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SIR,—Your excellent leading article on this subject (1 May, p 1033) draws inaccurate inferences from comparative anatomy when it suggests that adoption of the erect hominid posture, which started 12m years ago,[1] "increased the angle of flexion" of nerves, arteries, and veins passing into the arm and stretched them. In fact the forequarter of a quadruped is set during weight-bearing in the "military shoulder pose" and the greater extension present at the base of the quadruped's neck imposes inevitable stretch—particularly on the nerves. So that the change in posture is unlikely to have created the possibility of compression at the thoracic outlet.

Since most of the symptoms mentioned may be of cervical origin and there is no way of eliminating irritation of spinal nerve roots (if the value of nerve conduction tests is denied) as a cause, direct or indirect (for example, trapezius weakness), it is unfortunate that the importance of subclavian artery compression should have been played down. Without it the syndrome should not be diagnosed since to do so is to ignore a correctable spinal cause. In addition to nerve root irritation, both scalene spasm and abnormal elevation of the first rib should be remediable by spinal manipulation.

The part played by cervical ribs is of negligible importance since they are present in only 1% of the population[2] and when present less than 10% of them produce pain.[3]

JOHN EBBETTS

London W1

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SIR,—As you point out in your leading article (1 May, p 1033), it is often difficult to differentiate nerve entrapment at this level from cervical spondylosis—and indeed on occasion from carpal tunnel compression. I have found that the most useful diagnostic sign of this type of entrapment is tenderness over the trunks of the brachial plexus in the root of the neck. The commonest finding at operation in 10 consecutive personal cases was that the brachial plexus trunks ran across the sharp point of a cervical rib; the site of tenderness in the neck accurately located this state of affairs, which was found in four cases. The tip of the rib is always enclosed in muscle fibres which run down into the scalenus medius, but these do not protect it sufficiently to prevent considerable pressure on the brachial plexus trunks. Resection of the anterior part of the cervical rib solves this problem.

However, in some other cases in which cervical ribs were seen on *x*-rays the anterior ends of these ribs were found at operation to be too far posterior to impinge on the brachial plexus trunks. In these cases, and in some others in which no cervical ribs were present, vascular anomalies were found to be the cause of nerve compression. A plexus of veins draining into the transverse cervical vein ramifies in and out between the cords of the brachial plexus and can entrap individual cords or nerves. The first such patient I encountered had bilateral symptoms of brachial nerve root compression; resection of the offending veins on one side produced complete relief of symptoms and the patient then requested that the other side be similarly operated on; a similar state of affairs was found and again resection of the veins relieved his symptoms. Another cause of nerve entrapment, found in two cases, was that the first thoracic nerve root was tightly compressed against the first rib by a very small artery running backwards across it.

In the less common but important cases of subclavian artery compression with peripheral embolism which you mention it is important to realise that the artery may pulsate and look completely normal at operation externally, though permanent intimal damage has occurred. One such case was encountered in this series.

In other cases compression of the brachial plexus or major vessels by a variety of fibrous bands or tendinous arches may be the cause of the trouble. In view of the wide range of possible anatomical causes of symptoms in these cases I feel that exploration of the structures through a supraclavicular approach is a safer and more logical way of tackling the problem than resection of the first rib through the axilla, which may not reveal the problem.

B VICTOR JONES

Fareham, Hants

Osteopaths Bill 1976

SIR,—On 7 May the Osteopaths Bill was read for the second time. On the face of it it is a harmless measure, merely intended to decide who can and who cannot use the letters SRO (State-registered osteopath) after his name. At the moment MRO (member of the Register of Osteopaths) is used and is protected by trade-mark law. Unfortunately, the passage of the Bill will have repercussions reaching far beyond manipulative personnel.

Mrs Butler, who presented this Bill, has been importantly misled on the scope of osteopathy, for she uses the words "oseteopathy or treatment by manipulation." Strictly speaking, osteopathic dogma is not concerned with manipulation: it is an alternative system of medicine whereby disease is attributed to spinal displacements (the so-called "osteopathic lesion"). It merely happens that the chosen remedy of treatment is also used by doctors, physiotherapists, chiropractors, and nature-healers, few of whom believe in osteopathy. Bone-setters have manipulated the spinal joints for at least 2000 years.[1] What Mrs Butler clearly intended was a register of competent manipulators. What she is unwittingly likely to achieve is State recognition for osteopathy by the back door.

We have State-registered nurses, and all are agreed that nursing assists, and in no way conflicts with, the tenets of medicine. Moreover, nurses are taught and work in hospitals. They follow a medically approved syllabus and their examinations are supervised by external consultants. The public will understandably deduce that the Stage registration of osteopaths implies the same official acceptance of osteopathy as SRN indicates approval of nursing. If recognition is granted the State is in a dilemma, suddenly accepting two opposing views on the genesis of disease. I very much hope therefore that the appropriate committee of the BMA will look at the implications of this little Bill and take up the cudgels for medicine. They should also note that the registration is not, like nursing, physiotherapy, etc, for a profession ancillary to medicine but for an autonomous body making their own diagnoses and ordering their own treatment—in other words, doctors—but without having to obtain a medical qualification.

Public confusion can only be increased by this Bill, and Mrs Butler's misapprehension must be brought urgently to her notice.

JAMES CYRIAX

London W1

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Nurse specialists in family planning

SIR,—I would like to comment on the use of nurses as substitutes for doctors in family planning clinics.

It seems strange that Dr J Newton and others (17 April, p 950) should train nurses to do work which is normally done by doctors when there are large numbers of general practitioners willing to do this work in their own surgeries. It is less strange that the DHSS should give him a grant for this purpose. If training facilities are available they should be offered to doctors, who have great difficulty getting trained in the technique of fitting intrauterine contraceptive devices (IUCDs). My last four trainee practitioners applied for this and so far as I am aware only one has succeeded in getting a place on a course.

There are several medicolegal points arising from the treatment described in this article. The term nurse "specialist" has no legal significance. There is no register of nurse specialists in Britain. In the introduction it is stated that "adequate training" for nurse specialists in family planning is being provided in 27 countries. One must ask how adequacy is measured. It may be adequate by the standards of the barefoot doctors of the underdeveloped countries but not adequate by other standards. Family doctors in the Kings College district may be both relieved and surprised to read that a doctor was on call for problem discussions and visits. Is one to assume that a 24-hour domiciliary visit service is available to deal with emergencies when the clinic is closed? Another point of legal importance should be made clear. The nurses dispense contraceptive pills. They cannot prescribe them. These pills must have been prescribed by a doctor who would have to pay in the case of a successful claim for damages arising from the administration of these drugs.

In 1970 I consulted my defence society and

was advised not to "cover" a "specialist midwife" who was proposing to insert IUCDs as part of the domiciliary service provided by the local branch of the Family Planning Association. I presume the same advice would still be given. I do not think that nurses should be allowed to insert IUCDs as the complications which inevitably arise might bring this valuable method of contraception into disrepute.

T G E WHITE

Croydon, Surrey

Antibiotics again

SIR,—Your leading article (8 May, p 1107) disapproves of the fact "that chloramphenicol continues to be prescribed for illnesses other than typhoid fever." If this remark discourages use of chloramphenicol in haemophilus meningitis and other life-threatening infections due to *Haemophilus influenzae* Type b it could have serious consequences.

In their 1967 leaflet about chloramphenicol the Committee on Safety of Drugs stated: "It is a highly effective drug in typhoid fever and in *H. influenzae* meningitis. In these conditions its advantages outweigh its dangers." Since then the case for using ampicillin (the only serious alternative to chloramphenicol) for treatment of haemophilus meningitis has been weakened by reports of its failure to eradicate the infection in some cases despite normal ampicillin sensitivity of the organism[1]; of more rapid resolution of signs of infection when chloramphenicol is used[2]; and of cases of meningitis due to β-lactamase-producing (and therefore ampicillin-resistant) strains of *H influenzae*.[3]

I hope to publish soon laboratory data supporting the suggestion that chloramphenicol is more effective than ampicillin against *H influenzae* Type b in circumstances which may well be relevant to conditions in the meninges in haemophilus meningitis. Available information suggests that children with haemophilus meningitis and similar severe haemophilus infections who are given ampicillin rather than chloramphenicol may not improve as rapidly as they should, may relapse, or may (if they are unfortunate enough to have an ampicillin-resistant haemophilus) die from lack of effective treatment. In these circumstances I must sharply disagree with the reprimand implied in your leading article.

D C TURK

Bacteriology Department,
Gibson Laboratories, Radcliffe Infirmary,
Oxford

[1] Kandall, S R, Davis, T C, and Abramowicz, M, *Clinical Pediatrics*, 1972, **11**, 264.
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Devolution

SIR,—As a prospective Plaid Cymru parliamentary candidate I found that the transcript of your conference on devolution (8 May, p 1127) brought out some very interesting points.

Relating specifically to medicine, there are two points I would like to emphasise. Firstly, the medical service in Wales, in common with many parts of England, is grossly over-dependent on medical staff from other countries. Any suggestion that we could not plan our health service better than at present is quite laughable when one considers that our own doctors are frequently in a minority in our own hospitals. Such a situation would be quite unacceptable in any other country except possibly in the Third World, and then it would undoubtedly only be on a temporary basis. I have greater faith in the ability of the medical world in Wales to plan for this relatively small country in a more efficient manner and with greater foresight than the Elephant and Castle has done for the UK in the past and to develop such a service without constant political interference.

The other point I would wish to lay before the doubters of devolution is the important one of pay differentials arising in a devolved UK. My only comment here is that I should hope they would. Ironically, in *General Practitioner* the same week as the seminar it was shown that general practitioners in the UK are now the poorest in Europe. Even Ireland is apparently now in a position to offer medical staff a better deal than in the UK.

Things could hardly be worse in the Health Service than they are at present. There is a lack of confidence which I have not experienced previously and which I believe will be righted only as and when we have devolution and a system of government which is readily answerable to the people it serves. A self-governing Wales with its rightful priorities would indeed not only benefit Wales but help England to find its true role as a partner in Europe. A recent decision of the London Government, for example, to invest in 600 new multirole combat aircraft, despite our economic problems, at an average cost of £5m each smacks of imperialistic grandiosity. That age is gone if for no other reason than that the UK cannot afford such priorities, and I am convinced that this is the opinion of the vast majority of the English people too.

In the Western developed world many of our social problems arise through a lack of identity and rootlessness. In Wales particularly there is a very rich tradition of community. This can be enhanced only by relating this tradition to the ideal of full nationhood status for our country.

Of one thing we can be certain: the next five years will be very exciting ones for our respective countries.

CARL IWAN CLOWES

Llanaelhaearn,
Gwynedd

SIR,—Your discussion of devolution (8 May, p 1127) contained data on the under-financing and under-staffing of English hospitals which look even more remarkable on recalculation per caput.

Per head of population Scotland in 1973-4 compared with England had 17% more family doctors, 23% more nurses and midwives, and 54% more hospital doctors, and this year each Scot is to be allowed 23% more money on total health services than each Englishman.

J H BARON

London NW8

Oestrogens as a cause of endometrial carcinoma

SIR,—We have read your leading article (3 April, p 791) and related correspondence with considerable interest, for, like many other gynaecologists who were initially conservative towards oestrogen replacement therapy, we have come to appreciate the benefits that can be afforded to patients with climacteric and post-menopausal disturbances and have become "moderates," supporting some symptomatic therapy. Like other clinicians we have also been perturbed by the reports[1 2] from America suggesting that such therapy might be associated with an increased risk of endometrial carcinoma and have noted the criticisms of these studies by Mr J W W Studd (8 May, p 1144). His comments relating to the retrospective nature of these reports and the need for an independent review of the relevant histology seem particularly apposite. With regard to inadequate socioeconomic matching being a confounding factor, however, in the series of Ziel and Finkle[2] patients and controls were matched for areas of residence and one wonders therefore whether such socioeconomic groupings in this report were that unbalanced.

We note the reservations in your leading article on the value of administering progestational compounds with oestrogen therapy in hormone replacement regimens, but the results of treatment of persistent endometrial hyperplasia with progestogens by such authorities as Wentz,[3] Kistner, [4 5] and Taylor[6] and their effectiveness in causing regression of an endometrial state that many authorities believe antedates uterine carcinoma make the concomitant use of progestogens a very pertinent consideration. The observations of Dr E Schleyer-Saunders (8 May, p 1145) give further support to the adoption of an oestrogen-progestogen regimen and a sequential form of replacement therapy has been commonly favoured by Mr Studd[7] and other authorities.

The need for continued vigilance even with an oestrogen-progestogen mode of treatment nevertheless is emphasised by a small number of cases of endometrial carcinoma reported in patients taking oral contraceptives of both the sequential and combined forms.[8 9] It has been postulated that such patients may have localised "islands" of endometrium refractory to

	England	Wales	Scotland	Excess, Scotland *v* England
£/head population 1973-4 and 1975-6				
Central administration	0·45	0·41	0·44	−2%
General medical services	4·05	4·1	4·4	+9%
Personal social services	10·2	8·9	7·6	−25%
Hospital services	36·6	36·4	46·9	+28%
Total health services budget 1973-4	65·3	56·4	65·6	+1%
Estimated health services budget 1975-6	79	82	97	+23%
Health Services Staff per million population				
Hospital doctors	551	521	848	+54%
GPs (including assistants and trainees)	485	490	568	+17%
Community physicians	28	98	59	+110%
Hospital nursing and midwifery	6869	6385	8483	+23%