Burning feet

SIR,—Neurological manifestations, often suggestive of cerebral tumour, are a recognised association of polycythaemia rubra vera (PRV) though documented intracranial neoplasia are rare.¹ "Burning feet" have been described in other conditions but not, to our knowledge, as an isolated presenting feature of PRV.

A 74-year-old woman who was otherwise well presented at hospital with a history of a burning sensation on the soles of her feet continuously for 18 months. There were no aggravating or relieving factors. She was on no medication and neither drank alcohol nor smoked. On examination she was plethoric, and her spleen was enlarged 2 cm below the costal margin. Her peripheral pulses and neurological function were normal, and no other abnormal findings were evident.

Investigations revealed: Haemoglobin, 18.7 g/dl; PCV, 0.60; MCHC, 31 g/dl; platelets, $420 \times 10^9/l$; leucocytes, $12.7 \times 10^9/l$; lymphocytes, 16%; monocytes, 3%; neutrophils, 66%; eosinophils, 15%; and ESR, 1. Leucocyte alkaline phosphatase score was 237 (control 37). Total blood volume 117.8 (70 $\pm$ 8) ml/kg, and red cell volume 70.0 (30 $\pm$ 5.5) ml/kg. Serum B₁₂ was 1180 pmol/l, and folate was normal. In addition her uric acid was 0.34 mmol/l, (0.06-0.24 mmol/l) and acid phosphatase was 8.5 KA units. (1-4 KA units). Serum creatinine, urea, electrolytes, calcium, phosphate, alkaline phosphatase, and a glucose tolerance test were normal. Chest and pedal x-rays, urine analysis, and intravenous pyelography were also unremarkable, and plethysmography and oscillometry were within normal limits.

Having established the diagnosis of polycythaemia rubra vera, phlebotomy was instituted, 4 units of blood being removed in the initial 10 days of therapy. In this period the sensation of burning feet abated and has not returned during four months of continuing phlebotomy. The acid phosphatase has fallen to 5 KA units, without a change in the platelet or white cell counts.

A raised serum acid phosphatase would appear to be an unusual feature of PRV with a normal platelet count, although it has been described in PRV with thrombocytosis and in other haematological disorders.² In addition there appears to be a causal relationship between the institution of phlebotomy and the resolution of symptoms.

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¹ Sims, D G, and Husband, E M, *British Medical Journal*, 1972, 4, 115.

² Bodansky, O, *Advances in Clinical Chemistry*. London, Academic Press, 1972.

Infant feeding and cow's milk

SIR,—Dr D L J Freed (17 April, p 961) correctly points out that cow's milk should be avoided during neonatal life to prevent "wind" and atopy. Since working among rural populations we have come to believe that the parents living in farms tend to introduce fresh cow's milk to infants within 6 months of age. This is not known to occur in the cities. It is only natural for the parents living in farms to introduce fresh cow's milk early, as it is readily

available and comparatively cheap. We have lately encountered one case of cow's milk allergy in one such child. Another child developed iron deficiency anaemia with occult gastrointestinal blood loss due to fresh cow's milk feeding.¹

Further studies in farming areas will be instructive. Colleagues working in similar areas should be aware of this and warn parents against introducing fresh cow's milk early in life—especially before 12 months of age.

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¹ *British Medical Journal*, 1973, 1, 437.

Professorial imprint

SIR,—Thank you so much for treating us to Sir George R McRobert's classic comment (24 April, p 1021), "He moved from one chair to another, leaving his mark on each." Left to posterity, I presume.

G SICHEL

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Plight of the younger consultant

SIR,—To complain about money is unprofessional and in poor taste. However, it is high time that the dilemma of the younger consultants was better understood.

Entering my fifth year as a consultant my salary, because of implementation of the shortened incremental scale and the terms of the anti-inflation policy, is frozen at the first increment. The outcome of the recent negotiations on the junior doctors' contract means that no differential now exists between a registrar working a 1 in 2 on call, a senior registrar on a 1 in 3 on call, and a junior consultant without any official off-duty. It should also be noted that the juniors can put their medical skills to use in their own time while I, for some reason, must accept confiscation of 2/11ths of my salary without any reduction in my work load or responsibilities. The announcement of salary scales for family doctors doing hospital clinics has also brought it home that the real worth of a consultant is not greater than that of a family doctor, even in the specialist setting. Finally, it is likely that the impending review will have to concede a further £6 per week to all juniors but not to anyone at or near a basic salary of £8500 per annum.

It is hardly surprising that younger consultants are losing interest in their NHS work and that a growing number of full-timers reserve their concern for unofficial external means of restoring the income differential they have lost. At a time when consultant friends of my own have had to remove their children from direct grant schools and resign from their golf clubs it is perhaps overdue that action should be taken not to preserve private practice but to guarantee a specialist reward for years of study and sacrifice. Despite all that the last Review Body had to say about incentive for younger consultants, most now find themselves in the situation in which they must do private practice, either officially or illicitly, if they are to go on providing for the

expectation of their families. I am unable to find any solution to the paradox that effectively means that consultants now depend upon private practice but cannot expect a better deal until they allow the prospect of it to be removed from them. There are, however, real risks to the Health Service in the complete collapse of morale among the younger consultant community and it is certainly the case that only a lack of organisation on the part of these younger consultants is saving the hospital service from chaos far greater than anything the juniors might have caused.

ROBERT WOOD

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SIR,—Dr A L Hovenden's letter (27 March, p 773) on the Government's decision not to allow increments to consultants beyond the £8322 point certainly underlines what amounts to a policy of discrimination against younger consultants. It is also particularly niggardly not to allow those on £8322 to proceed to £8500 on their incremental date.

It may not be generally known that there is a strong possibility that this restriction has already been breached. In the *BMA News Review* for October 1975 (p 91) it was reported that in the case of medical teachers the University Grants Committee was proposing to pay both the first increment or the fraction (£178) of the second one to allow the salary to reach £8500. It has not been reported subsequently whether the UGC has done this or not. It has also been reported in the press¹ that 500 000 non-industrial civil servants are to accept pay rises of £6 per week from 1 April 1976, and the report goes on to say that "those getting between £8197 and £8500 get less, so as not to increase their pay to more than £8500 a year."

Consistency seems to be lacking in the so-called pay policy. I should be interested to know if the BMA is prepared to go to the Government again on this one and quote precedent.

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¹ *Glasgow Herald*, 18 March, 1976, p 1.

Incremental payments for consultants

SIR,—Hospital consultants and specialists in the Gwynedd Area view with grave concern the unjust Government decision to renege on a contractual salary agreement by withholding incremental payments. We have expressed this concern in letters sent to the Secretary of State for Wales, our health authority, and local members of Parliament.

The failure to pay increments has had a most serious and unjust effect on the full-time consultants because the cut-off point, in fact, has been put at £8322 instead of £8500. For the maximum part-time consultant the cut-off point is £6808. We recognise the need for an incomes policy but regard incremental payments as a contractual commitment made at the time of appointment. However, Government tinkering makes an incremental pay-structure of this kind unsafe and we therefore feel it should be abolished. Equal pay for equal work and responsibility should, in future, be the aim of our negotiators.

This communication seeks the views of