indeed, by any consultant who has been fortunate enough to have an appropriate share of the services of a medical secretary. The contribution these women make to the hospital service is difficult to over-emphasize, and their important role should be recognized by providing much better salaries and career prospects than those which are currently available to them.—I am, etc.,

J. K. OATES

Westminster Hospital,
London S.W.1

St. Stephen's Hospital Group

SIR,—Dr. R. Lefever's letter (19 August, p. 475) echoes the widespread concern of both professional and lay users of our group of hospitals. His tribute to Dr. Gordon Signy and his laboratory is much appreciated by his colleagues. The comment of the laboratory's misplacement and the effect on the group, and St. Mary Abbots Hospital in particular, cannot go unheeded.

The decision to build the new district general hospital on the St. Stephen's site was made nearly 15 years ago and has been the subject of considerable controversy ever since. Whether the choice was made to support the postgraduate complex development in the area, or the early staff appointments at St. Stephen's Hospital encouraged its development, or there was an over-all strategy plan which was obscure to us, it resulted in the provision of the major component of our acute general hospital unit on the diminutive five-acre site at the southernmost part of our future area health board. Owing, however, to insufficient development to date we cannot effectively concentrate all our acute facilities on this site, and in any case we intend to go on providing acute outpatient and day-time casualty facilities at St. Mary Abbots Hospital and may well continue to house some acute inpatient facilities there, other than E.N.T., geriatrics, and psychiatry.

To this end we wish it to be widely known that near-equal outpatient and ancillary department facilities are offered at both hospitals and I do hope that local general practitioners and the public will continue to use St. Mary Abbots Hospital to its fullest capacity.—I am, etc.,

O. A. N. HUSAIN
Chairman,
Group Medical Advisory Committee

Chelsea and Kensington Hospital Management Committee,
London S.W.5

Problems with Asthma

SIR,—I would like to express my agreement with Dr. G. P. Maher-Loughnan's letter (15 July, p. 173) on problems in the treatment of asthma and also, if it is not too late, to comment on your article on steroid drugs in chest disease (20 May, p. 459).

Chest physicians spend much time in trying to wean patients, sometimes children, off steroids which may have been started some years earlier. I agree that asthmatic patients should be put on long-term steroids only when all other approaches have failed—including, indeed hypnotherapy in appropriate cases. I think that in elderly patients with intrinsic asthma a small daily dose may often be justifiable. I am glad to note that much higher doses of steroids are now being applied to the relief of status asthmaticus.

I believe there has always been some confusion in the minds of physicians on the significance of side effects when steroids are used in high dosage for a short period for a specific purpose and in long-term low dosage. If I refer briefly to the use of steroids in pulmonary tuberculosis apropos of your article this is not an irrelevance. Originally steroids in massive dosage were used (with chemotherapy) in cases of fulminating phthisis with gross toxaemia (hypersensitivity).[1] The immediate effect was hyposensitization with rapid clinical and radiological improvement, which was maintained. These results were confirmed by good controlled trials in this country[2] and the United States.[3] The overall findings were summarized in 1966.[4] Also in the original publication it was stated that in cases of drug hypersensitivity (streptomycin and PAS) lasting desensitization occurred if the allergens (drugs) were given in maximal dosage under immunosuppressive dosages of steroids. In both these situations hyposensitization depended on the confrontation of high antigen stimulation and massive (immunosuppressive) steroid dosage.

Modifications of this regimen were not successful. Unfortunately in the early fifties doctors had not been allowed to use steroids for a time and subsequently were admonished to use only minimal dosage. As a result there were very many reports of small doses of steroids being used (with chemotherapy) in limited and relatively inactive cases of pulmonary tuberculosis. Likewise small steroid dosage was added during the course of conventional desensitization in cases of drug hypersensitivity. These measures were virtually useless and may well account for the reference in your article to a "brief vogue" for the use of steroids and for what I consider to be its incorrect conclusion that steroids have little value in tuberculosis.

This same technique has been used by me and my colleagues in cases of allergic asthma since 1958. When a specific allergy has been demonstrated maximal antigen administration was started at once without a slow build-up and this was covered by immunosuppressive steroid dosage (ACTH 80 units and prednisone 120 mg daily) for seven days followed by rapid reduction. The antigen was continued for a total of 10 days without reaction. Patients treated in this way were closely followed for 10 years.[5] This curious empirical clinical phenomenon is now under examination and trial at Benenden Chest Hospital, monitored by sophisticated clinical and laboratory techniques.—I am, etc.,

L. E. HOUGHTON

London W.1

1 Houghton, L. E., *Lancet*, 1954, **1**, 595.
2 *Tubercle*, 1961, **42**, 391.
3 Johnson, J. R., *et al.*, *American Review of Respiratory Diseases*, 1965, **92**, 376.
4 *Lancet*, 1966, **1**, 192
5 British Allergy Society, *Acta Allergolica*, 1966, **21**, 523.

Latex Agglutination Test and H.A.A.

SIR,—The paper of Dr. J. M. Leach and his colleagues[1] describing the latex agglutination reaction as a screening test for hepatitis associated antigen (H.A.A.) prompts us to describe our experience with a similar method.[2]

A 30-year-old woman and her 36-year-old husband first donated blood in July 1971. Routine tests were positive for H.A.A. in the former, though inquiry showed that neither she, her husband, nor her 5-year-old son had a history of hepatitis or blood transfusion. The H.A.A. reaction was positive in two different tests[3 4] and remained so until February 1972. In the latter month the whole family underwent full physical examination and a series of laboratory tests, including a liver biopsy. The results showed no evidence of liver disease in any of the three, though the latex agglutination test gave positive results for H.A.A. in specimens of sputum, urine, and faeces from all three members of the family, and, additionally, in specimens of serum from the mother. —We are, etc.,

MUNTHER AL-HUJAJ
HERMANN SCHÖNTHAL

Ev. Johanneskrankenhaus Bielefeld,
West Germany

1 Leach, J. M., and Ruck, B. J., *British Medical Journal*, 1971, **4**, 597.
2 Bonacker, L., and Stärk, J., *Klinische Wochenschrift*, 1972, **50**, 166.
3 Al-Hujaj, M., and Schönthal, H., *Diagnostik*, 1971, **4**, 530.
4 Wallis, C., and Melnick, J. L., *Applied Microbiology*, 1971, **21**, 867.

Lumbar Disc Problems

SIR,—There is one awkward fact that Mr. A. H. G. Murley (26 August, p. 529) must bear in mind in attributing backache largely to overuse of worn posterior vertebral joints. If such degeneration were the chief cause the incidence of backache would increase as age advanced. In fact it reaches a peak at 50 years old and diminishes after the age of 60.—I am, etc.,

JAMES CYRIAX

London W.1

Defence Society Subscriptions

SIR,—Dr. J. D. J. Parker's letter (19 August, p. 477) draws attention to a rather important state of affairs in that membership of a defence society is usually obligatory and that these societies have exercised the advantages of a monopoly position. Any increase of the order of 100% surely demands more explanation than the bald statement that the increase is necessary.—I am, etc.,

J. H. MACLAUGHLIN

Greenisland,
Co. Antrim

Placental Tumour

SIR,—Recently I predicted that a patient had twins. The leading vertex was engaged in the pelvis and there was a ballotable mass the size of a fetal head in the fundus. I was surprised when straight abdominal *x*-ray examination showed a single fetus. The patient had a normal delivery of a normal female infant. The cord, however, came away with very little traction and the placenta, which was inserted in the fundus, was removed manually. There was a large placental mass (8 x 8 x 6 cm) just under the insertion of the cord. The histology showed a "haemangioma placenta" with "a

myxomatous matrix maintaining small blood-containing spaces lined by endothelium." This was the patient's fourth baby, one of which was an anencephalic. I have seen only one other placental tumour, and it was coincident with marked dysmaturity.—I am, etc.,

LOUIS D. COURTNEY

Lisdarn,
Co. Cavan, Eire

Cold Drink and Syncope

SIR,—Flight Lieutenant D. J. Rainford's letter (19 August, p. 475) reminds me of a verse I learnt at my mother's knee (she came from a medical family).

Full many a man, both young and old,
has gone to his sarcophagus,
Through pouring water, icy-cold, down
his too hot oesophagus.

—I am, etc.,

R. H. TOWNSHEND

Sheffield Chest Clinic,
Sheffield

Contraception and Infertility

SIR,—May I comment on the interesting dialogue between Dr. K. L. Oldershaw and Mr. Michael Brudenell concerning contraception and infertility (9 September, p. 637).

Dr. Oldershaw states that he removed the cervical plug of mucus with a Spencer-Wells forceps on the thirteenth day of the menstrual cycle preparatory to a postcoital smear examination. The fact that a plug of mucus was present on the thirteenth day of the cycle (presumably when the ovulation chart showed a rising temperature) is indicative that all was not well with the patient's sex hormone balance, because during this time of a normal cycle the cervical mucus should be as glycerine and impossible to pick up with forceps. A mucus plug will act as a barrier to sperms.

The presence of living sperms in a postcoital smear is not absolute proof that the husband is *not* the cause of the sterility (relative to his wife). On several occasions during A.I.D. a patient has been made pregnant by donor semen when a previous donor's semen was unsuccessful. The only proof of normal semen (that is. sperms) is the production of a normal child.

Mr. Brudenell refers to the growing number of post-termination infections in relation to tubal infection and blockage. "Growing number" in relation to which numbers? Does he suggest that there were fewer post-termination infections in the illegal-abortion days before the 1967 Act? If so, presumably we have something to learn from the back-street abortionists.—I am, etc.,

JOHN SLOME

London W.1

Overseas Conference

SIR,—Those still deeply concerned with Britain's continued dependence on overseas doctors in the hospital training grades will see little purpose in the exchange of views that took place at the recent Overseas Conference of the B.M.A. (*Supplement*, 12 August, p. 135). For example, Swedish medical practice is generally known to be more highly socialized than our own for reasons that are very well recognized. A special visit from a Swedish representative to describe it seemed superfluous. Ghana's contribution to the conference was interesting but did little more than outline terms and conditions of service in one of the underdeveloped countries of Africa, of which ample is already known. The Ghanaian representative also stated, somewhat surprisingly, that consultants from Britain, presumably very few in number, wishing to practise in Ghana are subject to assessment, an aspect prospective emigrants to Ghana must clearly note.

The President of the American Association was forthright, and bluntly pointed out that "when something was free it was a natural reaction for many people to abuse it." The representative from Fiji was even more blunt, stressing that Fijian doctors did not want to work in rural districts because it led to "rusting of the brain." The President of the Royal Netherlands Medical Association scarcely enlivened the discussion when he intimated that specialists' incomes in the Netherlands were coming under fire and that his medical association was "right in the middle of the arguments about abortion." Finally, it was unfortunate that the chairman of the conference, because of lack of time, was unable to call on representatives from other countries to speak. It would have been useful had your report named the other countries represented.

At least 44% of all overseas graduates currently employed in the National Health Service are Indians. If many of these return home our situation would clearly become dangerous. This is hardly an immediate threat, but the Prime Minister of India is determined to meet the medico-social needs of her country. Furthermore, continued agitation from Indian Medical Association for improved terms and conditions of service is also gaining ground and may well in due course attract home significant numbers of Indian doctors now working in Britain.

There seemed therefore to be little purpose at this juncture in holding an Overseas Conference largely devoted to an exchange of irrelevant information while far more pressing problems need urgent attention. The continued migration of doctors from the poorer countries to the rich ones, a constant source of anxiety in all the underdeveloped territories, would have been a more appropriate subject for discussion.—I am, etc.,

H. VINCENT CORBETT

Liverpool 1

*** We are informed that besides the countries mentioned in our report Australia, Belgium, India, New Zealand, and Sierra Leone were represented at the Conference.—ED., *B.M.J.*

N.H.S. Reorganization

SIR,—Surely the time has now come for the B.M.A. to denounce unequivocally the recent "management" proposals for the reorganization of the N.H.S. For those able to decipher the clotted jargon the vital clue is found in the phrase "accountability upwards and delegation downwards." It must be said that this is impossible and indeed a reversal of the real situation.

I and indeed all consultants and general practitioners can never render accountability "upwards" to anyone or be "monitored" by anyone. I am accountable to my patients and no one else. If anything is rendered upwards it is not accountability but a form of delegation. I delegate upwards to the hospital management committee and then on all my needs and requirements in the way of equipment, staff, facilities, etc. The whole crazy pyramid right up to Sir Keith Joseph himself exists only to supply me and all practising clinicians with the resources, etc., to do our jobs.

Once this elementary but vital point of who exists to serve whom is made clear then all else can fall into place with negotiation. Without this agreement the answer must be total non-cooperation.—I am, etc.,

A. J. CHADWICK

Coventry,
Warwicks

Regional Hospital Staffing

SIR,—Mistakes of fact are rare in the *British Medical Journal*, but the letter from the Regional Hospitals' Consultants and Specialists Association (16 September, p. 696), is a notable example. Your correspondents stated that the D.H.S.S. imposed an embargo on new registrar appointments, and they quoted figures derived from the D.H.S.S. to support their statement. The figures they quoted are selective.

The figures for 1971-2 are not yet available; however the percentage by which each grade increased in the year 1970-1 is as follows:

Grade	% increase 1970-1
Consultant	2·6%
Senior registrar	6·7%
Registrar	3·5%
S.H.O.	6·3%
House officer	1·4%
All training grades	4·5%
Senior reg. and registrar	5·0%

It will be seen that the registrar grade expanded by a greater percentage than the consultant grade, and the training grades as a whole by double that of the consultants. This trend has been unchanged since the beginning of the N.H.S.

Thus it is completely untrue to say that there has been an embargo on new registrar appointments: there is if anything an embargo on consultant and house officer appointments. The result of this trend is a continued decline in the prospects of hospital junior staff, and a dismal outlook for Britain's patients, who I believe are entitled to be treated by trained consultants rather than untrained juniors.

Many of the signatories of the letter from the R.H.C.S.A. are known to me personally; they are all men of principle and integrity, and I know that they would not want to put false facts before the profession.

I hope you, Sir, will more carefully scrutinize any further communication from this organization, before lending your columns to its propaganda.—I am, etc.,

F. J. BRAMBLE

London N.W.10