prefer treating smaller babies in the constant negative pressure respirator.—I am, etc.,

J. C. THOM

Department of Paediatrics,
University of Stellenbosch,
Tiervlei, C.P.,
South Africa

¹ Gregory, G. A., *et al.*, *New England Journal of Medicine*, 1971, **284**, 1333.

Solids and "Sleeping through"

SIR,—A survey into infant feeding habits has been carried out in South-east Monmouthshire on 100 mothers with babies between 6 weeks and 6 months of age. The major purpose of the survey was to ascertain whether there was a demonstrable link, as popularly believed, between introducing solids into the diet and giving up the 2 a.m. night feed. Only eight of the 100 mothers had not yet started solids (cereal in all but two cases) and all these had babies between 6 and 12 weeks old.

Of the 91 babies in whom the age of dropping the night feed was known, 49 had done so before, 18 during, and 14 after the introduction of cereal. Thus in only 32 cases could one even postulate a relationship between the introduction of cereal and sleeping through the night, and in 14 of these there was a delay of two or more weeks.

We are therefore unable to sustain the belief of many mothers (and others) that cereal feeding leads to babies sleeping through the night. If there were such a relationship it would be difficult to blame a mother who tried to ensure a good night's sleep for herself and the rest of the family. Perhaps these findings may help to counter some rather persuasive advertising and to avoid sowing some of the seeds of infant obesity.—I am, etc.,

R. M. ROBERTSON

Newport, Mon.

Time of Death

SIR,—In the course of a recent Horizon broadcast the statement was made that most deaths occur about three o'clock in the morning, and this is a widespread belief both in the profession and elsewhere. Among the distinguished authors who have perpetuated the myth was Robert Louis Stevenson.

Over the past two years I have kept a note of the time of death of every patient in this long-term and terminal care unit and, as the chart shows, these were distributed fairly

Distribution of times of death (corrected to nearest hour) of 363 patients.

evenly throughout the 24 hours with, if anything, a slight decrease in the small hours of the morning. Possibly being at a low ebb ourselves when called from a warm bed we feel that the patient should be at the point of death.—I am, etc.,

JOHN FLEETWOOD

Our Lady's Hospice,
Dublin

Intermittent Claudication and Vitamin E Therapy

SIR,—I was most interested in the finding by Mr. J. A. Dormandy and others (8 December, p. 576) of raised red cell malonyldialdehyde content in patients with intermittent claudication. I understand that this reflects the susceptibility of red cell lipids to auto-oxidation, malonyldialdehyde being a secondary breakdown product of lipid peroxides. Lipid peroxide is known to damage cell membranes and is known to be present in human atheromatous lesions.¹ Perhaps, as Mr. Dormandy and his colleagues suggest, the breakdown products of auto-oxidation have an effect on blood vessels and in pain causation.

In an excellent survey of the therapeutic value of vitamin E Marks² reviews the evidence for its use in intermittent claudication and concludes that there is a very sound basis for its use on grounds of clinical improvement. Vitamin E is known to inhibit lipid peroxidation *in vitro*³ and is a known *in vivo* lipid antioxidant. These facts and the authors' findings in patients with intermittent claudication might add more weight and some theoretical basis for vitamin E therapy in this potentially crippling yet often unrelievable condition.—I am, etc.,

WILLIAM D. ALEXANDER

Bristol Royal Infirmary,
Bristol

¹ Glavind, J., Hartmann, S., Clemmesen, J., Jessen, K. E., and Dam, H., *Acta Pathologica et Microbiologica Scandinavica*, 1952, **30**, 1.

² Tappel, A. L., *Archives of Biochemistry and Biophysics*, 1959, **80**, 333.

³ Marks, J., *Vitamins and Hormones*, 1962, **20**, 573.

Doctors in South Africa

SIR,—In your leading article on the World Medical Association (3 November, p. 245) you state that "too little credit is sometimes given to the Medical Association of South Africa for what it does under difficult circumstances." This opinion is most unlikely to be shared by any of the Black doctors in South Africa. On numerous occasions Black doctors in Cape Province, Natal, and Transvaal have separately urged the M.A.S.A. to take up their grievances with the authorities. It is interesting to note that the Federal Council of the M.A.S.A. has never included an elected representative of Black doctors whenever they have met the authorities to discuss their grievances. Blacks in South Africa are naturally very suspicious when matters of vital importance to them are discussed by Whites in their absence.

Despite the fact that all English-speaking newspapers in South Africa now use "African" when referring to the indigenous population, the *South African Medical Journal* continues using "Bantu" irrespective of the wish of the authors. The Nationalist Government never uses the word "African" as

this would in a way acknowledge that they were the earliest inhabitants of South Africa. This is contrary to their version of South African history. The editor of the *S.A.M.J.* also does not allow the use of "Black" instead of "non-White." However, "Whites" have never been referred to as "non-Blacks" in the journal. We should all strive for the day when people are no longer referred by their colour. Anyway, Blacks and Whites are incorrect terms; we are all varying shades of brown, pink, and yellow.—I am, etc.,

F. DINDAR

Etobicoke, Ontario

Testing Factory Workers for Glycosuria

SIR,—Clinistix strips were placed, with suitable instructions, in the pay envelopes of 13,466 employees working in an aero engine factory in Bristol. This exercise was publicized on the works notice boards after the permission of the management and the co-operation of the unions had been obtained. Known cases of diabetes were excluded. A total of 7,169 strips were returned. When the result was positive the urine was re-tested, and in 67 cases was found to contain sugar in amounts varying from $\frac{1}{4}\%$ to 2% . All employees with more than 1% of sugar in their urine were referred to their own doctors for further investigation. In 38 of these cases the diagnosis of diabetes was confirmed after a glucose tolerance test. Of these 38 diabetics, 21 are now controlled by diet only and the rest, showing smaller amounts of sugar in the urine, are also sugar-free with carbohydrate restriction.

This exercise, the cost of which amounted to £147, was thought to be a useful preventive measure in a large works. We have now passed on to phase 2 of our preventive measures and are testing the blood pressure of all employees over the age of 40.—I am, etc.,

E. P. GRIFFITHS

Senior Medical Officer,
Rolls Royce (1971) Ltd.,
Bristol Engine Division

Bristol

Glucagon in Acute Pancreatitis

SIR,—I was interested to read your leading article "Glucagon Therapy in Acute Pancreatitis" (1 December, p. 503). Unfortunately, the trial of glucagon reported by Condon *et al.*,¹ to which you refer, has done little to establish the drug's usefulness since they had no controls and, like your article, used the figures of Efron² and of Trapnell³ who reported mortalities of 22% and 23% respectively. Of Trapnell's series only 63% were diagnosed clinically and only 95 of his 324 patients underwent laparotomy. Efron does not give his laparotomy figures. Trapnell considered diagnostic laparotomy to be a fairly safe procedure, a point which may be debatable, but interestingly enough 13 patients out of Condon's series of 30 underwent laparotomy. Corlett and Mishell,⁴ studying the disease in pregnancy, (admittedly a selected group) had no mortality. Unpublished figures for this area on a series of 45 patients give a mortality of 8.8% or, excluding postoperative deaths, 4.7%. My point is that statistics of mortality from acute

pancreatitis are very variable and comparisons should be made cautiously.

Corlett and Mishell considered early diagnosis to be important in the management of the disease. Apart from pethidine and the debatable use of anticholinergics they suggest giving dextran to decrease pancreatic secretions. They also suggest giving saline intravenously initially since blood sugar levels influence pancreatic secretions, both exocrine and endocrine. However, there is probably an equally good argument for giving dextrose initially to prevent any vagal stimulation associated with hypoglycaemia. Glucagon is certainly a hyperglycaemic drug and may act in this way.

It may yet be shown that it is the first few bottles of intravenous fluid which influence the outcome of the acute attack rather than recent therapeutic innovations.—I am, etc.,

A. J. SLADE

Nevill Hall Hospital,
Abergavenny, Mon

¹ Condon, J. R., Knight, M., and Day, J. L., *British Journal of Surgery*, 1973, **60**, 509.

² Efron, G., *British Journal of Surgery*, 1966, **53**, 702.

³ Trapnell, J. E., *Annals of the Royal College of Surgeons of England*, 1966, **38**, 265.

⁴ Corlett, R. C., and Mishell, D. R., *American Journal of Obstetrics and Gynecology*, 1972, **113**, 281.

Clues to Multiple Sclerosis

SIR,—Mr. W. Calvert (5 January, p. 40) raises yet again a sore point among full-time consultants, many of whom now complain to me of their dissatisfaction. Full-time consultants are now in the ranks of the lower paid.

The editorial note at the bottom of Mr. Calvert's letter regarding £5,750 as the Review Body's recommended net income for general practitioners is firstly the *average* and secondly the amount they receive from *N.H.S. executive councils* (my italics). What would be more revealing and a more fair comparison would be to compare the average actual earned incomes of principal general practitioners at the age of, say, 50 with the average actual earned income of full-time consultants at the same age. Such a comparison, even without the differences of taxation treatment, would establish who are now the lower paid. It is to be hoped that the fashion of upgrading lower paid workers will continue in this respect!—I am, etc.,

BRYAN O. SCOTT

Divisional Representative, B.M.A.

Oxford

Medical Officers' Prospects

SIR,—As a former cadet who has recently finished a short service commission I would like to comment on your leading article (3 November, p. 247).

Most doctors leave the service at the end of a short service commission because of lack of professional satisfaction; not because they are "not strongly motivated towards the services and have no intention of staying." The factors affecting their decision are: (1) The pay of the service general practitioner may be as much as £3,000 per annum below that of some of his civilian counterparts, while his on-call periods are usually alternate nights, though not hectic

duty periods. (2) In the specialist sector the trainee specialists are paid as general practitioners and their specialist pay added, giving an average of £5,000 per annum, considerably over the civilian equivalent, but the range of work and work load are considerably reduced. With staff shortages the arrangements for postgraduate education are non-existent unless one is lucky enough to have an enlightened consultant. (3) Waste of medical manpower on the administrative side of the medical services rankles more than pay or loss of experience, especially when one knows of the acute doctor shortage. The general opinion of clinical doctors is that very few administrative positions could not be filled by non-medical personnel who, if trained in business administration, would make for a better co-ordinated service.

In my opinion recruiting to the general practitioner cadre of medical officers can be stimulated only by a substantial increase in pay. Some of the cost could be recouped by equalizing the training appointments for specialists to N.H.S. rates of pay and by paying all full-time medical administrators at general service rates of pay.—I am, etc.,

BRIAN H. VALENTINE

North Baddesley,
Hampshire

Pensions Again

SIR,—Among a number of subjects on which the B.M.A. has been working, as reported in Dr. Derek Stevenson's recent letter to members, is "Pensions Again."

The continuing effort put into this subject, from which we will all benefit, and now the success achieved for the 1969-72 group deserve our recognition and thanks, both too often forgotten. To the chairmen and committees concerned and to Dr. Stevenson and

his staff for all the hard work they do on our behalf may I say publicly, "Thank you."—I am, etc.,

W. H. HAYES

Mevagissey,
St. Austell, Cornwall

Pay Freeze

SIR,—It now seems inevitable that there will be a pay freeze at some point in the spring. For many years the Review Body's report has been delayed and hospital doctors have never received increases in pay on the correct date. I hope that we can be assured that the B.M.A. will have completed its evidence to the Review Body in sufficient time for the Review Body report to be handed to the Prime Minister and for him to present it to Parliament so that we can for a change receive our increase with effect from 1 April.

In view of the fact that the provisions of phase 3 have been known since October, there can be no excuse for the Review Body reporting late. If they do report on time it will at least minimize the chance of the profession again being the first to suffer under the total pay freeze.

As far as I am aware, the present programme for submitting evidence to the Review Body will result in a delayed report and it is almost inevitable that the total award will be lost in a pay freeze.—I am, etc.,

F. J. BRAMBLE

Member of Negotiating Subcommittee,
Hospital Junior Staffs Group Council

Bradford Royal Infirmary,
Bradford

* * It was reported to the Council at its meeting last month (*Supplement*, 26 January, p. 3) that the Secretary had already submitted a formal claim to the Review Body for an increase in pay for the profession from 1 April 1974—Ed., *B.M.J.*

Points from Letters

Vaginal Cytology

Mr. S. A. WAY (Queen Elizabeth Hospital, Gateshead) writes: For many years the Department of Health and Social Security has stood steadfast in stating that vaginal cytological examination is not necessary below the age of 35 and has only recently modified this viewpoint to include patients below this age who have had three or more children. . . . In 1973 at this hospital a total of 28,260 patients had vaginal cytological examinations. Of these, 216 had positive findings, of whom 138 (63.8%) were under the age of 35. Also during the year 47 cases of clinical carcinoma of the cervix were admitted. Eight of these patients were below 35. Five of these eight had had less than three children and in two of these, both under the age of 30, the tumour was so advanced that they needed pelvic exenteration.

Clues to Multiple Sclerosis

Dr. P. G. LYNCH (Group Laboratory, Royal Infirmary, Preston) writes: With regard to the possible virus aetiology of multiple sclerosis (leading article, 29 December, p.

750) your readers may like to know that in my own postmortem case records for 1968 there is a note that herpes simplex virus hominis was successfully isolated in tissue culture from necropsy samples of recent plaque material found in the pontine tegmentum of the brain of a patient suffering from a very acute form of multiple sclerosis.

Blood Levels of Anticonvulsants

Dr. ANNE E. McCANDLESS (Alder Hey Children's Hospital, Liverpool) writes: It has long been known that drugs which control epilepsy may, if they reach toxic levels in the blood, aggravate the condition and even produce status epilepticus. When a child on treatment deteriorates it is essential that measurements of the blood levels of the drugs used should be available to guide the clinician. This is particularly of value if the child is on more than one drug. . . . It is well known that on adding phenobarbitone to the treatment of a patient on phenytoin sodium the serum level of the latter may fall and that on adding sulthiame the phenytoin level may rise. We have, however, a great deal to learn