double-catheter venography will increasingly become the radiological investigation of choice for diagnosing lumbar disc disease because of its simplicity, accuracy, and low complication rate.

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[1] Meijenhorst, G C H, *Radiologia Clinica*, 1977, **46**, 439.

Chloroquine resistance in Zambia

SIR,—It is not unlikely that resistance of *Plasmodium falciparum* to 4-aminoquinolines has now reached Africa and that the report by Professor A A Khan and Dr M J Maguire (24 June, p 1669) reflects this unwelcome occurrence, fraught with serious consequences for much of tropical Africa. The technique of the described test does not fulfil all the World Health Organisation criteria[1]: thus there is no reference to the parasite count, even though the results of the blood examination are expressed in the arbitrary way of one or more pluses. The reported finding would have been more convincing if the authors had sought its confirmation by forwarding to the WHO headquarters in Geneva or to the Ross Institute in London a sample of infected blood for carrying out the in-vitro test devised by Rieckmann[2] and modified recently for field use. An evaluation based on one single hospital case is never free of uncertainty.

I am surprised at the use of doxycycline for treatment of a potentially serious case of malaria apparently resistant to a proper course of chloroquine. There is no place for any of today's antibiotics for the specific treatment of acute malaria. The tetracyclines have a slow and uncertain anti-plasmodial action and their frequent adverse effects, especially in children, outweigh their dubious value as antimalarial drugs. In cases of non-response of *P falciparum* infections to 4-aminoquinolines quinine and/or a combination of sulphadoxine with pyrimethamine are the best and well-proved[3–5] oral as well as parenteral treatment until other compounds, such as mefloquine, become widely available.

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[1] World Health Organisation, *Chemotherapy of Malaria*, WHO Technical Series, No 529. Geneva, WHO, 1973.
[2] Rieckmann, K H, *et al*, *Lancet*, 1978, **1**, 22.
[3] Peters, W, *British Medical Journal*, 1971, **2**, 95.
[4] Hall, A P, *et al*, *British Medical Journal*, 1975, **2**, 15.
[5] Hall, A P, *British Medical Journal*, 1976, **1**, 323.

PUVA or dithranol?

SIR,—I was most interested to read your leading article on the photochemotherapy (PUVA) of psoriasis (1 July, p 2), especially as I and my colleagues recently raised some questions on the safety of this procedure based on the capacity of the excited psoralen molecule to elicit mutagenic and possible carcinogenic changes in the epidermis (27 May, p 1418).

You comment on the attractiveness of PUVA for the treatment of psoriasis in contrast to the antisocial features of dithranol. It is true that conventional dithranol ointments and pastes are messy to apply and difficult to remove, and require protective dressings, which make this form of therapy inconvenient and therefore unsuitable for general use. However, although it is stated in the literature that dithranol undergoes decomposition in the presence of water,[1] our research department has succeeded in producing a stable aqueous vanishing cream formulation of dithranol (Dithocream) which largely overcomes the cosmetic problems. This should make dithranol therapy, which is known to be safe and effective,[2] much more acceptable to patients.

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[1] Kammerau, B, Zesch, A, and Schaefer, H, *Journal of Investigative Dermatology*, 1975, **64**, 145.
[2] Comaish, S, Smith, J, and Seville, R H, *British Journal of Dermatology*, 1971, **84**, 282.

Where are the untreated depressives?

SIR,—May I comment on the suggestion by Dr J C Little and others (17 June, p 1593) that untreated depressives should be looked for in general practices? I have run a weekly psychiatric clinic in a general practice in West Cardiff with four general practitioners and approximately 10 000 patients for some six months. Of the first 30 patients seen, 15 had personality disorders, eight neurotic disorders, and only three endogenous depression, all diagnoses being made according to the definitions of the 1968 Glossary of Mental Disorders of the *International Classification of Diseases*. Patients were usually seen within a week of referral and the general practitioners were especially asked to refer untreated depressives, as these were necessary for Dr David Shaw's research team at this hospital. Despite this, all three depressives had already been started on tricyclics.

Thus psychiatric clinics in general practice rarely include depressives[1] and even these few patients are usually on medication before psychiatric referral.

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[1] Shepherd, M, *et al*, *Psychiatric Illness in General Practice*. London, Oxford University Press, 1966.

Carcinoma of the male breast and oestrogen metabolism

SIR,—The overall response rate of female patients with advanced breast cancer to treatment with the anti-oestrogen tamoxifen is of the order of 30% in most reported series.[1 2] It would be surprising if a higher rate of response to the drug were obtained in male patients with this disease, even though the cases reported both by Drs D B Jeffreys and J E Efthimiou and by Dr R Abele and others (24 June, p 1697) did show objective improvements.

Our equally limited experience of treating such patients with this agent has not been so rewarding:

One patient had a mastectomy and postoperative radiotherapy at the age of 62 and developed lymph node metastases 2½ years later. These were excised but recurred eight months later. He was treated for four months with tamoxifen 20 mg twice daily, but the lymphadenopathy progressed.

The second patient was aged 63 at the time of mastectomy and radiotherapy; he remained well until seven years later, when he developed pulmonary metastases and a pleural effusion. Tamoxifen 10 mg twice daily was given for four months, during which time the radiological appearances were unchanged and new subcutaneous metastases appeared.

The evidence at present is obviously inadequate for any conclusion to be drawn as to the role, if any, of tamoxifen in the treatment of male breast cancer, but we do feel that in many cases a therapeutic trial of the drug is warranted. It is usually well tolerated and for patients of any age must surely be an immeasurably less distressing prospect than castration.

We thank Drs W D Fraser and F M Benton for permission to report on patients under their care.

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[1] Willis, K J, *et al*, *British Medical Journal*, 1977, **1**, 425.
[2] Kiang, D T, and Kennedy, B J, *Annals of Internal Medicine*, 1977, **87**, 687.

Confidentiality of medical records

SIR,—I was interested by Dr A B David's letter (1 July, p 56) about confidentiality because I recently had a similar experience.

I referred a child to a paediatrician and received a letter (endorsed as usual "carbon copy to Community Health") outlining investigations which were being undertaken. Before these had been done a teacher at the child's school spoke to the father and it became clear that the staff had been told the as yet unconfirmed diagnosis. The parents, who had had every intention of informing the school once the situation was clear, were very distressed. They did not know that the letter was being sent to the community health department, let alone to the school staff.

After an inconclusive exchange of letters with the community health department, I asked the local medical committee to look into the matter in general terms. The paediatric department said that parental consent is asked for before the school medical service is informed, so there must have been an oversight in this instance. However, such consent surely does not cover the transmission of medical information to lay people. The school is in loco parentis, so it could be argued that the staff has a right to know; but does the community have the authority to decide what is told, or is that the right of the parents?

I am not concerned whether my permission is sought, but I wonder if there are legal grounds for such dissemination of confidential matter without parental consent.

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SIR,—Dr A B David (1 July, p 56) states that since school medical examinations are no longer obligatory any information from hospital about schoolchildren is being distributed to people who may never have any professional relationship to these children.

Although this may be true in that the school doctor does not see the child, this same doctor has to advise the school about children's physical state to enable them to get maximum benefit from education. This may also be essential for the child's safety in school, especially for diabetics and epileptics. Parents are often very remiss in informing schools about their children's health problems, and if the school doctor (as is often the case) does not have information from hospitals how can he or she advise on school problems, especially