Department, Middlesex Hospital. President, Socialist Medical Association. Chairman of Board of Governors of Hammersmith, West London, and St. Mark's Hospitals Group. Chairman of London County Council, 1944–5, and previously chairman of its Hospitals and Medical Services Committee.

*CHARLES HILL, Luton, Liberal-Conservative. (1927).

M.P. for Luton since February, 1950. Secretary, British Medical Association, 1944–50. President, World Medical Association, 1949–50. Vice-president, and formerly chairman, Central Council for Health Education.

BERNARD HOMA, Hendon South, Labour. (1922).

In general practice. Honorary Anaesthetist, German Hospital, Dalston.

*SANTO WAYBURN JEGER, Holborn and St. Pancras South, Labour. (1923).

M.P. for St. Pancras South-East from 1945 to 1950; Holborn and St. Pancras South from 1950. Practises in London and has taken a prominent part in local government in Shoreditch.

*HYACINTH BERNARD WENCESLAUS MORGAN, Warrington, Labour. (1909).

Advisory medical officer, Union of Post Office Workers, and adviser and consulting specialist, industrial diseases, Trades Union Congress. M.P. for Warrington since February, 1950; previously sat for Camberwell North-West and Rochdale. Member, B.M.A. Council.

DYFRIG HUWS PENNANT, D.S.O., Pembroke, Liberal. (1912).

Member, Welsh Regional Hospital Board; Chairman, Carmarthen Mental Hospitals Group; Examiner and Honorary Life Member of the Order of St. John of Jerusalem. Former Chairman of South-West Wales Division of B.M.A.

*MALCOLM STODDART-SCOTT, O.B.E., T.D., Ripon, Conservative (1926).

M.P. for Ripon since February, 1950; previously sat for Pudsey and Otley. On medical staff of General Infirmary at Leeds, 1929–39. A.D.M.S. 48th Division, 1943–5. Chairman, British Rheumatic Association.

*BARNET STROSS, Stoke-on-Trent Central, Labour. (1925).

M.P. for Hanley Division of Stoke-on-Trent from 1945 to 1950; Central Division since 1950. General practitioner, Stoke-on-Trent.

*Rt. Hon. EDITH CLARA SUMMERSKILL, P.C., Fulham West, Labour. (1924).

M.P. since 1938 and Parliamentary Secretary to the Ministry of Food from 1945 to 1950, when she was appointed Minister of National Insurance.

JOHN RICHARD TIMMIS TURNER, Crewe, Conservative. (1936).

General practitioner, Nantwich.

Correspondence

New Voluntary Hospital for Kingston

SIR,—In the next few days most doctors in active practice will receive a letter (see *Supplement*, page 126) asking them to subscribe to the foundation of a new voluntary hospital for Kingston and Malden. We are emboldened to address this appeal to the whole medical profession for the reason that, although the immediate issue is a local one, the implications of the scheme may affect doctors everywhere.

Before 1948 large hospitals, both municipal and voluntary, were managed by bodies of local citizens who were aware of local conditions and needs, and who usually gave due weight to the views of their medical staffs. In addition, most rural and a large number of urban areas possessed hospitals of the cottage type where general practitioners could attend their own patients. We in Kingston had a hospital which had developed a little further from the latter class, in that it had a full consultant staff holding regular sessions and functioned in all respects as a general hospital, save that instead of residents the routine care of the patients was in the hands of their general practitioners. Its closure after a remarkable struggle to preserve it was deplored by the whole district.

There seems no reason why these arrangements should not have continued under nationalization, but in fact the hospital services are controlled by regional boards governing far too wide an area to be cognizant of the needs of particular institutions and districts, assisted by group management committees—nominated, not elected, bodies—who, judging by our own group, are permitted to have very little real power.

At the same time, as larger hospitals become governed by remote control the smaller ones seem destined to cease to exist, and, since they are the only places where the two great divisions of medicine—hospital and general practice—meet and truly collaborate, this would seem to be a most retrograde step.

If we succeed, as we have every confidence we shall, in making the Kingston and Malden Victoria Hospital rise from its ashes on a voluntary basis, we shall have established the principle that such hospitals ought to exist, set up a model which might well be copied in future developments of the National Health Service, and might even initiate administrative reforms that would make a healthier Health Service everywhere.

Cheques may be sent to the Hon. Treasurer, Dr. Desmond de Launay, 9, Coombe Rise, Kingston Hill, Surrey.—I am, etc.,

Kingston-on-Thames. F. B. LAKE.

Sulphamerazine Dangerous

SIR,—I was very interested in Dr. E. C. Atkinson's letter (September 15, p. 674). Since January, 1951, at the Department of Child Health, Cardiff, we have had four cases of haematuria with oliguria or anuria following the use of a sulphamerazine suspension. Brief details of these cases are given:

Case 1.—A girl aged 5 years developed respiratory infection. Given the suspension for six days before admission: dose two teaspoonfuls twice daily. Child drank little. Day before admission passed small amount of blood-stained urine. Almost complete anuria for two days. As no urine was obtained until diuresis started, sulphonamide crystals were never seen.

Case 2.—A boy aged 2 years 8 months. Given the suspension for bronchitis. Dose, one teaspoonful four-hourly for four days. Two days before admission passed blood in urine, but drug continued for a further two days. Developed anuria for two days. Urine contained many sulphonamide crystals. Blood urea rose to 70 mg. %.

Case 3.—A boy aged 4½ years. Given the suspension during the initial phase of measles. His mother used an old bottle of the medicine which she says was "rather thick at the bottom." Haematuria and oliguria developed.

Case 4.—A boy aged 6½ years. Given the suspension for a respiratory infection. He developed haematuria and oliguria.

Despite the manufacturers' clear instructions that for children the drug should be given at 12-hourly intervals, it is often prescribed more frequently. Also, sick children often have a poor fluid intake with consequent danger of urinary concentration; and failure to shake the bottle well results in the last doses being stronger than they should be. I can therefore support Dr. Atkinson's plea that the use of sulphamerazine suspensions should be queried when there are safe alternatives available.—I am, etc.,

Cardiff. JOHN RENDLE-SHORT.

SIR,—I was particularly interested to read Dr. E. C. Atkinson's letter on the dangers of sulphamerazine (September 15, p. 674), in view of the fact that only the night before I had been called out to deal with the following case. I had been treating a well-developed woman of 45 for *B. coli* cystitis with sulphamerazine. She had received an initial dose of 2 g. and thereafter a six-hourly dose of 1 g., which was continued for five days. Forty-eight hours after taking the last dose she was seized with violent pain in her right inguinal region passing backwards into her lumbar region, suggesting the passage of a renal calculus. Next morning the right kidney was a little tender on palpation. There was no history of a previous attack. I have no doubt that her symptoms were due to the passage of crystals of sulphamerazine, and that, had this occurred on a somewhat larger scale, symptoms of ureteric block would have supervened.—I am, etc.,

London, S.W.7. NIGEL LORING.