

instruction of students and junior staff in this most common and important procedure.—We are, etc.,

J. G. R. HOWIE.  
R. L. C. CUMMING.

Department of Medicine,  
Gardiner Institute,  
Western Infirmary,  
Glasgow W.1.

## REFERENCE

- <sup>1</sup> Howie, J. G. R., and Cumming, R. L. C., *Lancet*, 1962, 2, 851.

## Multiple Choice Examinations

SIR,—I was intrigued that my last "Personal View" article (17 May, p. 443) was described (31 May, pp. 572 and 573) by those who wanted to dismiss its main point as being on the one hand "pungent" (Dr. W. F. M. Wallace) and on the other "a jolly little article" (Professor J. N. Hawthorne). Dr. W. K. Cowan at least found it "humane," for which adjective I was grateful. The first two attacked mainly the phrase I used to express my concern for first-class candidates. Anti-intellectualism is only too common, it seems to me, in our medical schools. Now first-class men represent only about 10% of those reading for honours degrees (at least in this university).

May I make it clear that my major concern and interest, in both teaching and examining, is with the others, those "middle-of-the-road men," who are the backbone of the profession and the salt of the earth? In my experience the ordinary, generous-minded student is as glad to recognize the qualities of the outstanding man as are some, but certainly not all, university examiners. I think it is essential that these gifted individuals should be allowed to show their gifts, and make fools, if need be, of their examiners. This is something the multiple choice examination manifestly fails to allow. The really good man easily recognizes the ambiguities that are so often contained in both the question and in the "right" and the "wrong" answers. Unless he has confined his reading to the "permitted" text he is put at a real disadvantage, because he knows that under this or that circumstance this or that "answer" might be correct. He cannot demonstrate that he understands the subject better than his mentors do. This means the end of educational advance. Mediocrity is put at a premium. Admass is with us. Professor Hawthorne put his finger on the point when he dealt with the problem of increasing numbers: "How," he asked, "can the university teacher (who is also supposed to be actively engaged in research) possibly manage without the aid of computer marking?" Well, each must answer for himself. Expediency is important, but not all-important.

If increasing numbers lead inevitably to declining standards ("more meaning worse," to paraphrase Kingsley Amis's celebrated phrase), then there is something wrong with the system. It was the system that I was criticizing. I shall go on doing so whenever it produces a deceitful and anti-intellectual "solution," such as I believe the M.C.Q. method to be.—I am, etc.,

BERNARD TOWERS.

School of Anatomy,  
Cambridge.

## Auditory Testing in Infants

SIR,—Experience during the past five years has clearly demonstrated the usefulness of screening tests of hearing in infants. These tests should be an integral part of the work at infant welfare clinics. Few people will doubt that early detection of deafness makes all the difference as far as successful rehabilitation is concerned.

The methods of screen testing are comparatively simple. Selected test sounds are produced at very small intensities and a reaction of the baby is observed, the reaction being by turn of the head towards the source of the sound. The most important condition for satisfactory testing is a quiet environment. The quieter this environment the greater the probability becomes of noticing a small sudden change, in this case a sound. Unless these tests are carried out in conditions below a certain noise level the intensity of the test sound merges in the background noise and it becomes insignificant.

One must emphasize that it is impossible to carry out satisfactory hearing tests in a noisy place. No one would try to test the vision of a child in a dark room in which one is unable to see the test material. Yet many people are quite prepared to test hearing in acoustic "darkness."

Few infant welfare clinics have a quiet room where these tests can be carried out satisfactorily. This is now the greatest obstacle to implementing a successful programme for the early detection of deafness. It is particularly disturbing to find that new clinics continue to be planned and built without a quiet room. Financial considerations do not appear to be the reason for the failure to provide this accommodation, but rather a complete lack of understanding by local authorities of the importance of incorporating a quiet room in all clinic buildings.—I am, etc.,

Hearing Clinic,  
Heston, Middx.

L. FISCH.

## Drug Treatment of Thyrotoxicosis

SIR,—We feel we must challenge the statement that "propranolol . . . is generally less effective than reserpine and guanethidine" in controlling the peripheral manifestation of thyrotoxicosis, which was included in "Drug Treatment of Thyrotoxicosis" (24 May, p. 496). We respect the fact that there is individual variation in the management of thyrotoxicosis, but to our knowledge there has been no published study comparing the effects of sympathetic antagonists such as reserpine and guanethidine with beta-adrenergic receptor blocking drugs such as propranolol in controlling many of the clinical features of thyrotoxicosis.

It has been shown that oral or intramuscular administration of reserpine<sup>1</sup> reduces many of the features of thyrotoxicosis. However, nearly three weeks may elapse before improvement or alleviation of symptoms is achieved by oral therapy. On intramuscular administration side-effects such as weakness, dizziness, nasal stuffiness, headache, and insomnia were frequently noted, and nervousness and tremor were aggravated. Several studies have shown that guanethidine is also effective,<sup>2,3</sup> but on oral administration six days was the average time taken for a good response, and hypotension, which is posture dependent, occurred in several patients. It

should be pointed out, however, that none of these trials were double-blind. We have now used propranolol in over 100 patients with thyrotoxicosis as an adjunct to therapy with radioactive iodine, carbimazole, and in preoperative preparation for surgery. Propranolol produced marked reduction in the features of the disease within 24 hours of oral administration of the first dose. In a controlled double-blind trial in patients with thyrotoxicosis,<sup>4</sup> propranolol (40 mg. four times daily) was shown to be significantly better, on sequential analysis, in producing subjective and objective improvement in the clinical features of thyrotoxicosis than a placebo. In this trial and in all our patients we have experienced no side-effects from the administration of propranolol.

Other workers have shown that propranolol is extremely effective in the control of thyroid crisis.<sup>5-7</sup> McLean<sup>5</sup> found that his patient responded better to propranolol than to reserpine or guanethidine. It may be that beta-adrenergic receptor blocking drugs have an advantage over reserpine and guanethidine in that they avoid any undesirable central nervous system effects of reserpine and the postural hypotension of guanethidine.

This article again emphasizes the shortcomings of "Today's Drugs" and some leading articles in the *British Medical Journal* to which attention has been recently drawn by Dr. A. M. Barrett (1 February, p. 318) and Dr. G. M. Wilkinson (17 May, p. 446). Statements, such as the one we criticize, must be supported by references and must not be clinical impressions of the author. If these articles are to be of real value they must be backed by full references, must be up to date, and should preferably be signed by the author. Although several papers have appeared recently describing the use of propranolol in thyrotoxicosis, no mention was made of these.—We are, etc.,

D. A. D. MONTGOMERY.  
D. C. LOWE.  
R. G. SHANKS.  
J. A. WEAVER.

Royal Victoria Hospital,  
Belfast.

## REFERENCES

- Canary, J. J., Schaaf, M., Duffy, B. J., and Kyle, L. H., *New England Journal of Medicine*, 1957, 257, 435.
- Lee, W. Y., Bronsky, D., and Waldstein, S. S., *Journal of Clinical Endocrinology and Metabolism*, 1962, 22, 879.
- Waldstein, S. S., West, G. H., jun., Lee, W. Y., and Bronsky, D., *Journal of the American Medical Association*, 1964, 189, 609.
- Shanks, R. G., Hadden, D. R., Lowe, D. C., McDevitt, D. G., and Montgomery, D. A. D., *Lancet*, 1969, 1, 993.
- McLean, A. G., *The Medical Journal of Australia*, 1967, 2, 229.
- Parsons, V., and Jewitt, D., *Postgraduate Medical Journal*, 1967, 43, 756.
- Buckle, R. M., *Acta Endocrinologica*, 1968, 57, 168.

## Varicose Veins, Cotton Workers, and Diet

SIR,—With reference to the paper by Siza Mekky and others (7 June, p. 591) our work<sup>1</sup> would indicate that the factors advanced by the writers are essentially aggravating factors of a deeper-lying primary cause, without which they would not be able to produce varicose veins at all. Some of these factors, for example, can clearly have no reference to the varicose veins occurring in men.

Believing as I do that the primary cause of varicose veins is a weighted colon, arising from the consumption of refined carbohydrates and impeding the blood return from the lower limbs, I regret that the writers did