digitalization, during which they used an arbitrary fixed dosage schedule. They also give no information on the severity of the cardiac failure in their series of 43 children and the only comment on the clinical response is that "no toxic symptoms were noted on this regimen, and heart rate and failure were well controlled."

Digoxin was administered to all their patients by mouth as an elixir. Are they suggesting that intramuscular digoxin is unnecessary in cardiac failure or is the implication that in all their patients the failure was mild enough to permit oral therapy?

If the authors could provide the supplementary data on the clinical aspects of their cases, this would help considerably in the evaluation of their suggested dosage regimen. —I am, etc.,

VICTOR DUBOWITZ

Hammersmith Hospital,
London W.12

Hammer and Eye

SIR,—In relation to the correspondence on the subject of intraocular foreign bodies, the following case may indicate some further facets of the caution which is essential in the handling of these problems.

A young man attended with a history of a hammer and chisel injury and a perforating corneal wound near the periphery at eight o'clock. There was a hole in the iris and peripheral lens damage, and on inspection of the eye with an ophthalmoscope a shining metallic foreign body was clearly visible in the anterior vitreous. Nonetheless, an x-ray was taken and revealed an intraocular foreign body. Localization of this, however, disclosed that it was far away from the foreign body which could be seen. Neither was it visible ophthalmoscopically, being situated behind the lens opacities. Despite very close examination of the x-ray plates the visible foreign body could be detected only with the eye of faith. Only one entrance wound was found.

It seems clear that a fissured foreign body entered the eye and the relative masses of its two portions resulted in their separation inside the tissues. It hardly needs to be stressed that it is quite conceivable that without adequate investigation only one might have been removed at operation. Both foreign bodies were removed magnetically by the posterior route and the eventual outcome for the eye after the traumatic cataract had been dealt with was reasonably satisfactory.

The importance of avoiding all and any preconceptions and assumptions when dealing with these cases cannot be overstated.—I am, etc.,

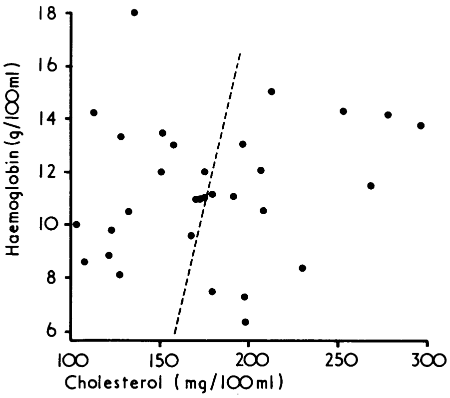
M. J. GILKES

Sussex Eye Hospital,
Brighton

Relation between Serum Cholesterol and Haemoglobin Values

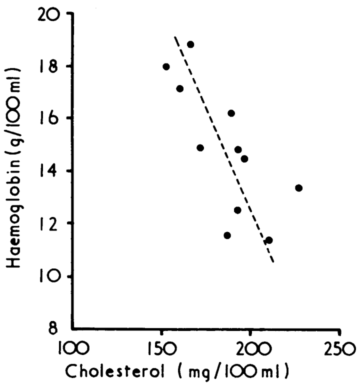
SIR,—We wish to add our experience to the data published by Professors L. E. Böttiger and L. A. Carlson (23 September, p. 731). According to their observations there is a more or less constant positive correlation between the level of cholesterol and the haemoglobin concentration in the blood of healthy non-anaemic subjects, a finding similar to those previously reported by others.[1 2]

We have collected data from patients with anaemia or polycythaemia due to various clinical conditions. Good positive correlations between the haemoglobin and cholesterol values were found in chronic myeloid leukaemia and multiple myeloma. This was not the case, however, in Hodgkin's disease,



chronic lymphoid leukaemia (fig. 1), and acute leukaemia; most of these patients had fairly low blood cholesterol levels in spite of varying haemoglobin levels.

Surprisingly enough, a negative correlation seems to be present in another myeloproliferative process, polycythaemia vera, in which the serum cholesterol, initially low, rises towards the normal level as the haemoglobin concentration is reduced as a result of adequate treatment (fig. 2).



Our own experience supports the finding of Professors Böttiger and Carlson that in normal subjects the blood cholesterol and haemoglobin levels run parallel to each other. However, this does not always seem to be the case in pathological conditions. Our detailed results will be published elsewhere.—We are, etc.,

MARIANNA BOGA
P. A. SZEMERE

Postgraduate Medical School,
Budapest

1 Rifkind, B. M., and Gale, M., *Lancet*, 1967, 2, 640.
2 Evans, J. G., and Prior, I. A. M., *Lancet*, 1967, 2, 1362.

Obstetric Prevention of Mental Retardation

SIR,—There can be little disagreement with the general theme of Professor Philip Rhodes's article (17 February, p. 399) on the benefits of obstetric detection and prevention of those pregnancies likely, or more likely than usual, to result in the birth of a mentally handicapped child. It appears to me, however, that many questions are left unanswered, particularly with regard to the "policy" as described at St. Thomas's Hospital.

While the criteria for detecting the potentially small-for-dates baby were those well accepted, we are not told at what stage induction was performed, what complications, particularly in terms of prematurity, resulted, and by what criteria the babies thus produced were judged to be likely to have become small for dates. Had the criteria of the control group—i.e., two standard deviations below the mean—been used then presumably these babies would not have qualified, as the whole purpose of the exercise was to avoid such babies.

It is also not clearly established in the article that smallness for dates per se is a cause of mental retardation—excluding those infants who suffer some degree of hypoglycaemia, which is well known both as a cause of retardation and as a complication in the small-for-dates baby. Might it not be that the improvement in mental performance in the series resulted not from the early obstetric management but from improvements in the detection and treatment of neonatal hypoglycaemia over the past five years?—I am, etc.,

J. C. SYMONS

Jenny Lind Hospital,
Norwich

Longevity of Women G.P.s

SIR,—Dr. R. A. Keable-Elliott, speaking at a meeting of the General Medical Services Committee on 15 February (*Supplement*, 3 March, p. 64) is reported to have "pointed out that it was in fact the lady doctors in pension schemes who had exploited the males over the years rather than the other way round. The expectation of a woman was so much greater than that of the male . . . [and] they drew benefit for a longer period." Whereas this is true of women in general, I doubt if it is true of women doctors. It is certainly not true of men and women doctors whose obituary notices appear in the *B.M.J.* In recent years I have made an analysis of the age of death of male and female doctors and in various categories of doctors. For instance, in 1968 there were obituary notices in the B.M.J. of 422 doctors, 389 male and 33 female. The average age at death of the men was 69 and that of the women 65. There were 158 general practitioners; the average age at death of the 144 men was 70 and that of the 14 women 62.

I am well aware that these figures are not necessarily statistically significant, but at the very least they throw some doubt on the statement that women doctors in active medical practice live longer than their male counterparts.—I am, etc.,

J. G. DENHOLM

Witham, Essex

Radiography of Potentially Pregnant Females

SIR,—In your issue of 18 November 1972 (p. 422) you published a letter from us relating to the radiography of potentially pregnant females. For those attempting to cope with