on the team will have a great deal of extra work to do and will be seen to share in decisions which offend at least some of his colleagues on numerous occasions. It will be a fortunate consultant "Mr. Big" indeed who can satisfy everyone all the time.

The rewards available to a consultant who co-operates in the reorganization of the N.H.S. by accepting membership of the district management team appear to be as follows. (1) The disapprobation of those of his colleagues whom he has failed to satisfy. (2) Financial loss. Any consultant who provides a direct service to general practitioners and whose clinical sessions are reduced in order to make time for committee work is likely to see his practice damaged not only for the period during which he is in office but perhaps for many years afterwards. A permanent reduction in the income which he had received from domiciliary visits, medical reports, and private practice can hardly be viewed with enthusiasm. (3) Energy, time, and enthusiasm may have to be diverted from teaching and the publication of papers to administration, and this change of emphasis may make the receipt of a distinction award less likely. (4) A nervous breakdown. It is envisaged that the district management team will act by consensus. It follows that the consultant member must be able to bring to the team the distilled and agreed advice of his colleagues. Anyone who can do that successfully at a time when the entire administration of the Health Service is wedded to the notion of increasing the "community share of N.H.S. resources" (and presumably reducing the hospital share) will have proved himself a genius of tact and conciliation. For most of us it would be a task impossible of fulfilment.

Anyone who accepts this challenge deserves to receive the wholehearted support of the great majority of his colleagues, indeed his position will be intolerable if this is not freely given. From the Department of Health and Social Security he deserves a much more generous financial bargain; the equivalent of a "B" distinction award might be about right.

I am certain that the Central Committee for Hospital Medical Services appreciates this problem, but I wonder whether the penny has dropped with the Department of Health.—I am, etc.,

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Therapeutic Non-equivalence of Digoxin Tablets

SIR,—We should be grateful to Dr. T. R. D. Shaw and his colleagues for setting out so clearly (29 December, p. 763) the reasons for the great disparity in the effectiveness of the different preparations of digoxin which are at present available in Great Britain. We should be much less grateful to the Committee on Safety of Medicines for permitting this state of affairs to continue. It is highly unsatisfactory and indeed dangerous. In theory, if Lanoxin is prescribed the patient receives Burroughs Wellcome's preparation. If digoxin is prescribed he receives one or other of the alternative preparations, themselves of less and varying bio-availability. In practice, if the patient receives a prescription for digoxin he may on one occasion receive Lanoxin. Next time if he takes the prescription to a different pharmacist he will receive one of the others. He therefore alternates between being under-dosed and correctly dosed, or else being correctly dosed and being over-dosed—that is, poisoned. In my own experience this has happened to several patients several times. The Committee on Safety of Medicines should take steps to have this put right without more delay.—I am, etc.,

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Abortion Compared with Contraception

SIR,—Professor H. C. McLaren (5 January, p. 37) has asked us several questions which we will answer. Firstly, he asks what precisely we mean by a "comprehensive" system. On p. 283 of our paper (3 November) we explain this—adequate hospital family planning clinics for youth advisory work and for general family planning and clinics for both male and female sterilization. Secondly, he asks whether we promise legal abortion if the contraceptive method fails. We do not, and our figures show quite clearly a rapid decrease in repeated terminations for patients who use adequate contraception. He also emphasizes that some of our patients were referred from local family planning clinics. These amounted only to 11 (1%) in 1972.

Our 1973 figures continue to show a decline in the number of terminations—1,060, with 43% at less than 8 weeks of pregnancy, 43·7% at 9-12 weeks, and 13·3% at more than 12 weeks.

We are still firmly convinced that comprehensive family planning follow-up is necessary for all termination patients.—We are, etc.,

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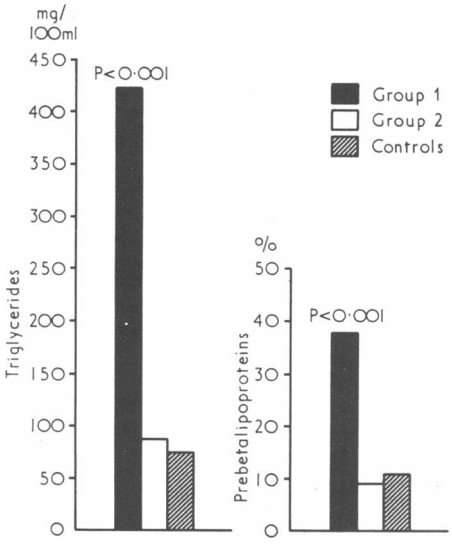
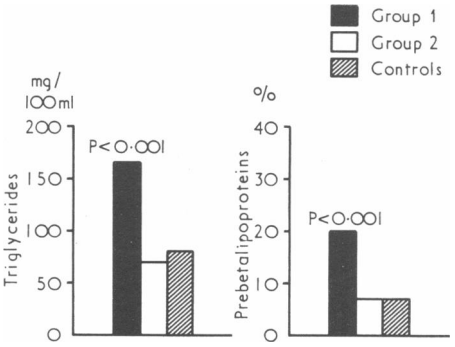
Type IV Hyperlipidaemia in Cord Blood

SIR,—With reference to the letter from Dr. F. M. Martins and others (8 September, p. 544) it may be of interest to report our findings in a similar study. Cord blood from 494 South African neonates of European origin was analysed for cholesterol, low-density lipoprotein cholesterol, and triglycerides. Cord blood levels greater than the mean value plus two standard deviations (S.D.) were arbitrarily defined as elevated. The mean triglyceride level for the whole series was 47 mg/100 ml with an S.D. of 17.

Eighteen neonates had cord blood triglyceride levels greater than the mean + 2 S.D. (81 mg/100 ml). Fourteen infants with raised cord blood triglyceride levels and 20 infants with normal levels were re-examined at one year of age. At this time both parents in all 34 cases were tested for hyperlipoproteinaemia. Six parents, from five families, were found to have hyperprebetalipoproteinaemia (group 1). This was confirmed on at least one other occasion. In all cases the fasting serum triglyceride level was above 150 mg/100 ml (mean value 421 mg/100 ml) and the prebetalipoprotein band was elevated as judged by electrophoresis on Cellogel membranes. In nine families in which the neonates had raised cord blood triglycerides (group 2) and in the parents of the 20 controls with normal cord blood triglyceride no cases of hyperprebetalipoproteinaemia were found (fig. 1). The mean triglyceride levels in group 2 and the control group were 88 and 77 mg/100 ml respectively, with no increase in the prebetalipoprotein band on electrophoresis.



At one year of age the infants from group 1 were found to have increased prebetalipoprotein bands on electrophoresis and significantly ($P < 0.001$) higher serum triglyceride levels (in all cases above 135 mg/100 ml) than the infants from group 2. This difference also existed between the infants of group 1 and the control group (fig. 2).



A serum triglyceride level repeatedly above 220 mg/100 ml was found in the one infant whose parents both had hyperprebetalipoproteinaemia. An infant with hyperprebetalipoproteinaemia and a similarly affected parent was therefore identified in 5 of 494 consecutive unselected live births in this series.

This study was reported at the Third International Symposium on Atherosclerosis held recently in Berlin and will be followed shortly by an extended communication on the complete cord blood lipid findings together with a one- and two-year re-examination of the infants and their parents. We are, etc.,

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