long-term availability of reprints means that the reports will be more accessible to a wider audience than much work which is conventionally published.

One important feature of the I.R.C.S. is that it will provide ready access to work done in non-English-speaking parts of the world. At the moment scientists from such countries are usually fully aware of what is published in English language journals. The reverse is unfortunately rarely true, and many English speakers seem to assume arrogantly if subconsciously that "if it's not in English it can't be good." The I.R.C.S. offers an ideal method for the communication of results from non-English-speaking countries and there are already clear indications that it is being very warmly welcomed in Europe, the Soviet Union, and Japan.

Finally, I should like to emphasize that at this stage the detailed application of the I.R.C.S. is flexible and open to modification. Informed criticism should be addressed either to myself or to I.R.C.S., P.O. Box 500, Lancaster. All suggestions will be welcomed and seriously considered.—I am, etc.,

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Strikes by Hospital Ancillaries

SIR,—I am certain that many ordinary members of the B.M.A. feel mystified as to how and why the Association decided to lend their weight to the demand for an inquiry into the wages of hospital workers.

The present strikes seem to many of us less about wage betterment than an effort to force the Government to back down and be discredited. That we should aid this effort makes one wonder whether the left wing has had a victory in our Council. This seems the more likely in that the B.M.A. has produced, over many years, no similar support or demand for inquiry into the salaries and service conditions of physiotherapists, occupational therapists, and others closely allied to us in our work and who are, considering their training and skills, much more deserving of our support and protest than many of those on whose behalf our name has been used—without our permission or preknowledge.—I am, etc.,

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Locally Advanced Breast Cancer

SIR,—In your leading article (17 February, p. 372), after describing Sonneland's recent paper¹ concerned with the destruction of a fungating carcinoma of the breast by means of zinc chloride paste, you mention that this is a technique of chemosurgery which has been used over the centuries. You add, however, that "this apparently first reported case of the use of chemosurgery in the primary treatment of advanced breast carcinoma is encouraging enough to warrant further serious consideration."

We would like to point out that a clinical trial of this method which included 60 patients with malignant disease, many of them with carcinoma of the breast, was reported in 1857.² In the Bland-Sutton Institute of Pathology at the Middlesex Hospital there is preserved in a specimen jar a

breast treated with this technique. Some limited benefit was obtained but the method was soon discarded. Coupland wrote of this study in 1902, "To us the lesson of this inquiry lies in the demonstration that the remedy, of which so much had been expected, which had long been kept a secret, was found to be no remedy at all and the fact that the practice of removal of growths by the slow and painful plan of mineral cauterization has not become established, except in isolated instances where no other procedure is available, goes to show that the hopes excited by this plan were soon falsified, and another method consigned to the limbo of discarded cures of this baffling disease."³

An occasional carcinoma of the breast where the tumour, though large, does not show wide infiltration of the surrounding tissues may be totally removed by any method which causes necrosis of the tumour. Such cases are limited in number and alternative methods of treatment which are less arduous for the patient are usually available. At a time when it is realized that clinical trials are major undertakings if significant conclusions are to be reached it is surely wrong to suggest the diversion of effort into a discarded field of treatment and wrong to subject patients to remedies of dubious value.—We are, etc.,

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¹ Sonneland, J., *American Journal of Surgery*, 1972, 124, 391.

² *Report of the Surgical Staff of the Middlesex Hospital to the Weekly Board and Governors upon the Treatment of Cancerous Diseases in the Hospital on the Plan Introduced by Dr. Fell*. London, Churchill, 1857.

³ Coupland, S., *Reports from the Cancer Research Laboratories, Middlesex Hospital*, 1902, 1, 1.

Hyperinfection with Strongyloides in Lymphomas

SIR,—Viral involvement in lymphomas may be secondary to chronic inflammatory states. The patients described by Dr. Malcolm Adams and others (3 February, p. 264) had overwhelming infection with strongyloides and also lymphomas. One had received immunosuppressive drugs, and conceivably this therapy later produced Hodgkin's disease. The two other patients had no treatment, and the lymphomas were therefore considered to have altered their immune responses. But why then did the reticuloses appear? Had the filariform larvae so thoroughly irritated the reticulo-endothelial system that normal contact-inhibition of the cells was lost? Such a mechanism locally may explain the increased incidence of bladder tumours in patients with bilharziasis. Hyperinfection with strongyloides is, however, rare, although the infestation is relatively common in the tropics. The infection more likely became "opportunistic" in the reported cases because of an earlier immune contest.

Candidiasis or aspergillosis often occurs in patients with "acquired immune deficiency," and recently infestation with *Giardia lamblia* was found in a case with severe hypogammaglobulinaemia.¹ Raised immunity may have in fact preceded both the hyperinfection and the lymphomas in these un-

usual examples of strongyloidiasis. Sensitized lymphocytes in lymphomas may be both the prop and the butt of an aggression, beginning years before. "Many immune responses confer unpleasant and even dangerous sensitivity on subsequent exposure to the provoking (or other) antigens."² Chronic malaria² and the prolonged cell-mediated immunity found in tuberculosis and particularly sarcoidosis³ are probably important factors in the aetiology of both reticuloses and other neoplasms. Cellular immunity to malaria may perhaps sometimes induce Burkitt's lymphoma; patients who have had tuberculosis more often develop gliomas than those who have not,⁴ while renal carcinoma,⁵ chronic lymphatic leukaemia⁶ and Hodgkin's disease⁷ have been reported following sarcoidosis.

A connexion exists between autoimmune diseases and neoplasms⁸ and this may be why malignancy occurs more often also after organ transplantation.⁹ Tumours have been found in patients with Hashimoto's disease, Sjögren's syndrome, and coeliac disease who had had, significantly, no immunosuppressive drugs. Hyperthyroidism, chronic thyroiditis, parathyroiditis, and Addison's disease are sometimes associated with sarcoidosis,¹⁰ probably more often than is realized. Erythema nodosum may be the only indication that sarcoidosis is present, and probably subcutaneous granulomas do not always occur in the legs. The infectious mononucleosis occasionally found in Hodgkin's disease may result from chronic immune alterations reactivating the Epstein-Barr virus. A similar reactivation may account for the occurrence of herpes zoster in patients with reticuloses and spinal metastases. The sustained immune stimulation of sarcoidosis may, for instance, excite anamnestic reactions and reactivation of viruses, leading sometimes to organ failure and later to neoplasms. The alternative proposal that virus infections induce sarcoid lesions does not sufficiently allow for the time factor.—I am, etc.,

GERALD A. MACGREGOR

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¹ Webster, A. D. B., *Proceedings of the Royal Society of Medicine*, 1972, 65, 589.

² Shaper, A. G., Kaplan, M. H., Mody, N. J., and McIntyre, P. A., *Lancet*, 1968, 1, 1342.

³ Caspary, E. A., and Field, E. J., *British Medical Journal*, 1971, 2, 143.

⁴ Ward, D. W., Mattison, M. L., and Finn, R., *British Medical Journal*, 1973, 1, 83.

⁵ MacGregor, G. A., *British Medical Journal*, 1972, 1, 375.

⁶ Ganpule, M., and Garretts, M., *British Journal of Dermatology*, 1971, 85, 587.

⁷ MacGregor, G. A., *Lancet*, 1973, 1, 322.

⁸ Fairley, G. H., *British Journal of Hospital Medicine*, 1971, 6, 633.

⁹ MacGregor, G. A., *Lancet*, 1973, 1, 200.

¹⁰ Karlish, A. J., and MacGregor, G. A., *Lancet*, 1970, 2, 330.

Breech Management with Fetal Blood Sampling

SIR,—Any obstetrician must welcome a system that could provide reliable warning of asphyxia during a breech labour. The changes in fetal pH in the second stage of a breech delivery, described by Dr. B. W. Eliot and Mr. J. G. Hill (23 December, p. 703), and the management that they have derived require careful consideration.

We have reviewed 46 unselected cases of breech presentation managed in labour by continuous fetal heart monitoring and, when indicated, by fetal blood sampling. Forty-