weakness in any other muscle groups. Two separate Tensilon tests (10 mg edrophonium chloride) with saline control were performed in a double-blind manner. After the first injection of edrophonium chloride the ptosis improved greatly, and two days later with the second test the improvement was less marked. After the Tensilon tests all therapy was stopped and the patient referred to the late Professor Andrew Wilson, who suggested that this myasthenic syndrome might be related to the practolol. Electromyography revealed no abnormality, nor did it six months later, when the patient had been off all therapy. Investigations including ESR, haemoglobin, blood urea and electrolytes, thyroid function tests, and x-rays of the mediastinum revealed no abnormality. The myasthenic symptoms have not recurred following the second dose of edrophonium chloride, but because the patient's blood pressure rose after stopping the practolol he was restarted on spirinolactone 100 mg daily and bendrofluazide 5 mg daily.

As remission may occur in myasthenia gravis perhaps a three-year follow-up period is too short to be sure that relapse will not occur. However, as the principal adverse effects associated with the use of practolol affect the eyes, skin, aural and nasal mucous membranes, and mesentery (14 June, p 577) and we have seen no mention of a muscular syndrome, we feel it worth alerting clinicians to the possibility of this syndrome being associated with practolol.

R OSBORNE HUGHES
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An unnecessary risk to children

SIR,—While I have considerable sympathy with the general contention that children should remain in the back seat (leading article, 24 January, p 180), in the present state of the law on seat belt equipment this may serve actually to increase the incidence of death and injury rather than reduce it. This arises because less than 1% of cars have seat belts in the rear seat, since they are not a mandatory requirement, and children between the ages of 8 and 14 rarely use the child type of harness. In these circumstances it is quite conceivable that it is safer to be in the front seat belted up than in the back seat unbelted.

While the article quoted some statistics, these were not on a comparative basis. In particular, the extent to which the front seat risk is higher than that for the rear and the savings likely to be brought about by the wearing of seat belts in each location. It may be that an expansion of your analysis would indicate that mandatory fitting of belts to the rear seats is a more beneficial proposal.

It continues to be important that new legislation is reasonably likely to bring about an improvement just as the effectiveness of new medications should be proved. Otherwise the public is brought into increasing conflict with the police for no benefit.

J S ANDERSON

Chorley, Lancs

Dukes classification of carcinoma of the rectum

SIR,—In your leading article (13 December, p 605) entitled "Search for presymptomatic large bowel cancer" it is stated that "on the

Dukes classification stage A is a tumour limited to the submucosa, B is with invasion through the muscularis without nodal metastasis, and C with spread to the nodes." With regard to group A and to some extent also to group B this seems to be wrong.

In the original article¹ and later papers and monographs by Dukes^{2,3} the definitions given are: in group A cases the growth is limited to the rectal wall (also including cases infiltrating into but not outside the muscularis propria); in group B the growth has infiltrated into the perirectal tissue but has not reached the regional lymph nodes; and in group C there are metastases in the lymph nodes. These groups are well illustrated by Dukes in the original paper and later articles.

As the Dukes classification for cancer of the large bowel is used world-wide it seems most important that workers in this field, in stating that this classification has been used, should adhere to the definition given by Dukes himself to ensure as strict comparability of material and results as possible.

CLAS G LINDSTRÖM

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- ¹ Dukes, C. E., *Journal of Pathology and Bacteriology*, 1932, **35**, 323.
- ² Dukes, C. E., *Journal of Pathology and Bacteriology*, 1940, **50**, 527.
- ³ Dukes, C. E., *Cancer of the Rectum*, p 66. Edinburgh and London, Livingstone, 1960.

* * * Dr Lindström is quite right; we quoted a widely used American version of the Dukes classification which, as he points out, is inaccurate. We agree that the definitions originally proposed by Dukes should be retained for international use.—ED, *BMJ*.

Folic acid deficiency during intensive therapy

SIR,—We have followed the recent papers on this subject^{1,2} and the ensuing correspondence³⁻⁵ with great interest. Ibbotson *et al*¹ point out that we did not state the exact type of intravenous nutrition in our paper⁶ and so we have now received our two cases. The first patient, who had a short illness following mitral valve replacement, received saline and dextrose only, while the second, who had septicaemia and renal failure, received Aminosol (without ethanol) for six days in his terminal illness. However, circulating megaloblasts were seen as early as 24 hours after commencing this treatment. There is no evidence that either patient received ethanol.

Although our two cases fit into the syndrome of rapidly developing folate deficiency during intensive therapy, they showed in addition extremely bizarre features (for example, giantoblasts, dyserythropoietic changes, frequent multinucleate cells, vacuolation) superimposed on the more usual megaloblastic changes. These additional changes may have been due to factors such as infection, drugs, uraemia, anoxia, etc, having a direct effect on erythropoiesis.

On an historical note, Ibbotson *et al*¹ inferred from our paper that the first description of this bizarre megaloblastic and dyserythropoietic anaemia of rapid onset occurring in seriously ill patients was that of Limarzi and Levinson.⁷ In fact we attributed this to an earlier paper by Harvier and Mallarmé published in 1938.⁸ Unfortunately this date was misprinted as 1968 in the list of references.

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- ¹ Wardrop, C A J, *et al*, *Lancet*, 1975, **2**, 640.
- ² Ibbotson, R M, Colvin, B T, and Colvin, M P, *British Medical Journal*, 1975, **4**, 145.
- ³ Wardrop, C A J, *et al*, *British Medical Journal*, 1975, **4**, 344.
- ⁴ Ibbotson, R M, Colvin, B T, and Colvin, M P, *British Medical Journal*, 1975, **4**, 522.
- ⁵ Colvin, B T, and Ibbotson, R M, *Journal of Clinical Pathology*, 1975, **28**, 1007.
- ⁶ Saary, M, *et al*, *Journal of Clinical Pathology*, 1975, **28**, 324.
- ⁷ Limarzi, L R, and Levinson, S A, *Archives of Pathology*, 1943, **36**, 127.
- ⁸ Harvier, P, and Mallarmé, J, *Sang*, 1938, **12**, 883.

Neonatal jaundice in association with operative delivery

SIR,—I read with interest Professor E A Friedman and Mr M R Sachtleben's paper (24 January, p 198) and their suggestion that clinically undetectable focal haemorrhage secondary to instrumental delivery might be a major contributory factor in the rising incidence of neonatal jaundice. I would like, however, to bring to their attention our findings published in August 1974.¹

On analysis of the full-term infants admitted to the special care unit of the Simpson Memorial Maternity Pavilion, Edinburgh, for hyperbilirubinaemia we similarly found no clear relationship with oxytocin administration, but the Kielland forceps delivery rate for the group was twice the mean for the hospital over the same period. Our conclusion was that the cumulative effects of induction plus operative vaginal delivery even near term probably produces a number of neonates not totally prepared for extrauterine life. In particular their hepatic conjugating mechanism might remain untriggered. We felt that focal haemorrhage too small to be clinically detected was unlikely to elevate the serum bilirubin concentration to such levels.

The morbid effects upon the fetus of modern obstetric practice must constantly be balanced against the undoubted rapid fall in mortality. With increasing vigilance of detection and improved treatment we have, as yet, no evidence that the "boom" of jaundiced babies has produced significant long-term effects on our population.

O B EDEN

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- ¹ Eden, O B, Revolta, A D, and Adjei, S K, *British Medical Journal*, 1974, **3**, 573.

Computers and privacy

SIR,—Your leading article on this subject (24 January, p 178) is of particular interest to this practice. Since August 1975 we have been using a computer to maintain our medical records in total. We are particularly concerned with confidentiality and your last paragraph sums up our conclusions exactly.

Each doctor has a unique secret password into the system. We also have a "p p" password which we release to our medical secretaries so as to allow them access to the records.

The reception staff have their own password, which allows access only to the patient's identification details and to repeat medication details. These passwords can be altered when we wish.

We have the facility to mark a record on the computer to allow access to read (but not to alter) to our nurses and health visitors. There is a facility to suppress information that allows access only to the doctor who records the information. This information can never be printed out or produced on microfilm. The staff of the Exeter Computer Project are all employees of the area health authority and are bound by the same code of ethics as we are. In fact they have no access to our records unless we give them our passwords.

In short, our level of confidentiality is as secure as ever and if it were not for the continued presence of the medical envelope in the filing cabinet we could truthfully state that it had improved.

J F SIDEBOTHAM

G WARD

J H BRADSHAW-SMITH

J G PEGG

J T ACKROYD

Ottery St Mary,
Devon

Clinical or administrative postal addresses?

SIR,—Why is it that health authorities insist on *hospital* notepaper having the name of the authority emblazoned at the top of the sheet?

The banner heading "Loamshire Area Health Authority (Teaching): Central Loamshire Health District" across the top of the page has no relevance whatever to a letter addressed from and requiring an answer to "The Royal Loamshire Infirmary." This practice not infrequently results in those who cannot be expected to know, and foreigners in particular, addressing their letters to "Loamshire Health Authority (Teaching): Central Loamshire Health District" and that letter finding its way to the ivory tower headquarters of one or other of these authorities, with consequent delay and frustration.

I suggest that planners and administrators of the DHSS should think again about this matter.

T B BOULTON

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Anaesthesia

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Preventive medicine—House of Commons inquiry

SIR,—The Social Services and Employment Subcommittee of the Expenditure Committee of the House of Commons is conducting an inquiry into preventive medicine and the BMA has been invited to give written evidence.

An ad hoc subcommittee of the Executive of the Central Committee for Community Medicine has been formed to prepare this evidence, which will cover the generality of preventive medicine and its effect on the life and health of the nation. We would, therefore, welcome observations on the subject, which may be incorporated in the Association's evidence: (a) in general; (b) on specific aspects which the House of Commons has particularly

requested. These include diet and nutrition (including alcohol), air pollution, water pollution, and urban planning.

The subcommittee would be pleased to have observations in writing, preferably by 28 February. These should be sent to me: Dr A W McIntosh, c/o Executive Secretary, Central Committee for Community Medicine, BMA House, Tavistock Square, London WC1H 9JP.

A W MCINTOSH

Deputy Chairman,
Central Committee for Community Medicine

London WC1

Consultants' ballot

SIR,—At a recent meeting of the Rochdale Area Health Authority Senior Medical Staff Committee the BMA's "A Ballot of Consultants" was briefly discussed. A strong feeling was expressed that yet again this document evidenced the gulf that existed between the members of the Council and the grassroots of the Association.

It appeared singularly inept to make resignation contingent upon the non-acceptance of the Goodman proposals. It was felt that there would be many consultants throughout the country who would share with the majority in Rochdale in doubting the adequacy of protection of the Goodman proposals but who would hesitate to accept that resignation was an appropriate alternative. Such action should be considered only in support of clear positive proposals which provided adequate safeguards advocated by our own negotiators and not by a third party retained by a fourth!

To have formulated the ballot in this fashion is likely to have weakened rather than strengthened our negotiating position and again raises doubts as to the knowledge and experience of our counsellors in the field of political and industrial dispute. It underlines the lack of sensitivity in the Central Committee for Hospital Medical Services to the needs and feelings of the majority of consultants. Had these been adequately appreciated we would have had leadership to a clear course and the direction of our undoubted strength to a positive end.

D H TEASDALE

Chairman,

DONALD S LYON

Secretary,
Senior Medical Staff Committee

and 19 other signatories

Birch Hill Hospital,
Rochdale, Lancs

Doctors' wives and the Sex Discrimination Act

SIR,—I was interested to see Mrs Mary J Glanvill's letter (7 February, p 343).

On 19 January my husband and his partner submitted forms ANC 1, 2, and 3 to the Nottingham Family Practitioner Committee, with a covering letter saying that both the word and the letter of the Sex Discrimination Act render the exclusion of related ancillary staff obsolete. They also pointed out that it is now an offence to persuade or coerce employers to breach the terms of the Act.

The Administrator of Family Practitioner Services replied on 29 January that the contents of the letter had been carefully considered "but it is not felt that the criteria for the em-

ployment of a doctor's dependants contravenes [sic] the Equal Opportunities (Sexual Discrimination) Act 1975." He went on to say that "a doctor's relatives are not precluded from the [ancillary staff] scheme by reason of their sex or marital status, but because of: (a) financial dependence on the doctor; and (b) live in his residence." He referred us to paragraph 80.1 of the Statement of Fees and Allowances.

Naturally we do not accept either his interpretation of the exclusion clause or of the new Act. I too work in my husband's practice and have done so since before 1966. As I work longer hours than Mrs Glanvill it is possible to compute our deficit to a figure even greater than hers. In my view this is a very strong argument in reply to the DHSS who have stated in correspondence with me that the country cannot afford to meet such "non-essential public expenditure." Should the country's finances be supported by a total lack of integrity?

JULIE STAFFORD

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Notts

Pay-beds in NHS hospitals

SIR,—I would like to congratulate Mr N H Harris (7 February, p 344) on extracting, albeit grudgingly, an admission from the Secretary of State for Social Services that the removal of pay-beds from NHS hospitals will not reduce the waiting lists she complains of so bitterly. That the pay-bed issue has nothing to do with improving the standard of medical care for NHS patients I can demonstrate.

The West Midlands Regional Health Authority, the largest single authority in England and Wales, reported on 31 December 1974 that there were 59 400 patients on the waiting list (the 1975 returns are awaited). Their statistical tables show, however, that out of this total 51 417 were waiting for a surgical operation of one sort or another. Some have to wait two years. In contrast the waiting list for general medicine was 214, and 169 of those belonged to one hospital group; out of the remaining 21 groups, 14 had no general medical waiting lists at all. The waiting list for paediatrics in the whole region was 19. The same report shows that out of the 17 508 beds available to NHS patients the average occupancy was only 12 653 or 72.2%. Therefore to increase the number of beds by adding in the pay-beds will only increase the number standing idle and unoccupied.

From the fact that 86.5% of the waiting list was confined to general surgery, ENT, orthopaedic and ophthalmic surgery, and gynaecology it follows that the waiting list is due to a shortage of operating theatres. It is the Health Departments who are responsible for the waiting list problem and no one else. They have failed to implement their building programmes over the past 20 years. As far as NHS patients are concerned the pay-bed issue is irrelevant.

F S A DORAN

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Fair allocation of resources

SIR,—The paper by Mr J H Rickard (31 January, p 299) is most welcome. Reorganisation of the Health Service has allowed the dis-