some strikingly characteristic thick-walled muscular arteries in subsynovial and par-articular tissues, sites which may be subjected to similar forces.—I am, etc.,

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¹ Little, J. M., and Goodman, A. H., *British Journal of Surgery*, 1970, 57, 708.

Aldosterone Excess and Adrenal Carcinoma

SIR,—We read with interest the report by Dr. R. V. Brooks and his colleagues of an adrenal carcinoma associated with hyperaldosteronism (22 January, p. 220). We were surprised, however, at the statement that the only similar case described was that by Foye and Feichtmeir.¹ To our knowledge, eight other cases have appeared in the literature.²⁻⁸ With the possible exception of the two patients of Harrison,⁷ for whom no details are given, these cases all had features which could differentiate them from the much more common form of "primary" hyperaldosteronism due to benign adrenocortical adenoma or hyperplasia. Thus the malignant tumours were large, often palpable, and in some instances displaced the kidney recognizably on the excretion urogram or renal arteriogram. Possibly all would have presented distinctive features on adrenal venography. Secondary deposits appeared in all except perhaps the cases of Conn *et al.*,⁴ Harrison,⁷ and Biglieri *et al.*⁸ As in the recent case report of Dr. Brooks and his colleagues, additional noteworthy characteristics included excessive production of corticosteroids other than aldosterone and rapid clinical progression with profound muscular weakness.

While, therefore, we agree with the recent comments by Dr. Brooks and his co-workers that the clinician should be alert to the possibility of adrenal carcinoma in patients with aldosterone excess, that detailed steroid studies should be performed in all cases, and that careful radiological steps should be taken to delineate the tumour when one is suspected, we do not accept their general conclusion that spironolactone has no place in the long-term treatment of hyperaldosteronism associated with adrenocortical adenoma or hyperplasia. The great majority of cases of this type do not show the above mentioned features of adrenocortical carcinoma (in our own series of over 100 we have not so far encountered a single example of carcinoma). However, many of these patients have long-standing hypertension, some are elderly, and may have suffered one or more strokes. Others are unsuitable on other grounds or are unwilling to undergo operation. For these reasons we believe that definitive spironolactone therapy is worthy of consideration as an alternative to adrenal surgery in some instances. This is particularly relevant to those who, on biochemical grounds, are more likely to have bilateral benign hyperplasia of the adrenal cortices than a discrete adenoma.⁹⁻¹¹—We are, etc.,

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- ¹ Foye, L. V., Feichtmeir, T. V., *American Journal of Medicine*, 1955, 19, 966.
- ² Brooks, R. V., McSwiney, R. R., Prunty, F. T. G., and Wood, F. J. Y., *American Journal of Medicine*, 1957, 23, 391.
- ³ Zimmermann, B., Moran, W. H., Rosenberg, J. C., Kennedy, B. J., and Frey, R. J., *Annals of Surgery*, 1959, 150, 653.
- ⁴ Conn, J. W., Knopf, R. F., and Nesbit, R. M., *American Journal of Surgery*, 1964, 107, 159.
- ⁵ Crane, M. G., Harris, J. J., and Herber, R., *Annals of Internal Medicine*, 1965, 63, 494.
- ⁶ Neville, A. M., and Symington, T., *Cancer*, 1966, 19, 1854.
- ⁷ Harrison, J. H., *Annals of Surgery*, 1966, 164, 609.
- ⁸ Biglieri, E. G., Slaton, P. E., Schambelan, M., and Kronfeld, S. J., *American Journal of Medicine*, 1968, 45, 170.
- ⁹ Ferris, J. B., *et al.*, *Lancet*, 1970, 2, 995.
- ¹⁰ Aitchison, J., *et al.*, *American Heart Journal*, 1971, 82, 660.
- ¹¹ Brown, J. J., Ferriss, J. B., Fraser, R., Lever, A. F., and Robertson, J. I. S., in *The Medical Uses of Spironolactone*. Ed. G. M. Wilson. P. 27, Amsterdam and New York, Excerpta Medica, 1971.

Care of the Mentally Handicapped

SIR,—Dr. A. Shapiro produces no evidence for his criticisms (29 January, p. 308) of *Better Services for the Mentally Handicapped*.¹ This document is seriously concerned to provide facilities which appear to have been regarded by Dr. Shapiro as unnecessary luxuries in existing hospitals. He has asserted that "All these facilities, clinical and social, can only be provided in a large hospital if the costs are not to rise enormously," and the experimental unit which works under optimal conditions with high staff ratios is criticized for creating "hot-house conditions."²

Dr. Shapiro does not cite any references to the experiments of which he is so critical. However, the child-care staff ratio at any time of the day in the well-known Brookland's experiment was, on average, one to eight children.³ It averages one to five children at any time of the day in the new Wessex units. These include (on the basis of geography) all of the non-ambulant, severely behaviour disordered and children with and without severe incontinence requiring residential care from that area up to age 16.⁴ Commonsense suggests that for someone caring for these children for eight or 12 hours continuously, such ratios are not generous and are urgently needed also in large hospitals.

There is also evidence in existing hospital policies of widespread therapeutic nihilism towards the profoundly handicapped and severely behaviour disordered. In 1968, subnormality hospitals in England and Wales reported to the Department of Health that nearly one-third of their residents were neither working, nor receiving educational, social, or vocational training because of "severe mental or physical handicap," "disturbed behaviour," or "senility." Only one hospital in England and Wales reported that this occurred entirely because of "lack of facilities."⁵

Given the necessary resources and opportunity, the Command Paper proposals of treatment-oriented hospitals serving smaller catchment areas offer exciting new possibilities for the residents, their families, and the staff of all disciplines who work with them. These proposals require detailed programming, consultation, and managerial sophistication of a high order. Implementation will be beset by many problems, not the least of which will be shortage of money and sites. What is so badly needed now are some early successes which can, in their turn, generate more optimism and more

confident and specific demands for the necessary additional resources.—I am, etc.,

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- ¹ Department of Health and Social Security. *Better Services for the Mentally Handicapped*. Cmnd. 4683. London, H.M.S.O., 1971.
- ² Shapiro, A., *British Journal of Psychiatry*, 1970, 116, 353.
- ³ Tizard, J., *Community Services for the Mentally Handicapped*. London. Oxford University Press, 1964.
- ⁴ Kushlick, A., *Royal Society of Health Journal*, 1970, 90, 255.
- ⁵ Department of Health and Social Security. *The Facilities and Services of Psychiatric Hospitals in England and Wales 1969*. Statistical Report Series No. 10. London, H.M.S.O. 1970.

Whittingham Committee of Inquiry

SIR,—The Committee of Inquiry into Whittingham has been less than fair to the Chairman of the Medical Advisory Committee in stating that "... the acceptance for so long by the Board, the Hospital Management Committee and his colleagues of a virtually absentee Chairman who was heavily committed elsewhere was profoundly mistaken."¹ In fact the medical administrative structure was not merely "accepted" by the Board but created by it, and that the individual who accepted the post of Chairman was merely at the receiving end of the Regional Hospital Board's arrangement.

The actual position was that the Senior Administrative Medical Officer of the Manchester Regional Hospital Board personally contacted the doctor concerned and strongly urged him to take up the post, knowing full well that at the time his sessions at Whittingham Hospital were limited, and, as a matter of fact, were reduced on the instructions of the Regional Hospital Board in April 1962 to one session per week. The Board knew full well at the time that the doctor undertook no routine clinical duties at Whittingham Hospital and his other commitments did not allow him to give more than a very limited amount of time, namely one session per week, to the hospital. In spite of these circumstances, during the whole of his term of office as chairman he did not miss one meeting of the Medical Advisory Committee, he was available when required to advise the chairman of the Hospital Management Committee, and he made a monthly report to the Hospital Management Committee. Moreover the minutes of the Medical Advisory Committee, which frequently referred to the problem of long-stay patients, were made available as a routine to the Hospital Management Committee.

The emotive phrase "a virtually absentee Chairman" lifted, as it was, out of context by the lay press, is therefore demonstrably unfair.—I am, etc.,

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- ¹ *Report of the Committee of Inquiry into Whittingham Hospital*. Cmnd. 4861, London, H.M.S.O., 1972.

Unplanned Pregnancy in an Epileptic

SIR,—A woman graduate, aged 28 years, who for several years had been taking phenytoin 100 mg twice daily, sulthiamine (Ospolot) 50 mg daily, and Folex (ferrous gluconate and folic acid) 3 tablets a week for epilepsy, had also taken an oral contraceptive containing 0.05 mg ethinyl oestradiol and 3 mg norethisterone acetate

regularly for four months when she had amenorrhoea. She continued all her therapy for a further two months, during which amenorrhoea persisted. She insists that she neither missed nor delayed taking a pill. At this stage (3 months amenorrhoea) she had a pregnancy test which was positive so she discontinued the oral contraceptive. Her last menstrual period finished on 3 March 1971, and she bore a normal female child (5½ lbs) on 15 December.

In recent years we have come to regard pregnancy as virtually impossible for a woman taking oral contraception correctly, and the occasional amenorrhoea experienced by many subjects as of no consequence.¹ Earlier, however, some concern was felt about the efficacy of oral contraceptives in a subject who was concurrently taking regular doses of certain other drugs (including those drugs used in treatment of epilepsy) on account of a laboratory investigation which had shown in mice that such drugs could stimulate enzymes which promote metabolism of the contraceptive.² The F.P.A. *Clinic Handbook*³ states that there is no evidence that this investigation has any relevance to a woman taking ovarian steroids at oral contraceptive dosage. The case cited, however, suggests that epilepsy-therapy drugs may reduce the effectiveness of oral contraceptives, as indicated by the experiments with mice.—I am, etc.,

IDA E. KENYON

Hale, Cheshire

- ¹ Mears, E., *A Review of Oral Contraception*, p. 27, Burgess Hill, Shering Chemicals Ltd., 1971.
- ² Family Planning Association, *Medical Newsletter*, 1966, no. 23, p. 3.
- ³ Family Planning Association, *Clinic Handbook*, p. 45, London, F.P.A., 1970.

Occupational Health Service

SIR,—Dr. P. R. Richards's letter (12 February, p. 438) is misleading. No employer who has half an eye to the true interests of his business in both financial and human terms will long tolerate a doctor seeking opportunities quietly "to bury the subject under the carpet."

Perhaps some of the difficulties which Dr. Richards relates stemmed from the personal style of those trying to influence the organizations in which they worked. "To fight their employer" is likely to be a less successful strategy than trying to change the climate of the organization so that management and doctor come nearer to sharing a common set of values. Co-operation is then a more appropriate behaviour than fighting.

It is to the mutual advantage of worker, employer, and doctor for the latter to pursue his work energetically and forcefully. At the same time the interests of a public increasingly concerned with safe products and a healthy environment will be served.—I am, etc.,

F. W. BEST

Epsom, Surrey

SIR,—It is surprising to read the sort of views expressed by Dr. P. R. Richards (12 February, p. 438) coming from someone acquainted with industrial services in this country.

The situation he describes may occur in some industries, but we think it must be comparatively rare for an industrial medical officer's loyalties to his employer and to his patients to be in conflict. We are concerned

not only with the treatment of disease and injury at work, but with the prevention of these by ensuring a safe working environment and fitting any patient with disability into suitable work within his capacity. This means he will be working efficiently and it follows that the interests of patient and employer almost invariably coincide; if this were not so why should the company bother to employ a doctor at all? It can seldom be true that promotion and career prospects are enhanced by toadying to management.

To suggest that certain doctors in occupational health services have abrogated their duty to their patients in order to lead a quieter life is both absurd and a slur on this branch of medicine. Whether or not a national occupational health service is established as part of the N.H.S., as an independent body, or as an amalgamation of existing industrial medical services with these, is irrelevant from the ethical point of view. It is the integrity of the doctor involved which is important.—We are, etc.,

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Chief Medical Officer

J. D. BARRETT
Medical Officer, Luton Plant

R. A. BATTEN
Medical Officer, Luton

R. W. BOWMAN
Medical Officer, Dunstable Plant

Vauxhall Motors Ltd.,
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SIR,—Dr. P. R. Richards's contention (12 February, p. 438) that doctors working in industry have great problems regarding loyalty is an often repeated myth. Occupational health physicians have the same ethical code as the profession in general, and base their decisions on scientific and medical principles in the interest of the patient. The respect of management and unions and effectiveness as an adviser would be quickly lost by any sign of bias on the part of the doctor.

The suggestion that some doctors opt for a quiet life as a company servant conflicts with the statement that "their promotion and career prospects depend largely upon the service they give to their employer." A doctor basing decisions on the wishes of his employer would be seen to be of little value to the company. Most employers have an enlightened approach towards doctors working in industry and expect them to give unpalatable advice at times. By the same token, the employer benefits when the doctor's advice is accepted by the workers because he is known to be a man of integrity.

It should be remembered that without the contribution to occupational health by the medical services of large and small industrial concerns the skills and experience in this field of medicine presently available would be virtually non-existent in Britain.—I am, etc.,

D. P. MANNING

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Ampicillin and "Sore Throat"

SIR,—We have been following with interest the correspondence arising out of your leading article on "Skin Reactions to Ampicillin" (22 January, p. 195). We feel, however, that not enough emphasis is being placed on the preventive aspects, for though it has been

acknowledged for some years now that a very high proportion of patients suffering from glandular fever will develop a rash if given ampicillin, there has been no significant reduction in the number of such patients hospitalized with this rather distressing and often protracted form of skin reaction. This is undoubtedly due to the widely prevalent practice of treating "sore throats" with ampicillin, with the result that by the time the correct diagnosis of glandular fever is made more often than not the patient has already received ampicillin. The remedy of the situation lies in wider publicity of the fact that the only significant bacterial organism involved in "sore throats" is β -haemolytic streptococcus, for which penicillin is by far the most effective antibiotic available and also the cheapest. Use of an alternative drug, such as ampicillin, which is costlier, potentially less effective, and liable to produce unpleasant side effects in those patients who later turn out to be suffering from glandular fever, can only be regarded as bad practice of medicine.—We are, etc.,

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Skin Reactions to Ampicillin

SIR,—With reference to your leading article (22 January, p. 195) we feel that several points of distinction should be emphasized between the maculopapular rash associated with ampicillin therapy and the maculopapular rash sometimes occurring as a Jarisch-Herxheimer reaction in the initial treatment of infectious syphilis with penicillin. In the past year we have seen two patients suffering from early syphilis in whom this confusion arose.

A 31-year-old nurse presented to her family doctor in early February 1971 with vague complaints of malaise, sore throat, and joint pains and was prescribed ampicillin 250 mg 6-hourly. Within 24 hours she had developed a macular rash and pyrexia and the treatment was discontinued as this was thought to be an ampicillin reaction. In May 1971 she presented with meningismus, polyarthralgia, generalized lymphadenopathy, and a generalized maculopapular rash which was eventually diagnosed as secondary syphilis.

On 5 May 1971 a 19-year-old female was admitted to hospital in Belfast with superficial slightly tender lymphadenopathy and mucous membrane lesions. A provisional diagnosis of infectious mononucleosis was made and treatment with ampicillin started for a presumed associated respiratory tract infection. After 500 mg of ampicillin orally a generalized macular rash especially prominent on the palms and soles was noted. Treatment with ampicillin was discontinued and the advice of a consultant dermatologist taken. In this case the correct diagnosis of reaction to the antibiotic treatment of early syphilis was made.

The Jarisch-Herxheimer reaction in early syphilis occurs in the first 12 hours following penicillin therapy and is frequently associated with pyrexia.¹ It is associated with the development of a maculopapular skin eruption resembling secondary syphilis and if cutaneous secondary syphilis is already