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.

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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.

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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

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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.

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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.

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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