in its longest diameter was the only lesion detected. No evidence was found by which the latter could be aetiologically linked to the hydrops. In particular, there were no "vulnerable" blood vessels of the placenta that might have been obstructed by the tumour, nor was this excessively vascular, so that an arteriovenous shunt effect was unlikely. Explanations such as protein sequestration by the tumour or unduly rapid increase in the vascular bed are within the realms of speculation.

This association has not been reported before so far as I am aware (although Macafee *et al*[5] mention a case of mediastinal teratoma associated with hydrops) and I should be grateful to hear from any of your readers who know of a similar observation.

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[1] Lie-Injo, L E, *et al*, *British Journal of Haematology*, 1962, **8**, 1.
[2] Halle, H, *Zentralblatt für Gynäcologie*, 1972, **94**, 1487.
[3] Turbeville, D F, *et al*, *Obstetrics and Gynecology*, 1974, **43**, 567.
[4] Kohler, H G, Unpublished observation.
[5] Macafee, C A J, *et al*, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, **77**, 226.
[6] Alexandrowsky, A, Inaugural Dissertation, University of Berne, 1916.
[7] Tait, L, *Transactions of the Obstetric Society of London*, 1875, **17**, 307.
[8] Jones, C E M, *et al*, *Pediatrics*, 1972, **50**, 901.

Death from asthma

SIR,—I am guilty—according to Dr E Posner (17 July, p 179)—of a most heinous crime: that of not referring every asthma patient to a "specialist." While I fully agree that patients with severe recurrent symptoms require specialist supervision, I am rather annoyed by the implication that we general practitioners are incapable of dealing with mild to moderate asthma.

Do we really need to send this latter group to a consultant chest physician for diagnosis and follow-up for "at least five years"? Perhaps Dr Posner should be reminded that we have access to simple but useful investigations such as differential white cell counts, chest *x*-rays, peak flow meters, and Vitalographs—and some of us even use them. If it is not justified to send them to a chest physician, then should they perhaps see a general physician? Consultant physicians probably see no more cases of mild to moderate asthma than do most GPs. Certainly this is true of the junior hospital doctors—in many cases housemen and senior house officers—who see the majority of the "follow-ups."

Perhaps Dr Posner did not really mean every patient, but none the less he might add to his list of quotations as follows: "Not all asthma that is treated in general practice alone is done so negligently" (Woodward, 1976).

R B WOODWARD

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"Comprehensive Psychiatric Care"

SIR,—Your reviewer of *Comprehensive Psychiatric Care*, my old colleague and opponent Dr H R Rollin (24 July, p 242), has been a distinguished contributor for many years. His review will appeal to those who still regret the passing of the medical superintendent and the style of life in mental hospitals which that system represented. Criticising the present concept of multidisciplinary team work Dr Rollin says, "in the bad old days pretty much the same relationship existed between those parties who worked together towards a common end." In the "old days" the medical superintendent controlled the nurses, administrators, social workers, and doctors. Perhaps Dr Rollin has not noticed that the first three are now independent professions and that doctors prefer a more democratic system. Whether doctors like it or not, decisions on patterns of care for patients can be reached only by agreement with the other professions and not because the doctor has authority over them. His criticisms are of importance because they stem from a failure to come to terms with the new relationships between the professions. This failure is not uncommon and explains many of the current complaints by doctors about nurses, social workers, and administrators and complaints of the latter about doctors.

His comments on leadership do not correspond with the opinions expressed in the book—for example, page 211 commences with, "The consultant has a major leadership role in many situations." He also criticises the nurse's and the administrators' chapters, but it will be of interest to see whether nurses and administrators make the same judgment.

May I suggest that readers compare Dr Rollin's review with that in the *Lancet*[1]? Better still, they might read the book for themselves to see whether or not it represents the realities of psychiatry in 1976.

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[1] *Lancet*, 1976, **2**, 129.

New look at monoamine oxidase inhibitors

SIR,—Your leading article on this subject (10 July, p 69) practically repeats what we reported over 10 years ago in *Physical Methods of Treatment in Psychiatry*[1] on the value of the monoamine oxidase inhibitors (MAOIs). This knowledge was obtained from the bedside; double-blind testing is useful only for leading astray chairborn professors who are not active bedside observers. What caused so much trouble was that a later Medical Research Council double-blind trial of phenelzine on "Bedlam melancholics," for whom the MAOIs alone are useless, was reported[2] and this specialised finding got applied to the rest of the anxiety states and lesser depressions.

And now Dr C L Brewer's figures (10 July, p 110) on the increasing number of tricyclic antidepressant suicides and deaths also repeat our similar bedside observations. If a patient feels much worse when given tricyclics during the day don't go on giving them till he tries to kill himself; for this worsening with tricyclics is often an important indication for the substitution of an MAOI, just as it is when a patient with depression still sleeps deeply.

Finally, the results of the trials on combined antidepressants which, you state, are now in progress will depend on the clinical types of depression chosen for them. The combination of MAOIs with other drugs will not work if the patient sleeps deeply but only if he has the type of depression characterised by early morning waking. And the doses of both drugs must be individually adjusted to the patient's depth of symptoms. How can you double-blind test all this?

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[1] Sargant, W, and Slater, E, *An Introduction to Physical Methods of Treatment in Psychiatry*, 4th edn. London and Edinburgh, Livingstone, 1963.
[2] MRC Clinical Psychiatry Committee, *British Medical Journal*, 1965, **1**, 881.

Detection of scanty blood parasites

SIR,—Mr M Conradie and Professor P Jacobs (17 July, p 181) point out that buffy coat smears are superior to thin films, thick films, and cytocentrifuge techniques for the identification of protozoa in the blood, particularly in the diagnosis of malaria. They ask for comment.

I would like to support their observation and add a few points. Firstly, it is my impression that in buffy coat preparations gametocytes are even better concentrated than trophozoites, and among the latter *Plasmodium vivax* appears also to be preferentially concentrated as compared with *P malariae* or *P falciparum*; this must be due to differences in density, and it is known that red cells containing *P vivax* are swollen. Secondly, as mentioned by your correspondents, the morphology of the parasites themselves and of the surviving erythrocytes containing them is much clearer in buffy coat films than in thick films, which lyse the latter. Thirdly, malarial pigment in phagocytes (monocytes and neutrophils) is more readily identified in such preparations and, especially in partly treated cases, this may be an aid to diagnosis. Finally, giant nuclear masses, which may well be of endothelial origin and indicative of microvascular damage, can best be seen in buffy coat preparations and, given several buffy coat smears from blood samples of the order of 1 ml, can possibly be used to assess the presence of such damage in subtertian, malignant malaria.[1]

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[1] Goodall, H B, *Lancet*, 1973, **2**, 1124.

Management of acute myocardial infarction

SIR,—Professor J F Pantridge and Dr J S Geddes (17 July, 0 168) draw attention to the installation of life support systems in American factories and office blocks, and quote the recent report of the Royal College of Physicians and the British Cardiac Society[1] which advises that lay or medical personnel working in factories should be trained in cardiac resuscitation techniques. Information on the extent of the problem would be useful to those who may be considering the matter. In a recent study of myocardial infarction in an Oxford car assembly plant[2] we were able to obtain some data on the number of heart attacks occurring at work.

In the seven years 1966-72, with a mean of 8300 male employees, there were six fatal heart attacks at work. The factory operated day and night shifts with cover from a medical centre that was not equipped with facilities for cardiac resuscitation, but another 23 attacks

at work were survived, 20 of the employees concerned being back in their jobs within four months. One can only speculate on how many of the six deaths might have been avoided had special facilities been available at the factory. Women formed only a small part of the work force and they had no known heart attacks during the period of the study. Otherwise the factory population was fairly typical for its size, with 35% of the men in the 45-64 age range but with relatively few in the 65+ group. Turnover rate was 5-6%.

The study showed up differences in incidence between office and shop-floor workers, and the Oxford area as a whole has a low incidence of heart attacks compared with other parts of the country,[3] but generalisation on this rather slender basis would suggest between one and two fatal attacks at work per year per 10 000 male employees.

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[1] Joint Working Party, *Journal of the Royal College of Physicians of London*, 1975, **10**, 5.
[2] Baxter, P J, *et al*, *British Journal of Industrial Medicine*, 1976, **33**, 1.
[3] Kinlen, L J, *British Heart Journal*, 1973, **35**, 616.

Requests for references

SIR,—I endorse the letter from Dr T B Boulton (24 July, p 236) on ill-mannered requests from health authorities for references for medical appointments.

This week I received a request from the North Yorkshire Health Authority which was not signed at all. It consisted of a form and an envelope addressed to an anonymous district administrator. Neither the form nor the envelope was marked "confidential." The devaluation of a professional training was evident from the form. In descending order of importance I was asked to comment on the candidate's character, initiative, drive, leadership, management ability and potential, professional ability, and capacity for getting on with people.

I suggest that ethical considerations would be met if references were sent only to the consultants concerned and fatuous forms ignored.

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Dextropropoxyphene poisoning

SIR,—We were interested to read the letter by Drs D J L and E D Carson (10 July, p 105) regarding death following the ingestion of analgesic preparations containing dextropropoxyphene. We agree with these authors that the potentially serious danger of acute respiratory depression is often forgotten in patients poisoned with this drug. Equally, many doctors fail to realise that the most commonly prescribed combination of an analgesic and dextropropoxyphene (Distalgesic) also contains paracetamol and therefore do not anticipate the hepatotoxic effects which may ensue.

Between 1970 and 1974 approximately 28% of the deaths from paracetamol poisoning in the United Kingdom were in those who had ingested a dextropropoxyphene-paracetamol mixture.[1] A detailed analysis of 1369 cases of paracetamol poisoning reported to the London centre of the Poisons Information Service between January 1975 and June 1976 indicates that 35 of these patients died. Paracetamol alone was responsible in 29 cases; dextropropoxyphene in 4 cases; while other drugs were the cause in the remaining 2 cases.

We believe that the letter from Drs D L and E D Carson is a timely reminder of the potential seriousness of a dextropropoxyphene overdose. May we therefore emphasise that naloxone is a safe and specific antagonist for dextropropoxyphene[2-4] which should be administered—to symptomatic patients—as soon as possible after ingestion. Repeated doses of this antidote may, however, be required as the duration of action of dextropropoxyphene exceeds that of naloxone.

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[1] Volans, G N, *Journal of International Medical Research*, 1976, **4**, Supplement (4), 7.
[2] Kersh, E S, *Chest*, 1973, **63**, 112.
[3] Tarala, R, and Forrest, J A H, *British Medical Journal*, 1973, **2**, 550.
[4] Lovejoy, F H, Jr, *et al*, *Journal of Pediatrics*, 1974, **85**, 98.

Diagnostician of the year

SIR,—If there was an annual distinction awarded by the Royal College of Physicians of London for the title of "Diagnostician of the year" surely the award for 1976 should go to the laudably obdurate mother of the family discussed in your report of the Clinicopathological Conference (31 July, p 285). She sequentially correctly diagnosed her husband's complaint, then her own, and then her son's—all diagnoses apparently at variance with the original opinions of the experts of the medical entourage.

MAX HONIGSBERGER

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Contract dispute

SIR,—I wish to comment on your leading article (24 July, p 201) and the reports of meetings held to discuss the juniors' contract dispute (24 July, p 254). The fact that perhaps 60% of health authorities have already been paying juniors on the basis that they are entitled to regular overtime payments (for that is what they are) while they are on leave, and in addition paying them for covering the absence on leave of colleagues, does not make such an arrangement permissible under the contract arrangements as agreed between junior doctors' representatives and the DHSS and issued to health authorities. The amount of work performed for a doctor by other colleagues when he is on leave exactly matches the additional amount that he will be required to perform when they are on leave, in a properly constructed prospective contract.

Where such contracted income is paid in equal amounts over 52 weeks it does meet Dr Wardle's criterion on which, he says, that the original agreement was made, namely, that the "new contract contains contractual payments for additional work; these continue during holidays and study leave and can easily be used for mortgage." It is Dr Wardle's misunderstanding of his own quotation which is the cause of the whole problem and which is why I refer to UMTs paid over and above the standard working week as "overtime." These payments are, as Dr Wardle says, "for additional work." I submit that additional work cannot be performed when a doctor is on leave, so that when he is on leave his entitlement for payment for additional work ceases, so that where an authority pays him for this unperformed work it must be matched by an equivalent amount of additional work performed, and this is what he does when his colleagues on the same rota are on leave in their turn.

The number of contracted units has been further confused by quite irrelevant matters such as notional assessments for flexibility and secretarial work and the inaccurate assumption that the more doctors there are on a rota the more UMTs need to be contracted for in order to cover the additional work occasioned by their absence on leave. The junior doctors' representatives are not alone in misunderstanding their contract, but as an officer of an authority which understood the full and ominous implications of the new contract from the start—gleaned only from the same information available to everyone else—I feel bound to protest at these belated and unfounded expressions of horror and betrayal.

N H N MILLS

Ebbw Vale

Armchair theorists

SIR,—The interview with Mr Alan Fisher (24 July, p 227) deserves comment. His undoubtedly sincere views confirm what many of us have been saying for a long time, namely, that NUPE's and other union's statements about the Health Service are based either on ignorance or on misunderstanding of the facts. The reasons are not far to seek because, as with Department of Health officials, they have no practical experience of what really goes on in our hospitals.

According to Mr Fisher phasing out of private beds is a moral issue. I have no quarrel with this view, but I would ask him if he would agree that unilaterally breaking of a consultant's contract is also a moral issue. I doubt if union members would accept this treatment.

He goes on to repeat the same old fantasy about people being allowed to use NHS facilities to carry on their private practice. As with others who make this statement, he fails to produce any evidence that this is the normal practice in our hospitals. My colleagues and I perform operations in a private operating theatre situated in a building which is attached to, but in all other respects separate from, an NHS hospital, using nurses not employed by the NHS. This theatre is used regularly for NHS patients when the one in the main hospital is either out of action or fully occupied. He obviously does not appreciate this facility would no longer be available for NHS patients when private facilities are phased out.