"depression" is as precise as the diagnosis and therapy of "anaemia" without further analysis.¹

I recently listened to a lecture for general practitioners on depression by a consultant psychiatrist, in which nearly every psychiatric complaint or condition other than schizophrenia, mania, and sociopathy was accused of being "depression." Does anyone else share my misgivings about the near-total victory of "depression" over psychiatry?—I am, etc.,

Gnosall,
Stafford.

H. M. FLANAGAN.

REFERENCE

¹ Cawley, R. H., quoted by W. H. Trethowan in "Mental Myths and Mechanisms," Inaugural Lecture, University of Birmingham, 1963.

Requests for Abortion

SIR,—I agree with Mr. Wilfrid G. Mills (30 December, p. 802) that an increase in requests for termination of pregnancy has already occurred. This has not only increased the work load of gynaecologists but also of general practitioners who sift and prepare the medical and social backgrounds before patients are referred to the consultants. Many of these cases do not reach the outpatient clinics. However, there should be no criticism of the Act on this account. If a law is socially just then a place must be found for it on the statute-book. One might as well say that a crime cannot be punishable by imprisonment because there are not enough prisons to contain the offenders.

The answer may well be to press for additional outpatient sessions and the consequent appointment of more gynaecological consultants. The public will also have to be educated to the fact that this is not an Act for abortion on demand.—I am, etc.,

Stourport-on-Severn,
Worcs.

W. T. MACKIE.

Congenital Dislocation of the Hip

SIR,—I have read with interest the recent correspondence (9 December, p. 618, and 23 December, p. 745) on early diagnosis of the unstable hip in infancy. I hasten to congratulate Dr. H. V. L. Finlay and others on the excellence of their article (18 November, p. 377). While wholeheartedly agreeing with the principles laid down in their paper and while paying tribute to the sterling work of Van Rosen, Barlow, and others, may I be permitted to record a note of caution?

It is now accepted that if the unstable or dislocated hip is detected within the first few days of birth subsequent luxation is largely preventable. That the corollary to this implied in recent publications and Ministry¹ statements holds—that is, that all babies with unstable hips can be easily spotted by routine testing by competent staff—is, in my experience, open to question. Numerous colleagues in paediatric and orthopaedic practice in this country still suspect that, despite most careful examination of the newborn by medical personnel in well-run maternity units, there are still intrinsic difficulties involved in total prophylaxis of congenital dislocation of the hip. In other words, notwithstanding the apparent simplicity of the Barlow manoeuvres, some cases still escape diagnosis and present months hence with established dislocation. (Corroborative data are available if needed.)

This is a disturbing state of affairs, but nevertheless needs emphasis at this time. It follows that although every effort must be made towards "total diagnosis" some regimen is needed to detect the admittedly few cases that escape the sieve. Indeed, such a scheme of further examination by public health personnel at the second or third month may well be the answer.—I am, etc.,

ROBERT OWEN.

Robert Jones and Agnes Hunt
Orthopaedic Hospital,
Oswestry, Salop.

REFERENCE

¹ Screening for Congenital Dislocation of the Hip, prepared by the Standing Medical Advisory Committee for the Central Health Services Council and the Ministry of Health, 1966. Ministry of Health.

British Association of Manipulative Medicine

SIR,—I should be grateful for space in your correspondence columns to correct an erroneous impression which I gave general practitioners in the London area when announcing a few weeks ago the opening of the British Association of Manipulative Medicine Evening Clinic at the Italian Hospital, Queen Square, London W.1. I gave the telephone number correctly as 01-834 6524 ext. 804, but by stating that this was the telephone number of the B.M.A.'s Emergency Treatment Service I seem to have given the impression that the British Medical Association sponsors this new outpatient clinic for patients of limited means suffering from minor locomotor disabilities and painful spinal origin.

Such is not the case, and I have been asked to make it clear to all concerned that the B.M.A. is not associated with the B.A.M.M.'s venture.

I apologise to all those who may have been misled inadvertently by the announcement.—I am, etc.,

JOHN EBBETTS,
Hon. Secretary,
British Association of Manipulative
Medicine.

London W.1.

Bethanidine in Hypertension

SIR,—We were interested in the report of Dr. J. Bath and his colleagues from Edinburgh (2 December, p. 519) on their experience with bethanidine in the treatment of hypertension.

We have treated 65 patients with bethanidine for periods ranging from three months to a year and have found that larger doses were required for adequate control than were found necessary in the Edinburgh series (Table I).

Our experience also differs in that tolerance was not a negligible factor and many patients taking bethanidine required frequent increases in dosage. As the average dose after initial stabilization was 44 mg., the figures in Table I emphasize this point.

TABLE I

Duration of Treatment	Sheffield Series. Average Dose of Bethanidine	Edinburgh Series. Average Dose of Bethanidine
3 months ..	61.5 mg.	32.5 mg.
6 " ..	59.5 "	37.0 "
9 " ..	87.0 "	—
12 " ..	71.5 "	45.0 "

Blood-pressure control in our series was closely similar to that in the Edinburgh series (Table II).

Further, after eight years' experience in the use of guanethidine we cannot agree that bethanidine has replaced guanethidine as the drug of choice.

In our hands blood-pressure control with guanethidine has been as good as with bethanidine (Table III) and is rapidly achieved

TABLE II.—Blood Pressure Control on Bethanidine

Good control ..	51%	33 cases
Moderate " ..	32%	21 "
Poor " ..	17%	11 "
	100%	65 "

TABLE III.—Blood-pressure Control With Guanethidine¹

Good control ..	63%	140 cases
Moderate " ..	20%	45 "
Poor " ..	17%	29 "
	100%	224 "

using the test dose technique recommended by Leishman and Sandler.¹ Tolerance has not been a greater problem with this drug.—We are, etc.,

A. W. D. LEISHMAN.

J. L. THIRKETTLE.

B. R. ALLEN.

Royal Infirmary,
Sheffield.

REFERENCES

¹ Leishman, A. W. D., and Sandler, G., *Lancet*, 1965, 1, 668.

² ——— *Angiology*, 1967, in press.

Cause of Death

SIR,—Dr. S. Bradshaw suggests (30 December, p. 806) that you should publish the cause of death in your obituary notices. We read this letter the day after noting with dismay the American trend in a list of notable deaths in 1967 in a "quality" Sunday newspaper. In one of these it read "by decapitation, in a car crash," as if "in a car crash" is not enough for our modern curiosity.

The facts of (medical) public interest are the ending of a professional life and the review of that life. Its mode of ending is not relevant, and should properly be allowed to remain private to the family and close friends. If the family wish the cause to be published (as may be the case in the death of a young person in an accident) this can be done.—We are, etc.,

V. H. A. BLACK.

MARIE T. KENNEDY.

W. O. MCCORMICK.

Department of Mental Health,
Queen's University,
Belfast.

SIR,—The bastions of good taste in British journalism are falling fast. The omission of the cause of death in your obituary notices is one of the few still remaining. Dealing as we do in disease and death surely makes it all the easier for us to suppress our mild morbid curiosity about the aetiology of the ultimate cardiac arrest in our colleagues. If we require a more eloquent reminder of our own mortality than the weekly pages of obituary notices we can always seek out the lurid details in the popular press.