propects and the work load. The Faculty is represented in its own right on the Joint Consultants Committee. One of its principal terms of reference is "To formulate policy and to consider all matters of policy that from time to time may arise relating to consultant and hospital practice including . . . utilization to the best advantage of skills and resources; but excluding the remuneration and terms of service of hospital medical and dental staff, so that the Committee shall not engage in the pursuit of political purposes." (*Supplement*, 7 November 1970, p. 32.)

The Faculty also has representation on the new Central Manpower Committee which has been called "The watchdog of Hospital staffing with the important aim of securing better distribution of medical staff in our hospitals throughout the land." (*B.M.A. News*, December 1971, p. 3.) It is clear therefore that the Faculty is not only concerned with training but contrary to your assertion it is, through its voice on these bodies, clearly in a position to influence these very decisions concerning promotion prospects and work load. You do not offer any factual justification for your suggestion that an independent organization such as a College of Anaesthetists could more effectively deal with these matters.

The reference to the "friendly interest of our surgical colleagues" has been taken out of context in the President's newsletter³ which in fact said that it would be "regretfully" that the Royal College of Surgeons would face such a separation of the Anaesthetists to form a college of their own. Those who are actively studying the feasibility of such a move can see that it might be a very costly venture (not least financially to individual anaesthetists) fraught with the risk of impairing for a long period the ability of the Faculty or its successor to carry out its primary aims and duties in the maintenance of standards.—We are, etc.,

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¹ Vickers, M. D., *Survey of Postgraduate Training in Anaesthesia*, London, Faculty of Anaesthetists, Royal College of Surgeons of England, 1971.

² Faculty of Anaesthetists of the Royal College of Surgeons of England. *Criteria for the Recognition of Hospital Posts in Anaesthetics under Paragraph 23 of the F.F.A.R.C.S. Regulations*. Revised 1971.

³ Holmes Sellers, T., *President's Newsletter*, No. 6, London, Royal College of Surgeons of England, 1971.

Use of Amphetamines by Drivers

SIR,—Doctors are still being approached by drivers asking for prescriptions for amphetamines to combat fatigue in night driving. The British Medical Association has advocated a voluntary ban on the prescribing of these drugs¹ except in those very rare conditions for which they are required as medical treatment. Any person who is found to be in possession of these drugs and has obtained them otherwise than on prescription from a doctor is guilty of an offence and risks prosecution.

The B.M.A. Working Party on Amphetamines, which reported in 1968,² came out strongly against the use of these drugs to combat fatigue as in long-distance driving. The top rally drivers, who perform enormous feats of endurance, do not take any stimulant

pills but rely on physical fitness, training, discipline, and their acquired skills. They also adopt sensible precautions, such as fresh-air ventilation, and have learned to sleep for short periods when the opportunity presents. The use of amphetamines can seriously affect a driver's judgment and under certain conditions can produce dangerous side effects such as hallucinations.

It is hoped that doctors will not provide amphetamines for those engaged in long-distance driving. The Royal Automobile Club, the controlling body of motor sport in Britain, The Royal Scottish Automobile Club, and the Automobile Association have been consulted by the British Medical Association and fully support this statement.—I am, etc.,

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¹ *British Medical Journal Supplement*, 1970, 3, 48.
² *British Medical Journal*, 1968, 4, 572.

Diagnosis of Established Deep Vein Thrombosis

SIR,—We were very interested to read the paper by Mr. N. L. Browse and his colleagues (6 November 1971, p. 325), and the letters of Professor J. G. Murray and of Mr. P. A. Griffiths and Dr. S. Talbot (4 December, p. 624). We would like to emphasize that there is a place, which has not been mentioned, for the ¹²⁵I-fibrinogen test in the diagnosis and management of extending thrombi in patients with established venous thrombosis.

Though we are now investigating the accuracy of other methods of diagnosis, we agree with Professor Murray that venography is the most accurate method in assessing the site and extent of established thrombi.¹ Patients with thrombi extending into the popliteal or more proximal veins should be actively treated, since they are at great risk of pulmonary embolism.^{2,3} Most patients, however, have thrombi which are confined to the calf,^{4,5} and the risk of pulmonary embolism in these patients is minimal.⁴ They should be ambulant, wearing elastic stockings, and have their legs elevated when not walking, since such measures tend to help these thrombi lyse spontaneously.^{3,6}

This management is safe, however, only if the patients are screened with the ¹²⁵I-fibrinogen test.⁷ Whether the established thrombus in the calf diagnosed by venography becomes radioactive or not in these patients is unimportant. Any extension of the thrombi during screening will be radioactive, and when the increased radioactivity reaches the level of the popliteal vein, which will occur in 20% of such patients,² active therapy will be instituted. Thus the majority (80%) of patients with early thrombi will be spared from anticoagulant therapy with its inherent dangers.—We are, etc.,

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¹ Nicolaides, A. N., Kakkar, V. V., Field, E. S., and Renney, J. T. G., *British Journal of Radiology*, 1971, 44, 653.

² Murray, J. G., in *Modern Trends in Surgery* 3, ed. W. T. Irvine, p. 192. London, Butterworths, 1971.
³ Kakkar, V. V., Howe, C. T., Flanc, C., and Clarke, M. B., *Lancet*, 1969, 2, 230.
⁴ Flanc, C., Kakkar, V. V., and Clarke, M. B., *British Journal of Surgery*, 1968, 55, 742.
⁵ Kakkar, V. V., Howe, C. T., Nicolaides, A. N., Renney, J. T. G., and Clarke, M. B., *American Journal of Surgery*, 1970, 120, 527.
⁶ Flanc, C., Kakkar, V. V., and Clarke, M. B., *Lancet*, 1969, 1, 477.
⁷ Kakkar, V. V., *British Journal of Hospital Medicine*, 1971, 6, 741.

Castration by Neglect

SIR,—I was amazed to read in your leading article "Castration by Neglect" (15 January, p. 128) the statement that "in any event, epididymitis is exceedingly rare in the absence of obvious evidence of urinary infection." As a venereologist I must have seen several hundred cases of acute epididymitis, the vast majority of them having been of the "non-specific" variety in which there was no evidence of urinary or urethral infection, macroscopical or microscopical. I know that many of my colleagues in my specialty have had the same experience. All these cases have resolved in a week or two and none have turned out to be torsion of the testis. Some are left with a "residual node" in the lower or upper pole of the epididymis for a few months, but none have had any clinically detectable permanent damage. I consider that it is quite wrong to advise that these cases of non-specific epididymitis should all be explored surgically.—I am, etc.,

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SIR,—I was very glad to read the leading article "Castration by Neglect" (15 January p. 128). Anything that directs the attention of general practitioners to the early diagnosis of torsion of the testis is invaluable. May I comment on two statements?

"Torsion of the testicle . . . occurs only when there is a congenital anomaly of the mesorchium . . ." I just do not believe this. It is, I think, a legendary statement copied by successive generations. R. E. Smith, whose personal example first encouraged me to manipulate these patients, considers that most cases of torsion of the testis occur in anatomically normal and normally developed scrotums. I endorse his views. This is an aspect of torsion of the testis which needs a careful study and reappraisal.

" . . . manipulation, which is essentially a first-aid manoeuvre . . ." I much prefer to think of manipulation as an invaluable organ-saving procedure, always to be attempted when one first sees an appropriate case (that is one in which spontaneous reduction has not occurred). The onus falls on the general practitioner, and it will encourage us if we think of manipulation as an integral part of the clinical examination of these cases, and as a vital first step in their successful treatment.—I am, etc.,

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** Surgeons who have to explore these testicles are convinced that anomaly of the mesorchium exists. Without there being an underlying congenital anomaly, it is a little difficult to understand why one finds this anomaly so frequently on the contralateral