encephalitis during immunosuppressive treatment

SIR,—Your recent leading article on this subject (26 June, p 1552) draws attention to an important problem of management. However, while appreciating the importance of T-lymphocytes in the immune response to viral infection, we feel that the statement that "prophylactic irradiation of the central nervous system selectively reduces T-lymphocytes" is perhaps too dogmatic and that the relative radiosensitivities of T- and B-lymphocytes are far from clear. Our own experience[1] and that of others[2 3] shows that B-lymphocyte numbers are reduced relatively more than those of T-lymphocytes during remission and we have demonstrated the possibility that radiotherapy may be responsible for this reduction. There is also evidence that, in mice, B-lymphocytes may be functionally more sensitive to ionising radiation than at least one subset of T-lymphocytes.[4]

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A W CRAFT

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[1] Reid, M M, Craft, A W, and Todd, J A, *Archives of Disease in Childhood*. In press.
[2] Sen, L, and Borella, L, *Cellular Immunology*, 1973, **9**, 84.
[3] Winterleitner, H, *et al*, *Päediatrie und Pädologie*, 1975, **10**, 237.
[4] Carlson, D E, and Lubet, R A, *Radiation Research*, 1976, **65**, 111.

United profession

SIR,—Reports of the Annual Representative Meeting in the general press and in your pages convey the impression of a solidarity in our profession which does not exist. In more than 40 years I have not known a time of comparable dissatisfaction—not only with the actions of Government but even more with the lack of clear purpose in the profession. There are too many separate groups, from royal colleges to junior hospital staff, each pursuing limited, sometimes conflicting, ends.

The most recent casus belli concerns extra duty payments for junior hospital doctors. These payments might not have been introduced had the basic salaries of those staff been sufficient and their career development promoted as it should have been. These questions are partly, but not wholly, pertinent to the union-style activities of the BMA. I deplore the action accepted by the ARM, as do many —perhaps most—of the profession.

My concern now is with the other, greater interests of the profession as a whole which seem likely to go by default while the battles about money and pay-beds continue. We need a body which is able to present a broad medical view to Government. Sir John Richardson, Sir Thomas Holmes Sellors, and others advocated this three years ago.[1] Royal colleges, specialty associations, even this Association, have their own special fields of concern. At this time a Royal Commission is sitting and the Health Departments have published consultative documents; if we as a profession fail to offer coherent and unselfish advice on these proposals we shall have lost an opportunity which may not recur.

The Committee of Presidents of Royal Colleges and Deans of Faculties have a joint committee which made sound and welcome proposals to ministers nearly two years ago. That was a beginning, but it is not enough. A group of young doctors, starting from the Royal Marsden Hospital,[1] tried to present alternative views about career development late last year (15 November, 1975, p 412). We must have a body responsive to the views of the younger members of the profession and able to help in their presentation. It must relate to the other health professions also. The National Academy of Sciences of the USA has an Institute of Medicine with these objectives. Sweden has the Swedish Medical Society. We need to follow those.

The NHS, for all the harm done to it by the recent conflicts of personality and the years of inadequate funding in England, is still an asset to the public and profession alike. It cannot be isolated from our national financial problems. But it is surely our duty and self-interest to help it to survive as best it may. The priorities consultative documents are not "a policy of despair" as you described them (3 April, p 788) but opportunity for survival, as your conference on priorities (12 June, p 1447) shows.

GEORGE GODBER

Cambridge

[1] Sellors, T H, *et al*, *British Medical Journal*, 1973, **1**, 737.

Staffing in the hospital service

SIR,—With reference to your leading article on this subject (19 June, p 1492) the BMA through its Commonwealth Bureau has indeed helped 60 000 overseas trained doctors in guiding them to suitable employment, but has anybody followed their fate as to what happened throughout this period?

If you would initiate a follow-up research on the fate of the overseas doctors you will be surprised how correct the statements in the Community Relations Commission report are. Moreover, if you refer to BMA policy as reflected in motions passed by the Representative Body in 1970[1] and 1972[2] you will see that the whole overseas doctors problems were indeed initiated by the BMA.

Your veiled criticism of the formation of the Overseas Doctors' Association is, I think, unjustified. The Overseas Doctors' Association