Selection of Medical Students

SIR,—Dr. Andrew Smith's musings in "Personal View" (20 January, p. 176), though delightful to read, do scant justice to the problems faced by those of us who have to select n medical students from $x \times n$ applicants, where the real value of x (i.e., allowing for multiple applications) is probably never less than two. It is simply not true that "nobody questions" entrance requirements, and Dr. Smith really should know better than to generalize from a (very atypical) sample of two fellow-students whose basis of success seems evident through hindsight.

Dr. Smith is impressed by the Cambridge research. So am I. But just how relevant is it to the selection process for admission to medicine? Every admissions committee is interested in better methods of predicting student performance, if these are valid, reliable, and feasible, and many of us who are involved in the selection process would like to set up experiments to prove or disprove our ideas. It would indeed be fine if we could test Dr. Smith's view that advanced school qualifications in science are not a prerequisite for modern medical education—but what would happen to the failures? Would boys and girls with a school arts or "non-pure" scientific education who could not master first M.B. science really believe that they would have done no better with a pure science course at school?

Of course there is an occasional bright youngster who makes a late change in choice of career and presents the university medical selectors with good grades in arts subjects. In Aberdeen the door is not closed to such people, but we have had sufficient experience to know that it is unfair to both students and teachers to open wide that door. Young lives and aspirations are too precious to risk a policy that could severely damage even a few of them.

We selectors, I assure Dr. Smith, will continue to scrutinize, review, and modify our procedures in the hope that better understanding of what produces good doctors will lead to firmer predictive criteria for choosing who shall have the privilege of medical education. But I rather think that we shall always want a balance between "convergers" and "divergers."—I am, etc.,

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More Cases of Scabies

SIR,—The epidemic of scabies reported last year (18 March 1967, p. 669) is gathering momentum. The incidence of scabies in new outpatients in 1967 at St. John's Hospital for Diseases of the Skin, London, was 2.9% (490 of 16,661 new patients) according to the records department.

This represents a further rise of 0.5% on the previous year, so that over the last three years the incidence has trebled. If this rate of increase continues public facilities for therapy, such as local authority cleansing centres, may well prove necessary to cope with the problem, particularly for patients in poor housing and those who cannot comprehend the instructions for therapy. In Shrop-

shire in 1967 the incidence of scabies in new dermatological outpatients was 2%, indicating that the problem is of the same order in a rural population as in an urban one. Figures for previous years are not available, so the epidemic trend cannot be confirmed.

It is doubtful whether education or earlier consultation is sufficient to limit spread of the disease. A more vigorous concern for treating symptomless contacts may be effective, and perhaps our efforts should be directed to this end rather than simply to treating the patient.—We are, etc.,

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Restrictions on Doctor in South Africa

SIR,—In various letters and comments in the *B.M.J.* on the recent banning order served on Dr. R. Hoffenberg, of Cape Town University, half-truths and false impressions have been created, the most recent by Dr. S. Shapiro (16 December, p. 684). His final paragraph exposes him to severe criticism and creates an entirely wrong impression in the minds of thousands of colleagues who are not aware of the exact conditions existing in South Africa. In fact it reeks of the villainous anti-South-African propaganda poured out by an inimical lay press.

Allow me to put a few of his statements in the right perspective. "The major consideration that prompted my resignation was political." As a scientist and a medical man in South Africa there is hardly scope for politics. Medicine and scientific research extend over all sections of the population irrespective of colour, creed, race, or personal political ideas. It is true that South Africa has a relative shortage of doctors, but even so the standard of practice of medicine and medical research in South Africa compares favourably with the best in the world. There are ample facilities and a vast scope as well as material for research, and, even though the country has not as yet the vast resources to finance unrestricted research, any deserving project is amply provided for by funds from both the Government and provincial administrations as well as from the private sector of the population and commerce and industry.

As regards Dr. Shapiro's statement about "academic life in a politically suppressive atmosphere," nothing can be further from the truth. It exposes an absolute lack of knowledge of precise conditions in South Africa.—I am, etc.,

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G. F. C. TROSKIE.

Diffuse Fibrosing Alveolitis

SIR,—Professor Scadding, when he introduced this term,¹ interpreted it as indicating "that histopathological changes of a certain broad type are present in the lung"; he also stressed the advantages which stemmed from "the freedom of this term from aetiological implications. . . ." Subsequently,² in reply to Professor Gough,³ he defended the omission of the prefix "idiopathic" for conditions

in which the aetiology was unknown, on the grounds of it being very cumbersome. Your leader writer (27 January, p. 199) is of the same opinion. However, he would seem to be ill-advised to exclude some disorders (for example, beryllium disease) which fulfil the criteria that have been suggested. This is illogical and strengthens the case of Drs. J. M. E. Seal and J. C. Wagner, who would abandon the term altogether (25 November 1967, p. 485).

It is not my purpose to argue what term should be used, but its definition, once established on a basis of histopathology, should surely be adhered to regardless of aetiology and not altered unless it is found to be inadequate. On this basis diffuse fibrosing alveolitis may have an allergic origin, be due to inhalation of certain inorganic dusts, or arise in ways which at present should be described as idiopathic.—I am, etc.,

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REFERENCES

- ¹ Scadding, J. G., *Brit. med. J.*, 1964, 2, 686.
- ² ——— *ibid.*, 1964, 2, 941.
- ³ Gough, J., *ibid.*, 1964, 2, 818.

Cranial Bruits

SIR,—Dr. H. Gareebou (3 February, p. 294) draws attention to bruits over areas of the skull in three patients following acute blood loss. He states that severe anaemia in adults seems to be a fairly common cause of cranial bruit in general medical wards. In this centre we too recognize that cranial bruits occur in anaemia and can disappear when the haemoglobin is raised to normal. The patient who presents with symptoms of an intracranial vascular malformation and a bruit but who is also anaemic poses a problem in diagnosis, and arteriography is often necessary to exclude a malformation. The following case reports illustrate some of the problems.

Case 1.—A woman aged 23 was admitted on 15 December 1966 under the care of Dr. G. S. Graveson with a three-week history of frontal headaches, the first accompanied for two hours by nausea and retching. The aches became localized during the following days over the left eye and occiput, throbbing in time with her pulse, and she noticed a hissing noise in the left ear. She described occasional headaches for several years, and for three years she had taken Orthonovin (norethisterone, mestranol) as a contraceptive. The present headaches started in the middle of a course. There was no family history of migraine. General examination revealed no abnormality apart from pale mucous membranes and a blood pressure of 140/90 mm. Hg. There were no cardiac murmurs. A systolic bruit was heard over the right eye, and was accentuated by left and reduced by right carotid compression. Both plantar reflexes were extensor and the deep reflexes slightly increased on the right. Carotid compression was attempted but had to be discontinued after two minutes on the left side and after four minutes on the right owing to a feeling of faintness.

Relevant haematology was: Hb 6 g./100 ml., M.C.H.C. 28%, iron-deficiency changes on the film, and fasting morning serum iron 81 µg./100 ml. E.E.G. and skull x-rays were normal. The anaemia was corrected by transfusion of four pints of blood, which raised the haemoglobin to 11.3 g./100 ml.; the bruit disappeared at once and the headache had gone the following day. The abnormal neurological signs also disappeared, so no angiography was performed. The anaemia