of cigarette[3-5] and have also shown that smoking behaviour is influenced by personality characteristics.[6] Alterations in smoking behaviour involve changes both in puffing rate and in depth of inhalation, each of which may modify the amount of nicotine, tar, and carbon monoxide absorbed. The present subjects decreased their puffing rate as pregnancy progressed but presumably inhaled more deeply, with the result that they managed to obtain the same amount of nicotine but apparently less carbon monoxide.

The cause of these changes is not clear, but the findings illustrate the dangers of extrapolation of data obtained during structured smoking regimens to real-life situations.

HEATHER ASHTON

University Department of Psychopharmacology, Newcastle upon Tyne

1 Ashton, H, *British Journal of Obstetrics and Gynaecology*, 1975, **82**, 868.
2 Commins, B T, and Lawther, P J, *British Journal of Industrial Medicine*, 1965, **22**, 139.
3 Ashton, H, and Watson, D W, *British Medical Journal*, 1970 **3**, 697.
4 Ashton, H, and Telford, R, *British Medical Journal*, 1973, **4**, 740.
5 Russell, M A H, *et al*, *British Medical Journal*, 1973, **4**, 512.
6 Ashton, H, *et al*, *Electroencephalography and Clinical Neurophysiology*, 1974, **37**, 59.

Prevalence of thyroid disease in the elderly sick

SIR,—Dr A W Burrows and his colleagues (22 November, p 437) appear to have got themselves into a complete muddle regarding the prevalence of thyroid disease in the elderly sick. They "disagree with reports that thyroid disease is prevalent (5% or more of cases) in the elderly" as found by Jefferys[1 2] and Green[3] (note corrected reference). They cite Bahemuka and Hodkinson[4] and Thomson *et al*[5] in support of their claim.

Their own study related to the investigation of a heterogenous group of 88 geriatric in- and out-patients, selected as being clinically euthyroid. None the less, they found two hypothyroid subjects, giving a thyroid prevalence of 2·3% with "exact" 95% confidence limits of 0·3-8·0%. In other words their result is compatible with a prevalence of 5% or more despite their exclusion of clinically apparent thyroid disease.

Their comparisons are biased ones as they did not compare like with like. Jefferys's[1 2] prevalence of 5·7%, based on study of 317 unselected geriatric admissions to this department, referred to *all* thyroid disease, known, suspected, or unsuspected before investigation, and so did Green's[3] of "rather more than 7%," based on a small inpatient series. The prevalence of 3·4% found in 2000 unselected admissions to this department by Bahemuka and Hodkinson[4] referred to suspected plus unsuspected cases. The work of Thomson *et al*[5] refers to well old people at home and is in no way comparable.

The only appropriate comparisons are with the findings of Jefferys and of Bahemuka and Hodkinson, with consideration only of the prevalence of unsuspected thyroid disease. These are shown in the table. Confidence limits are very wide for the smaller series so that useful conclusions cannot be drawn, but the large series of Bahemuka and Hodkinson indicates that the true prevalence of *unsuspected* thyroid disease is unlikely to be as high as 5%. There is no justification for saying that the *total* prevalence of thyroid disease in geriatric patients might not exceed this figure, however.

Prevalence of unsuspected thyroid disease in sick elderly patients

Authors	No of cases/total	Prevalence (%)	Confidence limits (%)
Burrows *et al*	2/88	2·3	0·3-8·0
Jefferys[1 2]	9/308	3·0	1·4-5·4
Bahemuka and Hodkinson[4]	44/1986	2·2	1·6-3·0

H M HODKINSON

Northwick Park Hospital and Clinical Research Centre, Harrow, Middlesex

1 Jefferys, P M, *Age and Ageing*, 1972, **1**, 33.
2 Jefferys, P M, *et al*, *Lancet*, 1972, **1**, 924.
3 Green, M F, *British Journal of Hospital Medicine*, 1973, **10**, 700.
4 Bahemuka, M, and Hodkinson, H M, *British Medical Journal*, 1975, **2**, 601.
5 Thomson, J A, *et al*, *Age and Ageing*, 1972, **1**, 158.

Medical training in developing countries

SIR,—May I comment on the observations of Dr Joyce E Leeson and Professor R S Illingworth (1 November, p 282) and Dr A J R Waterston (15 November, p 406) on our article on undergraduate medical education in a developing country (4 October, p 27)?

Dr Leeson and Dr Waterston feel that the British curriculum is a "historical relic" and "a probably outdated structure." Before we replace it with some new and untried alternative I think it worth remembering that this "historical relic" has trained some of the best doctors in the world. These are people who were able to function equally effectively in Harley Street as well as in the depths of Africa over the past century.

What seems remarkable is that many of our reformists seem to have forgotten that preventive and social medicine was taught (and is still taught) by good teachers of *general medicine*. I was a "victim" of this "outdated structure" but when I received instruction in pulmonary tuberculosis by an ordinary common or garden physician (also a product of the outdated structure) in Dr Leeson's own country a discussion on drug therapy was followed by a discussion on the preventive and social aspects of this disease. I am glad that Professor Illingworth has pointed this out. We decried the *over-emphasis* of preventive and social medicine and the italics in our article were not accidental. It is interesting to note that this over-emphasis seems to be creeping into the new British curriculum. Professor Illingworth's fear that with some modern curricula new graduates will be unable to recognise an ill patient is, I am afraid, already a reality, and if a halt is not called the disease will spread.

Dr Leeson, having spent some five weeks in Ceylon, questions the validity of the figure of 973 hours spent in the teaching of preventive medicine in Colombo. This figure was quoted from one of the most extensive and exhaustive studies on medical education ever done in Ceylon. The members of the working group responsible for this report were the professors of psychiatry of Colombo and Peradeniya, the registrar of the university, the professor of obstetrics and the dean of medicine, Peradeniya, and the professor of physiology and the new head of the Postgraduate Institute, Colombo. These people, who were here when Dr Leeson visited this island, could have answered her queries.

Dr Leeson doubts our contention that tuberculosis presents the same problem in diagnosis and management everywhere. The disease was chosen after careful thought and we reaffirm that the management of this disease consists of recognition of the disease, therapy with effective drugs for a specified period, and the tracing of contacts and their management. These principles must be taught to medical students all over the world and this is what we meant when we said that there should be no difference in the basic training of doctors in developed and developing countries.

I do not disagree with Dr Waterston that poverty plays a major role in the causation of disease, but I fear the solution is more political than medical. To extend the example cited by him, consider an unemployed ex-tea-estate labourer suffering from protein malnutrition admitted to my ward. He is treated in hospital and returned to the street as Dr Waterston indicates. But why? It is not because my training has been such that I cannot appreciate the problem but because I am aware that until suitable employment is found and protein made available at a reasonable price there is no other alternative. He is returned to the street and not sent to a nutrition rehabilitation unit (leading article, 1 November, p 246). Even if they existed there would be only standing room since nearly half the population (and in Bangladesh almost the whole of the population) would be in them. That we in this fertile island, with water outside (by definition) and water inside (by the grace of God), are unable to provide an adequate supply of protein for our people is more a reflection of the way the country is run than on the way the doctors are trained. Changing the medical curriculum cannot provide either protein or employment.

B SENEWIRATNE

University of Ceylon, Faculty of Medicine, Peradeniya, Sri Lanka

British postgraduate qualifications in India

SIR,—Better late than never. At last, the Indian Medical Council (IMC) has "de-recognised" the so-called "high reputed" British postgraduate qualifications like the MRCP and FRCS. It was a move that had been pending for a long time, but no doubt hastened thanks to the GMC's recent decision about foreign doctors. It is a right and positive decision for the following reasons:

It is certainly going to dispel the illusion that exists in the minds of many Indian graduates about British postgraduate diplomas and thereby reduce the influx of overseas doctors into Britain. It will come as a great relief to those many immigrants who have wasted time, energy, and money over these postgraduate examinations—more so for those who doubt their impartiality. It will also, perhaps, stop the harassment of newcomers in having to undergo the General Medical Council's examination and the humiliation by the media of those overseas doctors who have already settled here. Many senior British doctors have the impression that the only reason immigrant doctors come to this country is to gain these postgraduate diplomas. This is far from being always the case and it should not therefore be such a prominent feature in interviews for medical posts. Many immigrant doctors come to Britain simply looking for better prospects in life—just like the British medical graduates who emigrate from this country.

The GMC does not recognise Indian post-graduate qualifications as the equal of similar British qualifications. The reason usually given is that holders of overseas postgraduate qualifications are not up to the same standard when they come to work here as British postgraduates. The same is perhaps true of MRCP and FRCS holders who go to work in India, where they face entirely different problems. It is not a question of differing standards so much as being trained according to different countries' needs.

Last, but not least, the IMC decision will stop the exploitation of the professional skills of hundreds of doctors who are rotting in specialties they would hardly choose to work in if given the choice. Personally, I think the GMC should thank the Indian Government —their decision will certainly save the GMC a great deal of work.

K K AGGARWAL

St Helier Hospital,
Carshalton, Surrey

Thrombocytopenia, haemolytic anaemia, and sarcoidosis

SIR,—Dr P A Semple (22 November, p 440) was careful in the interpretation of thrombocytopenia, haemolytic anaemia, and sarcoidosis occurring consecutively in a young patient. Sarcoidosis may really have protean manifestations and the connection between various symptoms must be evaluated cautiously.

In 1966, however, we saw a 23-year-old man with typical "idiopathic" thrombocytopenic purpura which responded to steroid treatment but in whom two years later recurrent bleeding and resistance to further steroid administration necessitated splenectomy. The unexpected histological finding was sarcoidsis of the spleen. He made an uneventful recovery and the thrombocyte count has been normal since the operation. In 1974 an enlarged lymph node was removed from the left axillary region, but histological examination showed only lymphoreticular hyperplasia without any obvious sign of sarcoidosis.

It is probably worth emphasising that occasionally thrombocytopenic purpura may be the single presenting sign of sarcoidosis.

M WINTER

Municipal Hospital,
Hódmezövásárhely,
Hungary

The ten day rule

SIR,—In your leading article (6 December, p 543) you imply, quite correctly, that it is unreasonable to allow a patient to come to the *x*-ray department for an examination, perhaps prepared by fasting or purgation, and then be turned away because she is in the wrong phase of her cycle. This is particularly true in the case of outpatients who may have had to travel on long and costly journeys by public transport, as well as having to take time off work or make arrangements for children to be looked after.

To overcome this problem we devised a simple scheme in conjunction with the University of Liverpool's department of doctor-patient communication[1] whereby women in the age group at risk who are given appointments within the first 10 days of their next expected period are also given a prepaid envelope and the following slip.

FAZAKERLEY HOSPITAL, LIVERPOOL L9 7AL

Please note: *X*-rays may be harmful if done at the wrong time of the month. This only applies to some women at some stages in their lives. In your case we want to do the *x*-ray test within 10 days or so after your period begins.

On the day of your x-ray: if your period has started within the past 10 days, that is fine. Just come along as planned. If it has *not* started within the last 10 days, do *not* come. Just tear off the bottom of this letter and send it back to us right away in the prepaid envelope (it does not need a stamp). We will send you another appointment in the next few days.

Date of examination .....

My period has not yet begun. Please send me another appointment.

Name .....

Address .....

.....

Surprisingly perhaps, such postponement does not happen very often and does not in practice interfere with the work of a busy department, but may well prevent the irradiation of a very recent conception.

Sometimes a patient phones instead on the day of her appointment to say that her period has not yet started, in which case she is told not to come but to phone again if and when the period starts. She is then given an appointment within the next few days.

MYER GOLDMAN

Fazakerley Hospital,
Liverpool

1 Goldman, M, *et al*, *British Medical Journal*, 1973, **1**, 739.

Acute cardiomyopathy with rhabdomyolysis in chronic alcoholism

SIR,—I read with interest the report by Dr B I B Seneviratne (15 November, p 378). It is a great pity that no mention is made of the liver pathology in any of the five cases described. In a previously reported case of alcoholic myopathy[1] associated with cirrhosis of the liver the ECG showed atrial fibrillation. At necropsy the heart weighed 420 g and there was dilatation of the left ventricle and some atheroma of the right coronary artery. Despite severe skeletal muscle abnormalities seen on light microscopy, the cardiac muscle fibres appeared normal. There was, however, evidence of interstitial oedema, especially in the left ventricle. Hypertension, thyrotoxicosis, and valvular and severe ischaemic heart disease were excluded.

The findings in this and Dr Seneviratne's cases tend to support the hypothesis that interstitial oedema and a leakage of potassium from ultrastructurally damaged cardiac muscle into the oedema fluid are major factors in the genesis of alcoholic cardiomyopathy. Ultrastructural changes have been demonstrated in skeletal muscle from chronic alcoholics[2 3] and similar changes might be expected to occur in cardiac muscle poisoned by ethyl alcohol or one of its metabolites. Consideration should also be given to the water and electrolyte disturbances of hyperaldosteronism possibly accompanying the liver damage that invariably occurs in chronic alcoholic poisoning.

PATRICK G LYNCH

Department of Neuropathology,
Royal Infirmary,
Preston, Lancs

1 Lynch, P G, *Journal of the Neurological Sciences*, 1969, **9**, 449.
2 Douglas, R M, *et al*, *Australasian Annals of Medicine*, 1966, **15**, 251.
3 Klinkerfuss, G V, *et al*, *Annals of Internal Medicine*, 1967, **67**, 493.

Private practice and the NHS

SIR,—There are important criticisms to be made of the thinking which has led the Joint Executive and Negotiating Subcommittees, the Central Committee for Hospital Medical Services, and the BMA Council to make their recommendations about strike action and resignation for senior hospital medical staff.

These decisions were taken because, it is said, the consultative document was going forward as a package and so must be opposed now. Another reason, explained to the Scottish CHMS in Edinburgh by Mr D Bolt, is that the Government are "masters of gradualism" and so the thin end of the wedge must be opposed now. This is a logical inconsistency. The consultative document is no thin end of the wedge and certainly not the gradualistic approach. Thus the decisions and their present implementation in England and Wales in fact constitute a pre-emptive strike, mainly against action which the Government may propose for legislation in the future in the realm of private medicine outside the NHS. The presently proposed legislation is confined to private medicine within the NHS and has long been a stated policy of a democratically elected Government and well known to the profession.

According to one of the ablest European politicians of this century, Haushofer, anyone dealing in politics must determine the maxima and minima of the attainable on any issue. It must surely have been clear for some time now that the permanent retention of private medicine within the NHS is beyond the maxima of the attainable in a socialist Britain, yet because of the anger and indignation caused by the consultative document the profession's leaders have been baited into making a stand for freedom and independence on the weakest issue and poorest ground. They have chosen the heroics of Montrose "to put it to the touch to win or lose it all" instead of adopting a much more realistic "Machiavellian" approach with its emphasis on his principle of "prudence." They must suffer a reverse on the pay-beds issue—at best they might manage to have the other aspects of private practice referred to the royal commission.

The result is that damage has been done to the status of the profession, to its confidence and self-respect, and to its future because the leaders ignored a basic precept of political thought and action—they have allowed judgment to be distorted by passion.

W M S DYKES

Department of Anaesthetics,
Western Infirmary,
Glasgow

SIR,—However much some of us would wish it otherwise, the current dispute with the Government over private patients is inextricably bound up with the much broader issue of professional independence. The part-time consultant contract represents the only significant area of practical independence