screening procedure in pregnancy cases would apply equally forcibly to the population at large, since glycosuria can be detected in every individual if looked for by special methods. In this connexion it may be conjectured whether some of these traces found may not be the result of contamination of the specimens.

It is agreed that blood-glucose estimations are preferable for the detection of diabetes, and I would suggest that a two-hour post-prandial estimation is preferable to a one-hour, as shown by Keen,² and Packer, Hawkes, and Ackerman,³ nevertheless the highest yield of positives will still be obtained from a full glucose-tolerance test.^{4,5}

Dr. Fine mentions four known cases of diabetes in his series of 2,547 cases, 0.28% of the total. I feel, however, that this figure is abnormally low, since nearly all cases of known diabetes would be attending the diabetic clinic at the Royal Gwent Hospital, Newport, under my supervision, and those becoming pregnant would not have been referred to the County Hospital, Griffithstown, from whence Dr. Fine's cases were derived. It is therefore to that extent an excluded population.

I find it puzzling to know how he obtained the 1,000 additional cases that are mentioned in an unspecified manner in the middle of his article, and which he merely refers to as "the second series of 1,000 patients." He mentioned "132 cases presented about half of the glycosurias of the second series of 1,000 cases," on whom blood-sugar curves were performed. How were these selected, and by whom? Were they cases which were also Clinistix-positive, or were they cases with minimal glycosuria? Or did they fall into both groups?

Finally, one may well ask by what criteria Dr. Fine determines that glycosuria below 16 mg./100 ml. is normal and abnormal above this level.—I am, etc.,

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REFERENCES

- 1 Fine J., *Brit. med. J.*, 1965, 1, 1209.
- 2 Keen, H., *Proc. roy. Soc. Med.*, 1966 59, 1169.
- 3 Packer, H., Hawkes, J. M., and Ackerman, R. F., *Diabetes*, 1961, 10, 280.
- 4 Sharp, C. L., *Proc. roy. Soc. Med.*, 1964, 57, 193.
- 5 *Brit. med. J.*, 1963, 2, 655.

Tybamate

SIR,—Your expert contributor quotes evidence (28 January, p. 223) that tybamate is remarkably free of side-effects.

In my admittedly very small and unrepresentative sample of seven patients treated with this drug two developed severe muscular hypotonia combined with marked ataxia.

Both patients were female, in their forties, and in good physical health. They were put on the dosage recommended by the manufacturers (1,400 mg. daily) and received no other drug concurrently.

The side-effects appeared in the second and third weeks of treatment respectively and remitted uneventfully and completely within 10 days on discontinuation of the drug.

Probably, therefore, until further evidence accumulates, caution should be exercised in

prescribing this drug freely and patients treated should remain under close clinical observation.—I am, etc.,

London N.W.3.

J. M. BACHNER.

Androgens in Metastatic Renal Adenocarcinoma

SIR,—Following the report by Bloom¹ of a patient with metastatic renal cell carcinoma who experienced a remarkable remission while receiving testosterone propionate, a trial of this hormone in the metastatic phase of the disease in males was undertaken at the Princess Margaret Hospital, Toronto.

Testosterone propionate, 150 mg. intramuscularly twice a week, was given for a period of three months unless there was definite evidence of advancing disease. The synthetic androgen fluoxymesterone was substituted in an oral dose of 5 mg. q.i.d. at three months if continuation of androgen therapy seemed warranted.

Of 15 patients entering the trial only one had an objective response. This was a man aged 62 years. Asymptomatic multiple pulmonary metastases were found incidentally in December 1963 during investigation of angina pectoris. A mass was found in the left kidney, and following nephrectomy a diagnosis of renal cell carcinoma was established.

In the Figure is plotted the mean of two diameters for three separate pulmonary metastases. The steady increase in size over a 10-month period of observation is evident. By October 1964 the patient had developed mild cough and continuous left upper chest pain quite distinct from his angina. No skeletal metastases could be demonstrated radiologically.

Within one week of commencing testosterone he lost his upper left chest pain, had decrease in cough and markedly improved well-being. Over the three-month period all pulmonary shadows decreased in size, as indicated graphically. Regrowth occurred after changing to fluoxymesterone. The patient died suddenly at home in June 1965, at a time when his malignant disease did not appear life-endangering. No necropsy was performed.

In two other patients having subjective response there was some evidence that testosterone slowed the growth rate of pulmonary metastases, but not to a degree that permitted classification as an objective clinical response. Hypercalcaemia in two patients was not influenced by testosterone. Seven of the 15 patients had subjective improvement, often of marked degree. No response was seen to fluoxymesterone in six patients. In every case hormone therapy was eventually abandoned because of relentless progression of disease.

The rarity of objective response, the chronicity of the disease and the occasional spontaneous fluctuation of growth rate (which would have been classified as an objective response in one patient in this series had the androgen been commenced at the appropriate time) make the assessment of hormone therapy difficult. If testosterone has a role in the management of renal cell carcinoma it is clearly a minor one. Nevertheless it does offer in the male an even chance of subjective improvement which is of a real value in the later stages of the disease.—I am, etc.,

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REFERENCE

- 1 Bloom, H. J. G., and Wallace, D. M., *Brit. med. J.*, 1964, 2, 476.

Referring the Patient

SIR,—Your leading article "Referring the Patient" (28 January, p. 190) quotes the existing ethical policy on the acceptance of patients by specialists. Quite reasonably it is suggested that cases should be seen only with the prior knowledge of their general practitioners. Two of the three exceptions to this rule, emergencies and those who have no family doctor, are obvious. I would like to question the third exception quoted: consultations in venereology.

Presumably, the tradition that patients who suspect a venereal infection may bypass their doctor and go directly to a venereologist is based on the assumption that some patients would be too ashamed to confess their fears to their family doctor, and, if a letter of referral was insisted on, might therefore be denied the benefit of early advice and treatment. Possibly this still applies to a small minority of patients, but I would like to suggest that the time has come for a more modern approach to the subject of venereology. Patients are expected to see their family doctors on all other medical matters. Letters of referral are expected on such personal matters as alcoholism, drug addiction, mental disease, illegitimate pregnancy, etc., and it seems rather naive to make an exception of venereology. Presumably this is only because of the association with sexual intercourse, either within or outside marriage. It seems that the family doctor is expected to be responsible (and interested) in every aspect of his patient's health with the exception of this group of conditions. It would be interesting to know if many general practitioners approve of this tradition which seems to assume that nothing can be more shameful than sex.

I am not suggesting any sudden and dramatic change in procedure in this matter. Patients could still attend V.D. clinics of their own accord under one of the other two exceptions. The remainder should be encouraged to attend hospital with a letter from their family doctor in the usual way. The general practitioner should then receive a report from the hospital on the diagnosis and treatment of his patient—also in the usual way.

On the subject of your leading article—what of the patient who attends a venereologist of his own accord and is found to suffer from some non-venereal condition after all? Is the family doctor to be informed, and, if so, is it to be by anonymous letter?