doctors can take to change Soviet policy. It is certainly true that progress is slow and that conditions remain grim for dissidents in prisons or psychiatric hospitals. However, the case of Dr Vladimir Brodsky suggests that Western doctors can have an impact.

Dr Brodsky, a Soviet physician, was imprisoned as a result of his membership of the independent Moscow based Group for Trust, which advocates greater individual contact between East and West. Through the organisation International Physicians for the Prevention of Nuclear War (IPPNW), the British affiliates (the Medical Campaign against Nuclear Weapons and the Medical Association for the Prevention of War) made sustained representations to the Soviet affiliate about Dr Brodsky's case. At the last conference of IPPNW in Cologne earlier this year it was publicly stated that the Soviet government would release another prominent member of the group and that Dr Brodsky's case would be given "favourable consideration." Since that time Dr Brodsky, his wife and child, and several other members of the group have been released to the west.

This example, together with the recent release of Dr Andrei Sakharov from internal exile, is a hopeful sign of change. Both underline the importance, as Ms White concluded, of making contact with Soviet counterparts in the belief that improved professional contacts can lead to an improved dialogue on this and other issues dividing East and West. The forthcoming IPPNW annual conference in Moscow in May will provide one such forum. An outstanding unresolved case in the field of human rights concerns Dr Anatoli Koryagin, who has suffered greatly for his courageous stand against the abuse of psychiatry in the USSR.

Another useful channel of contact is through the UK/USSR agreement on health cooperation. MCANW and MAPW have been pressing for the resumption of this intergovernmental agreement and this has recently occurred. It provides for an exchange of skill and knowledge in certain areas and should result in a modest but worthwhile improvement in communication between the medical professions in the two countries.

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Death in the clouds

SIR,—Mr Richard Wakeford's harrowing experience of the sudden death of a passenger during flight (20-27 December, p 1642) is rare, but the possibility must be addressed by those of us who are responsible for safety in commercial aircraft. Our own approach is different from the traditional one followed by British Airways.

All airlines provide basic first aid training for cabin staff but also rely on the chance presence of a doctor competent to deal with the more serious emergencies. This is often unrealistic because competence—and even credentials—are usually not assured, and circumstances and paucity of equipment limit what might otherwise be achieved. For example, most cabin staff are reasonably skilled in basic cardiopulmonary resuscitation, but this is unlikely to be useful for a victim of a cardiac arrest at 30 000 feet when no definitive treatment can be provided within an hour or more.

We have decided instead to train selected cabin staff to a high standard of skill in dealing with emergencies in flight and to provide equipment that offers a reasonable prospect of effective treatment for conditions that are dangerous or distressing. We believe that well motivated and highly intelligent volunteers among the crew of larger aircraft can be trained to diagnose and treat virtually all the important conditions they are likely to encounter.

An analysis of illness in flight from an experience of many years has shown that the variety of true emergencies is limited. With our system a cardiac arrest in an aircraft would involve the use of a semiautomatic ("advisory") defibrillator by a trained flight attendant and recovery is at least a possibility. We believe we are the first airline in the world to be equipped to deal with this and other important emergencies: though our experience is limited to a matter of months, we do not doubt that our policy of advanced first aid training will soon be shown to be capable of influencing favourably events such as that witnessed by Mr Wakeford.

We are interested to know that British Airways is now considering expanding their medical training for some cabin staff to enable them to function in a "paramedical" role when required. Our experience of training 150 such individuals leads us to encourage Lord King and his colleagues to follow this path. We believe that other airlines will appreciate the value of advanced first aid and will adopt similar schemes in due course.

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Dose dependent response of symptoms, pituitary, and bone to transdermal oestrogen in postmenopausal women

SIR,—Drs P L Selby and M Peacock (22 November, p 1337) claim to have shown "dose related" effects of transdermal oestradiol on climacteric symptoms, plasma follicle stimulating hormone concentrations, and urinary calcium and hydroxyproline excretion. However, it is unclear how the experimental design of the study could show such an effect.

They state that no patient had received any hormone replacement therapy in the month before the study. We are not convinced that this is an adequate "washout" period. Coope observed that the frequency of flushing was reduced to below pretreatment levels for at least two months after a changeover from oestrogen to placebo (which represents oestrogen withdrawal).[1]

The authors provide virtually no information on their assessment of symptoms. Were all assessments performed by one investigator? This is essential in a valid dose response study, particularly since the different oestrogen doses are achieved by patches of varying sizes and shapes which are clearly recognisable. It is not clear what exactly the symptom score comprised and how much weighting was attached to vasomotor symptoms. If this were large the investigators would have needed to study their patients for longer than three weeks. We have previously reported that transdermal oestradiol symptoms reduce the frequency of flushing episodes by 60% after three weeks but by over 90% after three months.[2] Why was therapy therefore administered for a suboptimal period?

In their statistical description the authors merely state that they used paired analyses within dose groups. The meaning of these differences between dose groups, to which a "dose related" effect refers, cannot be inferred purely from these comparisons. They should have tested specifically whether the same variable differed *according* to dose group.

The authors claim that each variable studied could be related to its own dose response curve for plasma oestradiol. The curves thus presented were, however, arbitrary lines drawn through the means of the given variable and of plasma oestradiol for the four dose groups. Surely this is not intended to be taken as further evidence of a dose related effect?

The authors cannot state, without qualification, that the dose response curves for the various variables are all congruent when the term "congruent" is used to apply to an arbitrary measure with little quantitative support. Similarly, this is not evidence to support a direct effect of oestradiol on bone independent of calcium regulatory hormones.

From the data presented, it is therefore impossible to agree that hormone replacement therapy producing an effect equivalent to higher oestradiol concentrations is likely to increase the risk of side effects without conferring any additional benefit. Clearly, further studies, including analyses of measures of lipid, lipoprotein, and carbohydrate metabolism, together with direct measurements of bone mass, are required before any such conclusions can be drawn.

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1 Coope J. Double-blind cross-over study of estrogen replacement therapy. In: Campbell S, ed. *Management of the menopause and postmenopausal years*. Lancaster: MTP Press, 1976:159-68.
2 Padwick ML, Endacott J, Whitehead MI. Efficacy, acceptability and metabolic effects of transdermal estradiol in the management of postmenopausal women. *Am J Obstet Gynecol* 1985; 152:1085-91.

A new health region for London?

SIR,—Professor J R Butler's leading article on primary care in the inner cities (13 December, p 1519) highlights one of the major problems in providing an acceptable standard of health care in large cities. The difficulties in matching primary care provision to hospital facilities of the right sort in the right place are not, however, considered, and I submit that for London at least this is a major concern. London's problems in regard to balanced health care provision are so large and so many that a radical revision of the administrative arrangements seems to be long overdue. It is doubtful that the division of the city and the home counties into the four Thames regions has worked well either for the capital or for the peripheral districts in each region. At a time when RAWP is reducing facilities in London itself it is less apparent that it is doing much to improve resources in other parts of each of the four regions.

Has the time not come to split off Greater London from the rest and make it into one health region in its own right? This London region could then concentrate on rationalising its own difficulties without looking over its shoulder all the time to worry about resources peripherally. The outer parts of the Thames regions could then be absorbed into the Wessex, Oxford, and East Anglian regions. A new region could be set up (the South Coast Region?) to look after the needs of Kent, parts of Surrey, and the whole of Sussex.

The advantages of such a change would be to enable a more rational and fairer allocation of resources to be made for the home counties generally, and to provide at last a means of organising health resources in London in a more logical and integrated manner, including primary care facilities. The immensely valuable teaching hospitals and their great contribution to teaching and research could then be organised in a more effective manner to the benefit of all.

It is with great reluctance that I suggest a further reorganisation to a part of the health service

that has already suffered much, but the present arrangements are not working to the satisfaction of anybody. No doubt there would be many drawbacks and difficulties to such an arrangement, but is it not at least worth considering?

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Manpower

SIR,—On behalf of the disabled doctors in the UK I express pleasure in the decision to approve the intermediate level service grade at the hospital junior staff conference (3 January, p 66).

Contrary to Dr Aubrey Bristow's view that approval implies that 10% of medical students are substandard, it does acknowledge that some 10% will become suboptimal during their careers, by virtue of physical or mental disability, for social reasons, or through bad luck.

National policy at the moment is to discard disabled doctors to the tip, and the implementation of the proposal would be a major step forward in securing not just better conditions of service for them but also the opportunity of serving.

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Scott: 75 years on

SIR,—One can agree with much of what Dr Michael Stroud writes about Scott's expedition to the South Pole (20-27 December, p 1652), but that does not mean that the criticisms which have been made of his leadership are not valid. Nor does it mean that critics regard him as "a weak willed fool." Nobody could deny that he and his men of the polar party were heroes, though tragic ones. The tragedy is all the greater when we remember how much of it was due to deficiencies of planning, organisation, supplies, and equipment.

The odd thing about the Scott legend, familiar to everyone, is that it has so obscured the story of the greatest British antarctic explorer, Ernest Shackleton. It was Shackleton who discovered the Beardmore Glacier route to the polar plateau and reached a point only 90 miles from the pole. It is a measure of his judgment and strength of character that he recognised that he must turn back at this point and so brought his party safely back to base. When Scott followed Shackleton's route three years later he carried Shackleton's journal as his main guide.

The differences which arose between Scott and Shackleton during their expedition of 1903 can be understood in the light of their very different characters and backgrounds. It was these very differences which made Shackleton so much greater as an expedition leader than Scott.

The crowning glory of Shackleton's career is still hardly known to the British public, mainly because it occurred during the first world war. This was his Weddell Sea expedition of 1914-7. His ship *Endurance*, commanded by F A Worsley, was crushed in the Weddell Sea ice and sank, leaving the party of 28 men on the ice with three boats. They lived for six months through the winter, encamped on the ice, and then as the ice began to break up in the spring the party took to the boats and made a hazardous five day voyage through gales and icefloes to reach Elephant Island in the South Orkneys. There they used two upturned boats to build huts on the narrow beach, and most of the party lived there through the next winter. Shackleton and Worsley, with four companions, made a heroic 800 mile boat journey through the autumn gales in latitudes 60-55° S to reach the uninhabited south west shore of South Georgia. Three of the crew, the most severely affected by the terrible sea voyage, were left to shelter in a boat-hut while Shackleton, Crean, and Worsley made an incredible climb over the mountainous interior, never previously traversed, with no more equipment than a cut down carpenter's adze, a small pocket compass, 90 feet of alpine rope, and some cooking gear.

They completed the climb in 36 hours to reach Stromness whaling station on the north east coast. After three attempts, first from South Georgia and subsequently from South America, all frustrated by sea ice, at the fourth attempt they reached Elephant Island and rescued the rest of the party. Not a single man was lost in the whole expedition.

Shackleton died in South Georgia in 1922, on his last expedition. He is buried at Grytviken, not far from Stromness.

I sailed in a ship following almost exactly the course taken by Shackleton's boat voyage from Elephant Island to South Georgia. I have seen the mountains of the Allardyce Range in South Georgia from a coastal peak. I have spoken to one of the Norwegian whalers who were in South Georgia when Shackleton, Crean, and Worsley arrived at Stromness. The Norwegians' knowledge of and admiration for Shackleton seem to be greater than among the general public of his own country.

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Points

Urinary frequency and urgency

Messrs P J O'BOYLE, G N LUMB, and S VESEY (Taunton and Somerset Hospital, Taunton) write: Ms Linda Cardoza (29 November, p 1419) is to be congratulated on producing a useful and logical pattern of investigation of urinary frequency and urgency. We share her enthusiasm for urodynamic studies and regret that her statement "Urodynamic investigations are not available in every district general hospital" is unfortunately true. There can, however, be little excuse for the absence of a urinary flowmeter and basic ultrasound in any clinic which claims to offer a service for lower urinary tract problems. In our practice a simple bladder ultrasound examination before and after voiding in conjunction with a flow rate is used routinely. This effectively shows both the clinician and the patient the true bladder function. These simple non-invasive investigations can be performed by the clinician and take little more time than is required to write a standard *x* ray referral form. From a urological point of view we thought that the dangerous concept of the "simple bladder papilloma" had finally been laid to rest. Well differentiated non-invasive transitional cell carcinoma should be managed by an adequately trained endoscopic surgeon. Long term endoscopic review will normally be required.

Dr ROSALIND MASKELL (Public Health Laboratory, St Mary's General Hospital, Portsmouth PO3 6AQ) writes: In an otherwise excellent review of urinary frequency and urgency in women I was sorry to see Ms Linda Cardozo perpetuating the well worn advice that the urethral syndrome should be treated with antibiotics, either in short courses or in long term low dose regimens. Patients who suffer from this distressing condition have long known that it is not relieved, and is often made worse, by antibiotics. There is now evidence that a major pathogenic factor is the distortion of the distal urethral flora as a result of such treatment.[1,2] We find that an explanation of this to the patient (which is readily understood if the analogy with thrush is pointed out), an alkalinising agent for symptomatic relief, and reassurance that the balance of normal commensal flora will take a little time to re-establish is helpful to most patients with this syndrome.

1 Maskell R, Pead L, Sanderson RA. Fastidious bacteria and the urethral syndrome: a 2-year clinical and microbiological study of 51 women. *Lancet* 1983;ii:1277-80.
2 Maskell R. Are fastidious organisms an important cause of dysuria and frequency?—the case for. In: Asscher AW, Brumfitt W, eds. *Microbial diseases in nephrology*. Chichester: Wiley, 1986;1-8.

Mr ROGER HOLE (South Cleveland Hospital, Middlesbrough, Cleveland TS4 3BW) writes: It is surely unhelpful that the treatment recommended for "urgency or urge incontinence" in the clinical algorithm for urinary frequency and urgency (29 November, p 1419) should state that "Oxybutynin . . . should be tried." Oxybutynin has not yet been approved for inclusion in the *British National Formulary* and is available only on a named patient basis. The manufacturers recently asked that all doctors should restrict their prescribing of this drug as much as possible.

Prescribing hypnotic benzodiazepines

Drs M W P CARNEY (Northwick Park Hospital, Harrow HA1 3UJ) and PETER ELLIS (South Harrow, Middx) write: By failing to define more closely the circumstances when a benzodiazepine hypnotic may be prescribed for "transient insomnia," Professor Malcolm Lader (25 October, p 1048) runs the risk of not being understood and his argument being lost by default. Surely the point is that the stress must be extraordinary and overwhelming? In fact, in view of the unwanted effects and the severe risk of dependence after even short term use, it is hard to see a case for prescribing benzodiazepines in everyday practice except in exceptional circumstances and in the treatment of epilepsy. Safer, non-addictive alternatives are available, and he largely ignored the use of non-drug strategies[1] like discussing changes in lifestyle, exploration and modification (if feasible) of underlying problems, and the prescription of relaxation and physical recreation.

1 Ellis P, Carney MWP. Managing anxiety. *Journal of Holistic Medicine* (in press).

Vaginal discharge

Dr PETER TOMSON (Abbots Langley, Herts WD5 0AL) writes: Vaginal discharge is common in patients in general practice and it would be logistically impossible, as well as clinically undesirable, for all cases to be referred to a sexually transmitted disease clinic (22 November, p 1357). The difficulty for the general practitioner is in knowing when to be suspicious of *Neisseria gonorrhoeae* and *Chlamydia trachomatis*, the diagnosis of which involves extra swabs (cervical, urethral, rectal, and possibly oral) and the rapid transmission of swabs in the appropriate transport media to the laboratory. The nodal point in the algorithm that decides this course of action seems to be: "Is there endocervicitis?" In the text it is admitted that the cervix may appear normal and yet harbour gonorrhoea and chlamydia. There perhaps ought to be an arrow from "Is she sexually active?" straight to the box "Consider gonococcal and chlamydial infection"; otherwise our threshold of suspicion will be too low.

Correction

Orchidectomy versus oestrogen for prostatic cancer

We regret that an error occurred in this letter by Drs Peter Henriksson and Olof Edhag (25 October 1986, p 1100). The p value given at the end of the second paragraph should have read $p=0{\cdot}5$, not $0{\cdot}05$.