way one knows they should be treated. A similar sort of thing occurred with the publicity over social induction at Christmas. I think this sort of publicity is to be abhorred.

My second protest is that newspaper journalists are allowed access to information about research on new drugs, the results of which are published in lay papers before members of the medical profession have a chance to hear and know about the actions of these drugs. The particular article to which I refer appeared in the *Daily Mail* of 30 January (p. 11) and was headed "How we tested the new Happiness Pill." A patient came into my gynaecological clinic shortly afterwards, flung this piece of paper on my desk, and said, "I want these drugs," which I had not even heard of. I now understand that the "happiness pill" is an oestrogen at present under clinical trial for the treatment of menopausal symptoms.

I should be grateful if something could be done to prevent publicity such as we have experienced in the past few weeks.—I am, etc.,

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Ouabain in Heart Failure

SIR,—Reading with interest your leading article "Problems with Digoxin" (11 January, p. 49), I was surprised not to find even a single mention of one of the drugs most favoured in Germany—namely, strophanthin-G or ouabain.

I remember well being taught in Britain that ouabain was out of date, offering generally less than intravenous digoxin, and even that its speed of action was no greater than that of the most rapidly acting digitalis preparations. But it is common clinical experience here that in acute congestive heart failure ouabain produces the most rapid increase in cardiac contractility and output and with the least risk of untoward (toxic) effects, though I am aware of the fact that it does, at least qualitatively, share the negative chronotropic and bathmotropic effects of its brother substances digoxin, etc.

There is another—however controversial—indication for the use of ouabain in Germany: in cases of reduced cerebral perfusion caused by decreased cardiac output due to degenerative heart and vascular disease. Here a single dose of 0.25–0.4 mg given daily or even only thrice weekly over a period of several weeks seems to restore cardiac energy and reserve for a much longer time than the period of actual treatment.

Thus I feel that even in our enlightened days this drug might still merit some thought and consideration.—I am, etc.,

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Essential Thrombocythaemia, Polycythaemia, and Peripheral Gangrene

SIR,—The paper by Dr. F. E. Preston and others (31 August 1974, p. 548) shows that it is important to look for thrombocythaemia in patients with peripheral vascular disease. Similar symptoms may be seen in

polycythaemia vera with an elevated platelet count,¹ and the distinction between the two conditions may depend on the criteria used and perhaps even on the effect of iron medication, as illustrated by the following case.

A man who, at the age of 40, had had one toe amputated because of gangrene, was two years later admitted to hospital on account of imminent gangrene of several toes. The peripheral pulses were palpable and blood examination revealed a hypochromic anaemia (haemoglobin 6.3 g/dl) leucocyte count $22.4 \times 10^9/l$ ($22\,400/mm^3$), and platelet count $1330 \times 10^9/l$ ($1\,330\,000/mm^3$). These findings should be virtually diagnostic of essential thrombocythaemia.² As the anaemia might be having an adverse effect on the ischaemic tissue iron was administered orally and the haemoglobin level reached normal values. Total red cell volume was then found to be 55 ml/kg and a diagnosis of polycythaemia was made. The platelets were morphologically normal, both by light and by electron microscopy (Dr. Skjorten, Ullevål Hospital). The platelets had a marked inhibitory effect on the intrinsic coagulation system. Biopsy from the posterior iliac spine showed a very hypercellular bone marrow with marked megakaryocytic hyperplasia (Dr. Marton, Aker Hospital). The patient was treated with ^{32}P and got rid of his symptoms within a few weeks. The platelet count decreased to $870 \times 10^9/l$ ($870\,000/mm^3$).

Some of the polycythaemia vera patients of Edwards and Cooley¹ could probably also have been classified as having essential thrombocythaemia. On the other hand we do not know if some of the patients described by Dr. Preston and his colleagues had iron deficiency and possibly might develop polycythaemia vera. In our patient the ischaemic symptoms were evidently due to the increased platelet count. The distinction between the two conditions is of some practical interest, for with a diagnosis of polycythaemia therapy against the enhanced platelet reactivity may not be instituted. As suggested by Dr. Preston and his colleagues, a therapeutic trial with aspirin is probably a useful diagnostic test of thrombocythaemia-induced gangrene, and it will be interesting to see this test performed in polycythaemia vera patients.—We are, etc.,

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¹ Edwards, E. A., and Cooley, M. H., *Journal of the American Medical Association*, 1970, 214, 1463.

² Gunz, F. W., in *Hematology*, ed. W. J. Williams, et al., p. 704. New York, McGraw-Hill, 1972.

Overseas Doctors in the U.K.

SIR,—The General Medical Council proposes shortly to introduce a test of the proficiency in the English language and the professional knowledge of those overseas doctors applying for temporary registration (7 December, p. 606). While this will give certain benefits to the N.H.S., how will the examination help the overseas doctors? I hope that the test will not prove just another hurdle and that passing the test will provide the foreign doctor with better job opportunities in the N.H.S.

Because of the unsatisfactory "training job" situation the foreign doctor often reluctantly has to prolong his stay in Britain. As a result of this he becomes accustomed to the British life style, may feel apprehensive of returning, and develops an apathetic outlook towards his own country. Therefore to achieve a symbiotic relationship, in addition to the proposed examination the

G.M.C. should permit the foreign medical graduate to work in Britain for only a set period of two or at the most three years. During this period the overseas doctor would be provided with programmed training in the N.H.S., and after the training period a "certificate of clinical training" would be issued. This procedure might rescue the overseas doctor from the frustrating experience of the completely uncertain outcome of the royal colleges' examinations, which, moreover, have a doubtful practical relevance in their own countries. At the end of this period the foreign doctor should be obliged to consider returning to his own country as a strong possibility. By this arrangement the foreign medical graduate would have a definite sense of purpose to keep his mental faculties alive and flexible towards his country of origin, and can carry back much "British goodwill."—I am, etc.,

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Kilopascals

SIR,—With reference to the letter from Professor J. H. Green (8 February, p. 333) I would like to enter a strong objection to the adoption of this particular SI unit. The trouble with the kilopascal is that it is simply far too large, and apart from its fortuitous numerical approximation to gas percentages at standard atmospheric pressure, has little to recommend it. This unit is being powerfully promoted by several bodies concerned with metrication, but surely should be discarded for clinical use in favour of the hectopascal, more familiarly known as the millibar. This, very closely approximating 1 cm H₂O, is of just the right size, both for gas tensions and for respiratory and blood pressures.

I am well aware of the recommendation of the 11th Conférence Générale des Poids et Mesures that prefixes should move up and down in steps of three powers, but the practical value of the litre and millilitre is so apparent that not even the dottiest purist of SI has yet attempted to constrain us to cubic metres and cubic millimetres. It seems likely that meteorologists will be as unwilling to discard the well-established millibar as we would be to discard the millilitre, so why should not we also use this convenient and accepted unit? By doing so, my blood pressure will certainly be likely to remain at 160/100 mbar and I trust that Professor Green's will not rise to 240/120 hPa.—I am, etc.,

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** Though the pascal is the official SI unit of pressure the bar, like the litre, is among those non-SI units whose use the 11th C.G.P.M. decided should be tolerated, though discouraged. The working party which drew up recommendations for the use of SI units in British hospital laboratories¹ advised that, for the time being, kPa should be used only for blood gas measurements. We have accepted this advice and shall await further developments before abandoning the use of mm Hg and cm H₂O in other contexts.—Ed., *B.M.J.*

¹ Baron, D. N., et al., *Journal of Clinical Pathology*, 1974, 27, 590.