

ditions at home in Britain under the title, let us say, of "Them and Us"?—I am, etc.,

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1 Platt, Lord, *British Medical Journal*, 1967, 4, 439.

SIR,—Your article (27 January, p. 225) was mildly interesting, but the life and work and problems of the British radiologist concerned are so far removed from those of the generality of the specialty that they are of little general concern.

The great majority of British radiologists, according to Dr. Rushton-Wilson, are condemned to a troglodytic existence in a basement surrounded by an unending pile of films for reporting, seeing neither colleagues nor patients, and having no idea whether their reports are true or false or even relevant. Dr. Rushton-Wilson is concerned (as are we all) by the shortage of British radiologists, but to suggest that this is all they will have to look forward to is hardly likely to encourage recruitment.

All this would not matter, but your journal is supposed to carry some authority, and a true picture of the life and work of a more generally representative radiologist might be of considerably more interest and value. We do not all live in basements, and even outside teaching hospitals, many of us have good contact with clinical colleagues and meet regularly to discuss films and problems, quite apart from informal contact over the lunch table. Some of us even find time for useful research; though in the very nature of the job, we do spend a lot of time reporting routine films and we do more than one half-day a week of service work. Most of Dr. Rushton-Wilson's registrars will end up in this sort of a life, so perhaps he should find out more accurately what their life and work will be so that he can teach them what they should be learning.—I am, etc.,

J. K. JOHNSON

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Shortage of Radiologists

SIR,—Dr. J. P. Grier suggests (3 February, p. 292) that the shortage of radiologists is the limiting factor in radiological services in his area. Personally, I find that the lack of purpose-built facilities, the large proportion of obsolete and inconvenient equipment, and the shortage of ancillary staff are the limiting factors in the amount of work I am able to do.

Given a well-equipped, purpose-built department, an increase in throughput of 10-15% would not be impossible. The problem is practically universal in the older peripheral hospitals and is simply an expression of the shoe-string improvisation seen outside teaching hospitals. Radiology is an expensive business which is always expanding and one which is probably unique in its dependence on its equipment for the quality of its results.

If we are to have any hope of keeping pace with the expanding work load, let alone the demand for open access facilities from general practitioners, priority must be given to modernization of x-ray departments—especially those in future district general hospitals—and adequate funds must be

forthcoming. Once working conditions have improved, solution of any staffing problems will not be far behind.—I am, etc.,

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Dangerous Patients

SIR,—May I take up three points in your leading article "Dangerous Patients" (3 February, p. 247)?

(1) The advantage of the indefinite restriction order over those for finite periods lies not so much in the fact of prognostication to which you allude but in the fact that the indefinite restriction order allows the patient to live outside hospital under conditional discharge for as long as is thought necessary clinically by the responsible medical officer in conjunction, of course, with the Home Secretary. The resultant increased flexibility often permits of much earlier discharge of the patient, particularly when it is realized that under an ordinary section 60 order, which is what a section 65 order for a finite period becomes after the period in question has expired, the 28 days of successful absconding means automatic and complete freedom. On the other hand, recurrence of disorder leading to the failure to fulfil the conditions of a conditional discharge can, for an indefinite length of time, mean the restitution of the section 65 order.

(2) I cannot understand how you can say in successive paragraphs that you object to N.H.S. hospitals playing a role in the treatment (and indeed in the rehabilitation) of previously dangerous patients under restrictions coming from the special hospitals; and that you find the existing arrangements sufficient to protect the public, since the existing arrangements are the very ones which involve the N.H.S. hospitals in accepting patients from the special hospitals. I personally can see no possible objection to suitable patients passing through the N.H.S. hospitals rather than directly to hostels (even if such hostels existed or were likely to exist in the foreseeable future). Surely proper flexibility requires the co-operative interplay of the special hospitals, medium security hospitals of the sort envisaged by the Oxford Regional Hospital Board, ordinary and open N.H.S. hospitals, and hostels.

(3) I am afraid I do not understand the point you make about the independent psychiatrist at the bottom of paragraph five of your article. The psychiatrist who examines a patient on behalf of the Mental Health Review Tribunal is not independent of that tribunal, though he is independent of the hospital: the forensic psychiatrist on the proposed advisory board would be equally independent of the hospital and equally un-independent of the advisory board of which he is a member. Or have I misunderstood? Surely the moot point here is whether the new advisory boards would differ significantly enough from the existing mental health tribunals for a new type of board and a new machinery to need to be set up, particularly when section 60 (6) of the present Act seems to supply the Home Secretary already with all the power that he needs.—I am, etc.,

SEYMOUR SPENCER

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Toxicity of Benorylate

SIR,—I read with interest Dr. R. E. Hope-Simpson's experience with benorylate (3 February, p. 296).

I have recently finished a double-blind study of benorylate and ibuprofen in 24 patients with classic rheumatoid disease. The study was for a period of eight weeks, with three weeks on each drug and a wash-out period in between. A point of particular interest was the symptom of tinnitus, which was complained of by four patients on benorylate in this series, sometimes associated with deafness. However, tinnitus with benorylate should not be regarded as a side effect but merely an indication that adequate salicylate levels have been achieved. An adjustment in the dose should relieve this symptom.

In most cases both drugs, apart from producing symptomatic relief, were found to reduce swelling and improve grip strength and functional capacity. There was also a reduction in erythrocyte sedimentation rate even in this short period. Out of 16 patients who stated a preference, 13 preferred benorylate. This study would therefore seem to indicate that benorylate is extremely useful as an antirheumatic agent.—I am, etc.,

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Subtypes of Hepatitis B Antigen

SIR,—In their most interesting report on the distribution of hepatitis B antigen subtypes in Swedish blood donors and in patients with post-transfusion hepatitis, Dr. Sten Iwarson and others (13 January, p. 84) discuss the possibility of differences in infectivity and in pathogenicity between the two subtypes *ad* and *ay*. They conclude, however, that the different distribution of the subtypes in their groups "might reflect epidemiological circumstances rather than biological differences in the two viral strains."

Studies of the subtype distribution in the same categories of patients in Copenhagen support the epidemiological hypothesis.¹ Subtype *ad* was found in 89 (95%) of 94 apparently healthy carrier of hepatitis B antigen and in 11 (92%) of 12 patients with post-transfusion hepatitis. Subtype *ad* also occurred in all of 17 patients with chronic hepatitis or cirrhosis of the liver and in 14 out of 15 patients with acute hepatitis without any known parenteral exposure or drug addiction. The only group of Danes, except for Greenlanders, in whom subtype *ay* is prevalent is drug addicts. Of these, 37 out of 42 yielded subtype *ay*, regardless of whether they were apparently healthy carriers or had acute hepatitis.

These findings agree with the opinion that the hepatitis B antigen subtypes are epidemiological markers of different strains of hepatitis B virus occurring in different population groups. However, these two strains of virus apparently show no difference in their ability to induce a healthy carrier state, acute hepatitis, or chronic liver disease.—I am, etc.,

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1 Skinthøj, P., *Scandinavian Journal of Infectious Diseases*. In press.