tion of cases of mitral stenosis should provide the proof, however.

An additional slight corrective may be worth while in case nihilistic conclusions be drawn on the therapeutic value of cardioversion. As it is emphasized in the title, at least, the evidence presented only refers to right ventricular output. If true, my alternative explanation of reduced benefit in patients with symptoms implies there could still be full benefit for left ventricular output.—I am, etc.,

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Infectious Diseases as a Specialty

SIR,—Your leading article (7 January, p. 2) has stimulated a brisk response, and sound points were made by your correspondents (21 January, pp. 170 and 171). The specific infections diphtheria, smallpox, and meningococcal meningitis were mentioned. I now present poliomyelitis as another illustration of the problem.

Paralytic poliomyelitis appears to have become an epidemic threat because of improvements in our living conditions; developing countries share this danger as their conditions improve, as can be seen by the emergence of epidemic poliomyelitis in several countries of Africa. Disease due to poliovirus is controllable, perhaps ultimately eradicable, by general and sustained immunization programmes. Decline of the disease as a result of immunization is followed by loss of interest by the public (and potentially by medical profession and administrators). Within sight of victory, inadequate immunization of a new generation results in the accumulation of pockets of susceptibles in which brush-fire outbreaks can occur (and have done so on several occasions in Britain).

Each case, sporadic or associated with others, paralytic or otherwise, presents a diagnostic problem requiring both clinical skill and virological assistance. Is the illness compatible with poliomyelitis? Is the patient infected with poliovirus? If so, of what type, and is it a "wild," "vaccine," or variant strain? If not, is there some other infection—for example, Coxsackie virus A7? In any case, do the findings suggest that the virus is the cause of illness or merely coincidental? What was the source of infection? What is the status of and what are the possible implications for the contacts and wider community? Is this a sporadic case or the forerunner of an outbreak or epidemic? Is there evidence to suggest that vaccine was ineffective or unsafe? How may all of this be most effectively and rapidly investigated and evaluated, and what control measures may be necessary or possible?

Clinical management of the patient requires the normal medical and possibly surgical skills—perhaps involving a short or permanent period of mechanical respiration—together with such special measures as are necessitated by the infectivity of the patient.

If the above train of thought and pattern of action are unfamiliar to others then there is a need for infectious disease specialists to whom they are not.—I am, etc.,

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Economics of Cosmetic Surgery

SIR,—After reading "What Price Anaesthesia?" (12 November 1966, p. 1190) I am tempted to ask, "What Price Plastic Surgery in Prison?" Lord Stonham, Parliamentary Under-Secretary at the Home Office, recently gave details of cosmetic surgery being carried out at three British prisons to remove obscene and particularly prominent tattoo marks on prisoners. This was in reply to a Labour M.P., one of whose constituents had complained that the operations could be done in prison but not under the National Health Service.

Apart from the undesirability of removing identity marks, has the question of cost been considered? In an investigation recently the cost of a simple appendicectomy was nearly £10, but I do not know if this includes medical personnel. Inclusion of this might double the cost. The long-suffering British taxpayer has to foot the bill for this psychiatric experiment and is entitled to ask if the money and time are being profitably spent.—I am, etc.,

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Casualty Management

SIR,—Problems of management[1] culminate in the casualty department, where diagnosis and treatment of a large number of patients on first attendance is carried out. In doing so it has to co-ordinate all the specialized services of the hospital. Also the requirements of many civilian authorities have to be considered. "The emergency situation" is not confined to the community and similarly the casualty department often has to do work arising in the hospital which cannot be otherwise departmentalized. The department is in every way an integrating body within the hospital and between the hospital and the community. There is hardly any aspect which is not dominated by immediate problems of management.

The casualty officer is continually estimating the order of importance of social and administrative demands. To do this, diagnosis must be made with certainty, and a regular and orderly mobilization of the resources for treatment and disposal must follow; he should know their potential and disposition. This involves an alteration in orientation from "everything for this patient now" to "what is best for the most," and the casualty officer must ensure this latter by keeping one eye on the department as a whole as well as one on the patient. The requirements of the essentially individual approach of "clinical consultants," "specialist assistants," and "general practitioners" advocated for the staffing of casualty departments by the Sir Harry Platt and Robert Platt reports are necessarily uncompromising and merely embarrass the equable management of the mass situation.[2]

Surely in every way the paper on management functions[1] supports the contention of the senior casualty officers that "top management" in the department can only be achieved by establishing a career structure to the level of "consultant in charge of a medical service department."

It is pleasing to see that this same paper finds anxiety in patient and staff distinguishes hospital management from that of other concerns, and this certainly accords with the circumstances of casualty work,[3] but it is surprising that having done so no mention is made of personnel selection. It is in context to quote a combatant Service officer: "Under fire there are three mutually incompatible and mutually indispensable types, those who 'go it alone,' those who 'take over the organization,' and those who 'take over the management.'" Whether or not there is any psychological foundation to this classification it certainly has relevance to the present administration of casualty departments.

Personnel selection should take precedence over academic ability, but, whatever the outcome of the casualty problem, I must say (as a "go it alone") that anxious and rigid management—the attitude that nothing must happen without my personal "say so"—is crippling to any organization. In medicine anxiety is born of inexperience, and it becomes necessary for the administrative authority in casualty to participate in the emergency work.—I am, etc.,

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REFERENCES

1 *Management Functions of Hospital Doctors*, Ministry of Health, 1966, H.M.S.O.
2 Abson, E. P., and Caro, D. B., *Lancet*, 1965, 1, 1158.
3 —— ibid., 1961, 2, 1256.

Leucine-sensitive Hypoglycaemia

SIR,—We were interested to read the article of Dr. D. B. Grant *et al.* (17 December 1966, p. 1494) reporting the abolition of leucine-induced insulin secretion in a child with leucine-sensitive hypoglycaemia treated with a combination of diazoxide and chlorthiazide.

We have treated two such patients with diazoxide alone and have shown a similar failure of the blood insulin to rise following leucine loading. Treatment in one patient had a satisfactory hyperglycaemic effect, but had to be abandoned after six months because of generalized hirsutism which caused parental distress. In the second patient a satisfactory hyperglycaemic effect has been achieved over a period of 12 months, and there have been no side-effects, apart from mild hirsutism. A full account of these two cases is to be published.[1]—We are, etc.,

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Guy's Hospital, London S.E.1. L. STIMMLER.

REFERENCE

1 *Arch. Dis. Childh.*, in press.

Cervical Cytology

SIR,—We were interested to read the report from Darbishire House Health Centre (10 December, p. 1454) describing the poor response of women when invited to attend for a cervical smear examination.

We have had a similar experience in Oxford.[1] Some months after a programme of population screening for carcinoma-in-situ of the cervix had been introduced a pilot study in two repre-