CORRESPONDENCE

Owing to the Government's restrictions on the use of power in industry, including printing, we have been obliged to defer publication of some letters and print others in shortened form. We regret this inconvenience. Correspondents are asked to help by keeping their letters as short as possible.

National Child Development Study

SIR,—We should like to take this opportunity to emphasize the importance of the medical examination of the 15-year-old children in the National Child Development Study. With the kind co-operation of every local authority in England, Scotland, and Wales doctors have commenced the examination of 15,000 schoolchildren born in the week 3-9 March 1958, and the parental interviews by health visitors and educational assessments by teachers will take place early in 1974. This will add to the valuable information already available from the first and second follow-ups at seven and 11 years.^{1,2}

In some areas, however, these examinations may be imposing an extra burden on an already over-stretched or depleted administrative machine owing in part to National Health Service reorganization. In addition, we anticipate some reluctance from the young people themselves when asked to absent themselves from school to attend for medical examination if this cannot be carried

out on the school premises. In most cases a personal approach will overcome this, though we do appreciate the additional burden such approaches imply.

In spite of these practical difficulties, we feel sure that local authority doctors appreciate that this is a unique opportunity to monitor the health of school leavers. We would be most grateful for the continued support of all health and other professional workers who are helping to gather this information.—We are, etc.,

N. R. BUTLER

K. FOGELMAN

CATHERINE S. PECKHAM

R. C. M. PEARSON

MARY D. SHERIDAN

National Children's Bureau,
London E.C.1

¹ Davie, R., Butler, N. R., and Goldstein, H., *From Birth to Seven*. London, Longman, 1972.
² Pearson, R., and Peckham, C., *Community Medicine*, 1972, 127, 113.

Swine Vesicular Disease: A Zoonosis

SIR,—Cases of swine vesicular disease have continued to occur in pigs sporadically in Britain since the condition was first recognized in December 1972. Infection appears to have been maintained by the slaughter of animals early in infection, possibly before clinical signs were present, the distribution from cold stores of the infected pork or pork products, and the subsequent appearance of infected scraps in pig swill. It can therefore reasonably be expected that further cases may from time to time occur, though the tightening up of the regulations for the control of waste foods and the boiling of swill fed to pigs will undoubtedly have an effect.

It has been established¹ that the virus of swine vesicular disease is related to the human Coxsackie B5 virus, and laboratory workers at this institute, studying the disease in pigs, have become infected,² showing clinical signs similar to those found in Coxsackie B5 infection. It is possible to differentiate between the two viruses by agar gel diffusion tests which distinguish between the antibodies in the convalescent sera. Infections have occurred in at least one other laboratory handling the virus, but though many farm workers, slaughtermen, and veterinarians have handled infected pigs during the 130 or more outbreaks recorded in Britain no illnesses have been reported from the field. While it may be that the contact between the animals and their attendants in laboratory conditions is closer than in the field, it is still somewhat surprising that no field cases have come to light. This may be due, of course, to the fact that the clinical

picture as observed so far is very similar to that recorded for Coxsackie B5 infection. Plans have been made for a survey of sera collected from volunteers among those who have been in contact with the disease. More important, however, is that patients presenting with signs of Coxsackie infection in areas where disease has occurred should be asked about their possible contact with swine.—I am, etc.,

J. B. BROOKSBY

Animal Virus Research Institute,
Pirbright,
Woking, Surrey

¹ Graves, J. H., *Nature*, 1973, 245, 314.
² Brown, F., Talbot, P., and Burrows, R., *Nature*, 1973, 245, 315.

Children's Bill

SIR,—I hope the medical profession will give every support to Dr. David Owen's Children's Bill, which will have its second reading in Parliament on Friday, 8 February 1974, by contacting their M.P.s and stressing the importance for legislation based on the recommendations of the Departmental Committee on the Adoption of Children (best known as the Houghton Committee).

This is a private member's Bill which Dr. Owen is bringing in because the present law does not offer adequate safeguards to protect children's rights and ensure their welfare and the Government has so far failed to take action. We may not agree with all the recommendations of the Houghton Report, but the present need is to ensure that the issues are thoroughly debated.

The Houghton Report made many practical suggestions for improving adoption and guardianship law and practice, including: putting the child's welfare first in disputed cases; allowing natural parents to give an early final consent to adoption; making it possible for a court to "free a child for adoption" under certain clearly defined circumstances; ensuring that foster parents who have cared for a child for five years and who to adopt can have a hearing before a court.

I hope as many as possible will realize the importance of this Bill and make every effort to contact their M.P.s and ask them to support it.—I am, etc.,

DUDLEY HEATH

B.M.A. Representative to the
Medical Group Association of
British Adoption Agencies

Birmingham

Are PUFA Harmful?

SIR,—In your leading article under this title (6 October, p. 1) you sum up the situation in the words: "No convincing case has been made that PUFA cause either premature ageing or cancer." Surely the case is not merely unconvincing; in respect of cancer it does not stand examination.

It is a curious fact that Pearce and Dayton's paper¹ which you quote has attracted a great deal more attention (particularly in the popular media) than the subsequent and far more comprehensive treatment of the subject by Ederer and his colleagues.² This second paper reviewed all the evidence then available from the five clinical trials (including that of Pearce and Dayton) which had used a polyunsaturated fatty acid diet and controlled this by an ordinary or usual diet. Ederer *et al.* sum up their results as follows: "None of the relative risks [of cancer incidence or cancer mortality] are significantly different from unity, so that the combined results of the five studies are consistent with the hypothesis that the cholesterol-lowering diets do not influence cancer risk." If Pearce and Dayton's study is excluded, the results of the other four centres combined produce (non-significant) relative risks in the opposite direction to theirs, whereas with their study included the overall result is slightly (but far from significantly) in the direction of a greater cancer risk in the experimental PUFA groups. Deaths from all causes, however, were fewer (though again not significantly so) in the experimental than in the control groups. Ederer *et al.* add that much more data even than the aggregate of these studies are needed to determine whether such diets, high in PUFA, alter the cancer risk.

Of the five studies considered in the paper by Ederer *et al.*, one, referred to by them

as the "London" study, was organized by a committee of the Medical Research Council³ and included just under 200 middle-aged men surviving a first myocardial infarction who were placed on a PUFA dietary regimen for an average period of more than four years. A similar number of controls continued on their ordinary diet. During the trial there were seven deaths from cancer, one on the experimental (PUFA) diet and six on the ordinary (control) diet. In addition there was one non-fatal case of cancer in a man on the experimental diet. Since the end of the trial it has been possible to keep track of virtually all deaths of men who participated in the study (through the National Health Service Central Register), though the number of new non-fatal cases of cancer is not known. The latest position is that six more deaths have occurred in which cancer is mentioned as a cause on the certificate (in four of them as a main cause and in two as contributing) and all of these have occurred in men who were on the control regimen. Thus there have been 13 known deaths in trial participants where cancer was either the main or a subsidiary cause. The site of the cancer was the lung or bronchus in eight of these cases—not a remarkable distribution for men of this age—but 12 have occurred in men who were taking their ordinary diet and one in a man who was on the PUFA diet during the trial ($P < 0.001$).

Taken together with the other evidence, this result may tell us something about statistics and about the numbers needed in trials. It certainly does not increase our confidence in attributing the cancer deaths in the Pearce and Dayton study to the PUFA diet; nor, I hasten to add, does it suggest that PUFA are a key to the prevention of cancer.—I am, etc.,

J. A. HEADY

M.R.C. Social Medicine Unit,
London School of Hygiene and Tropical Medicine,
London W.C.1

¹ Pearce, M. L., and Dayton, S., *Lancet*, 1971, 1, 464.

² Ederer, F., Leren, P., Turpeinen, O., and Frantz, I. D., *Lancet*, 1971, 2, 203.

³ Report of a Research Committee to the Medical Research Council. *Lancet*, 1968, 2, 693.

Treatment of Acute Exacerbations of Chronic Bronchitis

SIR,—Your leading article (24 November, p. 437) dealt succinctly with the problems of treatment with antibiotics, perhaps with more emphasis on aspects of treatment at home. When iller patients are admitted to hospital these problems differ. In patients who are severely ill, I find that the systemic administration of antibiotics is essential. Oral administration alone may give variable and inadequate blood levels of antibiotics, especially when patients are shocked, while high concentrations are required to deal quickly with the initial large bacterial population. When patients are very ill and elderly chloramphenicol does have advantages, albeit temporary, over high doses of ampicillin or tetracycline.¹ Some patients may get better with hospital treatment alone, without antibiotics.^{2,3} However, no outstanding features of such patients can be recognized so that, as your article stresses, it is best to treat all exacerbations, especially when they are severe.⁴—I am, etc.,

A. PINES

East Herts Hospital,
Hertford

- ¹ Pines, A., Greenfield, J. S. B., Raafat, H., and Siddiqui, G., *British Journal of Diseases of the Chest*, 1972, 66, 116.
- ² Elmes, P. C., et al., *British Medical Journal*, 1965, 2, 934.
- ³ Pines, A., Raafat, H., Greenfield, J. S. B., Linsell, W. D., and Solari, M. E., *British Journal of Diseases of the Chest*, 1972, 66, 107.
- ⁴ Pines, A., Raafat, H., Plucinski, K., Greenfield, J. S. B., and Solari, M., *British Medical Journal*, 1968, 2, 735.

"Normal" Blood Lead Levels

SIR,—The article "Blood Lead Levels in a Welsh Rural Community" by Dr. W. H. Beasley and others (3 November, p. 267) stirs yet further the already muddy pond of "normal" blood lead levels. As the supplier of the British blood samples for the Goldwater and Hoover W.H.O. exercise,¹ which gave a mean of 22 $\mu\text{g Pb}/100\text{ ml}$, as I recall in both Goldwater's laboratory in the U.S.A. and my own in Manchester, and having taken part in a recent Manchester taxi drivers' survey (to be published) where we find a mean of 23 $\mu\text{g Pb}/100\text{ ml}$, I have some interest in this matter.

The article itself leaves open some questions of technique: (1) The "blank" level of the heparin and containers used to take the samples—I assume that this was direct venous blood and not from the transfusion receiving bottle. On this matter, we use disposable syringes into which heparin is put by hand, before sterilization, at a reasonable but increased price per syringe, simply to avoid the problems of container and "handling" contamination. (2) The relationship between the technique used and the more classical ones, in the hands of that laboratory. (3) Whether there is any "non-resonant" absorption due to substances other than lead being extracted and introduced into the instrument.

With reference to the penultimate paragraph of the article, the various inter-laboratory trials have now been running for sufficient time for laboratories to know where they stand under "best conditions" with the mean values of the others. While we cannot wholly approve of democratic analysis, with the right answer being the mean of many wrong ones, in fact the laboratories which handle blood lead estimations on a large and continuing basis get reasonably similar results on the same blood samples, regardless of technique. In short, it is not so much the techniques that are at fault (the exceptions are the "direct" atomic absorption techniques which make no allowance for "blanks" and non-resonant absorptions, when consistently higher results are obtained), but the individual laboratories. But, on the whole, the good methods in good hands give the same results, certainly in batches if not on individuals.

It could well be that the Welsh rural community in question differs from the more normal 20–25 $\mu\text{g Pb}/100\text{ ml}$ population mean. However, to publish such data without evidence of the standing of the laboratory concerned in the inter-laboratory trials (almost 60 laboratories are involved in the British trials alone), or its relationship (in respect of blood lead) with other major laboratories in the field merely adds to the confusion. If the laboratory concerned is a "member" of the trial based on the Queen Elizabeth Medical Centre at Birmingham comparison of its results over the period of the trial as against the "mean" would at

least answer analytical (but not sampling) criticism. If not, we have to accept that it could be anywhere within the standard deviation of about 20 $\mu\text{g Pb}/100\text{ ml}$ common to the trials so far.—I am, etc.,

E. KING

National Occupational Hygiene Service Ltd.,
Manchester

¹ Goldwater, L. J., and Hoover, A. W., *Archives of Environmental Health*, 1967, 5, 160.

Doctors in South Africa

SIR,—The Full Time Joint Medical Staff Association (Witwatersrand), a body of over 300 full-time hospital doctors jointly employed by the University of the Witwatersrand and its associated Provincial teaching hospitals in and around Johannesburg, would like to inform you of a resolution passed at a recent general meeting of this association:

"The members of this association are totally opposed to any form of discriminatory salary structure for doctors, based on race, colour or creed."

In view of recent correspondence in the *B.M.J.* we thought that this might be of interest to you.—I am, etc.,

R. A. HINDER
Assistant Secretary,
F.T.J.M.S.A.(W)

Johannesburg,
South Africa

B.M.A. and R.H.C.S.A.

SIR,—My attention has been drawn to recent articles (*Supplement*, 8 December, p. 70, and *Supplement*, 15 December, p. 75) as well as to a letter addressed to members of the B.M.A. from Dr. Derek Stevenson.

The B.M.A. is a powerful and influential Association and quite rightly occupies a position of prestige both nationally and internationally. But it has failed an important section of the profession whom it claims to represent, namely the senior hospital doctors. Dr. Derek Stevenson directly, and Dr. C. E. Astley, Mr. A. H. Grabham, and Mr. Myles Gibson indirectly, poured scorn on the Regional Hospitals' Consultants and Specialists Association, and would have the uninformed reader believe that we are irresponsible. The difficulties now being experienced by senior hospital doctors, so adequately described in their various statements, have already been vigorously publicized by the R.H.C.S.A. during the past two to three years.

Consider the position in which the senior hospital doctor finds himself today—manacled by iniquitous and archaic contractual agreements. Basically he is subsidizing the N.H.S. with some 30–40 hours of his time per week. He is also subsidizing the N.H.S. by the provision of a car, a telephone, and an answering service. Hospital staffing is abysmally inadequate. Too many young doctors are being trained in some specialties for too few senior jobs. Yet in other specialties there is a dangerous shortage. Over half the registrar force is concentrated in London and the four Metropolitan regions. Yet some 3,000–4,000 excellent young doctors have left this country over the past 10 years. Had these been retained there would have been no staffing difficulties today. This situation has been achieved under the auspices of the B.M.A., through the Joint