will help them to view the position differently.
—I am, etc.,

R. M. JONES.

Matron, and Superintendent of Nursing,
St. Bartholomew's Hospital,
London E.C.1.

REFERENCE

- ¹ Report of the Subcommittee of the Central Health Services Council Standing Nursing Advisory Committee on the Use of Ancillary Help in the Local Authority Nursing Services, June 1965, M.O.H. Circular 12/65.

Cutaneous Anthrax—the Non-industrial Hazard

SIR,—I should like to add to this subject, having read with interest the paper by Dr. A. H. Knight and others (15 February, p. 416). During the past 17 years I have encountered about 20 patients with cutaneous anthrax, and of these there were three who had no connexion with the bone meal industry. Of these three, two were gardeners and the third was a boy of 12 years.

This boy denied handling bone meal or being in or around gardens. He lived in a tenement building, and the nearest he could have been to a source of anthrax infection was passing a bone meal processing factory which he did every school day. When admitted he had a typical malignant pustule over the left temple, and the diagnosis was confirmed bacteriologically. This skin lesion was four days old at the time of admission. The boy admitted that he and his friends frequently "skylarked" in the road outside the bone meal factory, and sometimes they rolled on the ground. Dr. Knight and others, in their paper, draw attention to the evidence that imported bone meal is highly infected, and I too commented on this in 1958.¹ It seems likely that this boy was infected from the dust on the ground outside this bone meal processing plant.

I agree that the infectivity in humans is low, considering the small number of cases notified annually and the high level of infection in imported bones. Nevertheless, all workers in our local bone meal and charcoal factory are being offered active immunization against anthrax. While I would not advocate immunization for all working with bone meal as fertilizer, it might be a good idea to warn such workers that there is a health hazard. I would suggest that the producers should have a warning on the sacks that the product should be handled with gloves, and any skin abrasions should be covered.—I am, etc.,

ROBERT LAMB.

Gateside Hospital,
Greenock.

REFERENCE

- ¹ Lamb, R., *Lancet*, 1958, 2, 151.

Episodic Giddiness

SIR,—Your otherwise excellent leading article on episodic giddiness (22 February, p. 457) is marred by a failure to emphasize the importance of neurosis as a cause of recurrent and episodic attacks of giddiness. These symptoms are very frequent in phobic anxiety states, where the sensation of giddiness tends to be situational and to occur only in specific environments such as on a bus or in open spaces. Other symptoms such as palpitations and fear of fainting help to form a clinical picture of acute anxiety or panic.

Your emphasis on the organic aspects of giddiness would certainly help to clarify the

diagnosis in many patients now labelled purely neurotic, but it seems to me a pity that your leader writer did not incorporate some of the points made by Professor Martin Roth on anxiety neuroses and phobic states in the same issue of the journal (p. 489).—I am, etc.,

J. A. HARRINGTON.

Uffculme Clinic,
Birmingham 13.

Cervical Cytology in Pregnancy

SIR,—Professor H. C. McLaren's advocacy of the wider use of routine cervical cytology tests has been of enormous importance in the education of the lay public and medical profession alike, and any comments we make on his paper (25 January, p. 216) on the positive smear in pregnancy are not an attempt to belittle his pioneering achievements but an example of the problems faced by those of us who believe routine screening should be extended to antenatal patients.

Since 1965 approximately 7,000 antenatal patients have been screened at Hackney Hospital. Twenty-five of these have now been treated with a final diagnosis of carcinoma in situ (3.5/1,000). While these figures are similar to those of Professor McLaren's, we have faced the problem of the positive smear in pregnancy differently. Believing that four-quadrant biopsies may miss the site of either preinvasive or invasive carcinoma and that only a full conization can establish the diagnosis—whether the patient is pregnant or not—we have selected certain patients for conization in pregnancy on the following criteria:

- (1) clinical suspicion of invasive carcinoma;
- (2) age over 30 years;
- (3) patient unlikely to co-operate in treatment after delivery.

The primary treatment of our twenty-five cases has been as follows: conization in pregnancy, 10; hysterectomy in pregnancy, 2; and conization or hysterectomy after delivery, 13.

The two patients treated by hysterectomy were in fact referred for therapeutic abortion and found to have positive smears on routine testing. In the ten patients treated by conization in pregnancy, the age ranged from 22 to 46 (average 33.7 years), and the parity from 2 to 7 (average 4.3). All operations were performed between the fourteenth and twenty-eighth weeks of pregnancy. The maximum measured blood loss at operation was 200 ml. None of the patients required transfusions and there were no secondary haemorrhages. Nine patients were delivered of living infants between the thirty-eighth and forty-first week without any dystocia. One patient aborted twenty days after conization, and we have reason to believe this was an induced abortion.

In conclusion, conization in pregnancy does not appear to carry undue risks for mother or foetus, enables a clear diagnosis to be established, and prevents the tragic fate of the defaulters so clearly demonstrated in the Birmingham series.—We are, etc.,

H. E. REISS.

J. A. U. MORGAN.

MARGARET R. A. UTIDJIAN.

Hackney Hospital,
London E.9.

Screening for Phenylketonuria

SIR,—After four years' experience of the plasma chromatographic technique described by Scriver *et al.*¹ I have considerable sympathy with the views expressed by Dr. Mary McMillan in her letter (25 January, p. 252). In addition I believe she underlines two very important points when she states that whatever the screening method employed the work should be carried out in a laboratory equipped to confirm the diagnosis in children suspected of having an inborn error of metabolism, and that the detection should rest with a team and not a single technician.

The Scriver method requires more experienced supervision than the Guthrie inhibition test for phenylketonuria, because it is possible to detect several abnormalities of amino-acid metabolism and this, inevitably, creates some difficulties in the interpretation of the chromatograms. This fact, plus the world-wide experience with the Guthrie test, influenced the Mental Retardation Committee Working Party in making its final recommendation. It did, however, suggest that "further study of other screening methods should be encouraged" (5 October, p. 7).

I believe that the Departments of Health should encourage the use of the Scriver method in a small number of centres (to cover, say, a population of five million). After three or four years it should be possible to compare the two methods both clinically and administratively and make such changes as may seem advisable. As a member of the Working Party I must emphasize that these are my personal views and not necessarily those of other members of the panel.—I am, etc.,

G. M. KOMROWER.

Mental Retardation Research Unit,
Royal Manchester Children's Hospital,
Manchester.

REFERENCE

- ¹ Scriver, C. R., Davies, E., and Cullen, A. M., *Lancet*, 1964, 2, 230.

Glasgow Primary F.R.C.S.

SIR,—Your leading article (22 February, p. 462) on "Anatomy for Surgeons" gave an incorrect and misleading account of one detail in the changes proposed by the Royal College of Physicians and Surgeons of Glasgow in its examination system.

The new examination to be held in May 1969 is for the primary F.R.C.S. only. No changes will be made in Part I of the M.R.C.P. examination, which is now common to the three British colleges of physicians, and takes the form of a single multiple-choice question paper.

The new primary F.R.C.S. examination shall consist of a written examination and an oral examination in each of the following subjects:

- (a) Applied anatomy.
- (b) Applied physiology (including biochemistry).
- (c) Applied pathology (including bacteriology).

Each written paper will be in two parts: a multiple-choice question paper replacing the usual two compulsory questions, and an essay type question paper with a suitable choice as at present. In the paper on applied anatomy candidates may still choose between general anatomy, anatomy related to ophthalmology,