Indeed, the problem is analogous to that obtaining in the case of the congenital deformities of the limbs.

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¹Penrose, L S, *Annals of Eugenics*, 1946, **13**, 145.

Asylums are still needed

SIR,—Your leading article (17 January, p 111) prompts me to suggest that, although still needed, asylums will be expected to play a more community-orientated role. Central to this role will be the "asylum" day hospital.

From a study of the records at this day hospital over a period of 14 years it appears that the day hospital may be assuming this community role. Over this period referrals from family doctors have increased from 16% to 39%; the remaining referrals in decreasing order of frequency have come from the parent hospital, social services departments, local employment offices, outpatient clinics, probation offices, and self-referrals.

Discharges from the day hospital to the parent hospital have decreased from 50% to 13%, and discharges to hostels, sheltered workshops, and training centres have increased eight times. Patients readmitted from the day hospital to the parent hospital were almost invariably suffering from severe functional or organic psychoses.

It would appear that the day hospital and the mental hospital complement each other and it is hoped that over the next 20 or 30 years we shall see them evolve further until they become indistinguishable from present-day community facilities. It is evolution, not dissolution, that is needed.

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Thyroid cancer

SIR,—Your leading article on thyroid cancer (17 January, p 113) requires some clarification in order to restore balance. The types of thyroid cancer described are based on the clinicopathological classification of Wooner *et al*¹ and Hazard² which is now widely accepted as the best available. Their evidence^{1,3} and that of others in the USA⁴ and ours in the UK⁵ on the behaviour of these tumours should lead us to recommend much less radical treatment for many patients than you advise.

Firstly, on diagnosis. You can hardly propose that a group of clinical signs is "highly suggestive of cancer" and then offer the option to classify it as "obviously benign"! In fact, the ways in which cancers present are: as a solitary thyroid nodule, which often feels soft; a thyroid nodule with lymph nodes or lymph nodes alone; a hard mass usually involving the whole thyroid; or, most rarely, as distant metastases. Some investigations you describe can be useful: needle biopsy can be diagnostic in anaplastic carcinoma and malignant lymphoma (which should be included in any description of these diseases) and can also show a benign condition where Hashimoto's disease occasionally mimics anaplastic carcinoma clinically.

The subclassification of papillary carcinoma

describes occult (diameter less than 1.5 cm), intrathyroid, and extrathyroid types according to their morbid anatomy in the thyroid. The occult tumours (which may be a chance finding in a thyroid removed for another disease) and the intrathyroid type may both be accompanied by bulky metastases in local nodes but require no more than lobectomy, with perhaps contralateral subtotal lobectomy to control the primary. Near-total thyroidectomy may be necessary in extensive extrathyroid tumours where the risk of producing hypoparathyroidism may be acceptable. There is evidence that the modified neck dissection is preferable to radical dissection,⁶ but it is doubtful if the former can be performed en bloc.

It must also be said that half follicular carcinomas are of the "microangiopathic" type which, like occult and intrathyroid papillary carcinoma, have a prognosis which is equal to normal life expectancy as measured by an actuary.³ Again, these are satisfactorily treated by lobectomy. The other half will be of the more malignant "angiopathic" variety which you described.

Since the occult and intrathyroid papillary and microangiopathic follicular carcinomas are satisfactorily treated by surgical excision it is nonsense to advocate using radioiodine for obliterating thyroid tissue and whole-body scanning. There is no evidence that this is necessary and the hazards and distress of inflicting these measures on patients who are often in their reproductive years are formidable.

Medullary carcinoma occurring sporadically is only rarely bilateral, so again total thyroidectomy is an unwarranted hazard when the disease is limited anatomically. In familial cases it is often bilateral, as it was in all four cases we reported.⁷

In what way is childhood cancer an entity? All types of tumour occur with increasing frequency in teenage children,⁸ and they should be treated as in adults. One hazard, however, is that a child with benign dysmorphogenetic goitre may be diagnosed as having a carcinoma.⁹ Hypoparathyroidism in children may be a more severe disability, but in our view this surgical penalty is to be avoided in all patients at all ages.

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¹ Woolner, L B, *American Journal of Surgery*, 1961, **102**, 354.

² Hazard, J B, in *The Thyroid*, ed J B Hazard and D E Smith, p 239. Baltimore, Williams and Wilkins, 1964.

³ Woolner, L B, *et al*, in *Thyroid Neoplasia*, ed S Young and D R Inman, p 51. London and New York, Academic Press, 1968.

⁴ Crile, G, jun, in *Thyroid Neoplasia*, ed S Young and D R Inman, p 39. London and New York, Academic Press, 1968.

⁵ Beaugie, J M, *et al*, *British Journal of Surgery*, 1976, **63**, 173.

⁶ Crile, G, jun, *American Journal of Surgery*, 1964, **108**, 862.

⁷ Beaugie, J M, *et al*, *British Journal of Surgery*, 1975, **62**, 264.

⁸ Campbell, H, *et al*, *British Medical Journal*, 1963, **2**, 1370.

⁹ Richardson, J E, *et al*, *British Journal of Surgery*, 1974, **61**, 85.

SIR,—In your valuable and concise leading article on thyroid cancer (17 January, p 113) you draw attention to the need for earlier accurate diagnosis of these tumours. An important aid in this objective must be the

joint head and neck tumour clinic or joint thyroid clinic within a head and neck unit. These clinics or units are gradually being established within larger hospital centres.

At this institution a consultant general surgeon, head and neck/ENT surgeon, and radiotherapist, with their senior registrars, see all patients referred together, plan their treatment, and jointly review their follow-up. This system has operated successfully since 1970 and has been of continuing practical benefit in the accurate diagnosis, selective treatment, and regular surveillance of these patients. The establishment of such clinics is now well known in the general field of cancer therapy but perhaps requires greater emphasis for the overlapping interests in the complex field of head and neck cancer.

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Multitudinous authorship

SIR,—Are we expected to believe that each of the 15 people named at the beginning of a recent article in the *BMJ* (7 February, p 318) actually contributed to the writing of the article? Surely this must be a notable feat of authorship by committee.

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Venous thromboembolism in pregnancy

SIR,—We have read your leading article (22 November, p 421) on thromboembolic problems during pregnancy with interest and would like to make a few comments.

As coumarin-like anticoagulants cross the placenta with the possibility of fetal malformations and fetal haemorrhage their use should be avoided, and as heparin treatment over longer periods is inconvenient for the patient, the diagnostic procedure is of great importance and must be correct. As clinical diagnosis of deep venous thrombosis is unreliable, the search for more objective diagnostic methods is an important task. We agree that the ¹²⁵I-fibrinogen test should be considered contraindicated in pregnancy but disagree that the diagnosis has to be based on clinical signs alone.¹ At least in the later part of the pregnancy ascending phlebography can be performed if the abdomen and pelvis are sheltered by lead.

Today there are, however, also non-invasive methods which can be used before therapy is instituted. Thermography, as originally described by Cooke and Pilcher,² has shown good diagnostic agreement with phlebography and is very simple to perform.³ However, deep venous thromboses in pregnancy are often located in the proximal part of the venous system. Plethysmography gives a functional diagnosis and the reliability is highest in proximally located thrombi.⁴ As modified by Hallböök *et al*,⁵ using strain gauges, the method is fairly simple.

Recently we have had good diagnostic help from these methods in two pregnant women in whom deep venous thrombosis was suspected relatively early in the pregnancy. A 31-year-old woman, in the 13th week of pregnancy, was treated with heparin for a fortnight because of a

clinically suspected thrombosis. One week after cessation of heparin treatment she again developed symptoms and thermography clearly showed a thrombosis. Phlebography below the inguinal ligament showed an occluding thrombus in the femoral vein just above the knee joint. She was followed thermographically once a week. Heparin treatment was given until one week before a normal delivery. Thermography became negative after about 10 weeks' treatment, suggesting an inactive thrombus. Phlebography one week post partum showed complete resolution of the thrombus. The other patient, aged 26, had a clinically suspected deep venous thrombosis in the 10th week of her pregnancy. Ascending phlebography showed normal deep veins in the calf and distal part of the thigh, but strain-gauge plethysmography showed a proximally located thrombosis. The record showed a two-stage venous emptying in the left leg, with a first phase of rapid emptying from the calf and then a slow one through the proximal veins. Intravenous and then subcutaneous heparin therapy was instituted but there was a spontaneous abortion in the 13th week of pregnancy.

Doppler measurement should also be mentioned in this context, although we have but little personal experience of this procedure in the diagnosis of deep venous thrombosis.

A BERGQVIST
D BERGQVIST
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¹ Ramsay, D M, *Obstetrics and Gynaecology*, 1975, **45**, 129.

² Cooke, E D, and Pilcher, M F, *British Journal of Surgery*, 1974, **61**, 971.

³ Bergqvist, D, et al, *British Medical Journal*, 1975, **4**, 684.

⁴ Bergqvist, E, et al, *Uppsala Journal of Medical Sciences*, 1973, **78**, 191.

⁵ Hallböök, T, Månsson, B, and Nilsén, R, *Scandinavian Journal of Laboratory and Clinical Investigation*, 1970, **25**, 413.

Women in medicine

SIR,—I was very interested to read the account of the second session of the *BMJ* Conference on Medical Manpower which dealt with the problems of women in medicine (10 January, p 78). I would agree with the chairman's opening remark that there has been too little serious thought given to the difficulties faced by women doctors, although there have been pockets of activity in this sphere for many years. The Medical Women's Federation has maintained a representative structure throughout the UK since 1917 which has attempted (with some success I believe) to identify these problems and initiate solutions in the places where these might be found. The Board of Science of the BMA also had an active sub-committee in this sphere some years ago which made some progress, and we have been able to pursue some of the practical anomalies and difficulties through the main committees of the Association, which usually consider sympathetically the matters in this field when these are placed before them (frequently by their women members) and lend strong support when this is reasonable.

The difficulties, we have found, have varied in character over the years from the original "struggle" to obtain adequate places in medical schools and hospital posts, through the difficulties of different pay levels for men and women doctors and the dismissal of female medical officers on marriage, to the present-day problems of recognition and provision of

part-time training in hospital and general practice and the scarcity and high cost (with no tax relief) of replacements in the home to care for children or elderly dependent relatives that face doctors who cannot devote themselves full-time to medical work.

I was, perhaps, even more interested in the correspondence (24 January, p 225) stimulated by the conference report. Dr Frada Eskin raises the interesting issue of the selection of medical students and, although it would be nice to feel one could forecast the future attitudes of female applicants in relation to their development and attitudes to interpersonal relationships as yet unknown, surely many doctors feel that better methods of assessment of motivation *should* be possible. She links this with the need for a counselling service early in the medical course. We have been encouraged to see the gradual increase in the appointment by area health authorities and boards of advisers to women doctors (sometimes linked with the network of voluntary liaison officers established some years ago by the Medical Women's Federation) who will, it is hoped, gradually extend their sphere into the undergraduate population as well as the graduate.

Drs C F Scurr and Charlotte F Paterson both write of the need for career choice and the need for guidance and advice in planning and training—points with which I heartily agree—and here again the advisers and the regional committees for post-graduate medical education have a great part to play and are, in my experience, becoming much more aware of the needs and possible provisions to meet them.

Dr Paterson goes on to make a plea for help in the area of the scarcity and current high cost of domestic replacement and Dr Nimi Ettlinger adds her voice too and asks for corporate action to promote such facilities. The Medical Women's Federation has in the past constituted such a group that has felt the need to devote time and energy (and funds) to an attempt to assess attitudes of women doctors throughout the country and identify situations where action seems necessary to try to promote solutions to problems they see arising. In spite of the increasing number of women doctors and the undoubted growing recognition of their career difficulties I believe a group of this kind will be necessary for some time to come. Not, I should like to suggest, as Dr Paterson says to "fight" but to undertake identification of anomalies and problems and to enlist the aid of their medical colleagues (usually given willingly in my experience) and the administrators in their alleviation.

JOAN K SUTHERLAND

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Medical Women's Federation

Edinburgh

SIR,—How sad to hear all those lady doctors advocating maternity leave, baby-minders, crèches, and project sessions in school in the holidays for their children. At a time when it is quite clear that maternal deprivation can have serious and lasting consequences it is strange that the very mothers who ought to be aware of this are putting their own careers first and their children's needs second. Should our offspring join the ranks of the deprived because their mothers are doctors?

Part-time work and career structures should be far more acceptable in as many specialties as is practical—for example, from one or two sessions per week when the children are babies or toddlers up to full time or almost full time when they are ready to leave the nest. I myself moonlight out to do family planning and cytology clinics when our three small children are in bed—not wholly by choice but because

tiny daytime jobs are impossible to come by. Unlike Dr Tom Arie (10 January, p 79) I do not find these soul-destroying—after all, every job is what one makes of it.

HAZEL O C CAMPBELL

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SIR,—I read with interest the discussion on women in medicine (10 January, p 78) but noticed one omission—no mention of the possibilities of part-time work in academic medicine and research. During the past 18 years three married women with children have worked part time for a PhD in the faculty of medicine at the Queen's University of Belfast and have been successful. Academic terms frequently correspond with school terms, and hours can be made flexible.

If Dr Mary White is happy as a surgeon's daily help there is no reason why a suitable female should not succeed as the professor's handmaid.

MARGARET ELMES

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Women in psychiatry

SIR,—I should be grateful if you would allow me through your correspondence columns to inform readers of the existence of the recently formed Working Party on Women in Psychiatry. This small group is seeking information and contributions from all doctors with an interest in women working in psychiatry. A high proportion of psychiatrists are women, but their distribution between the training and career grades shows that a relatively small proportion are appointed to consultant posts. The working party will be considering employment opportunities, with particular reference to types of post available and part-time employment, and the availability of training. We shall be looking at the experience required for specialist accreditation at higher professional training level. We particularly wish to look at the experience of women training in personal posts set up under HM(69)6 and hope to set up a register to monitor the eventual outcome.

Many women working in psychiatry are employed as clinical assistants for up to nine sessions weekly and have considerable experience in the specialty. They are not eligible for the hospital practitioner grade as this is restricted to principals in general practice. We would welcome the views of these doctors and others on an acceptable service grade contract.

The working party hopes to prepare a report for the Education Committee of the Royal College of Psychiatrists by the end of 1976. We should welcome contributions of personal experience and opinions relevant to our task.

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Not so double-blind?

SIR,—We are concerned at the rather loose way the term "double-blind" is often used in reports of clinical trials.

Surely, to justify the term double-blind the