To check everything oneself seems pedantic, and many anaesthetists using familiar equipment in well-staffed theatres take correct function for granted, with a confidence matching that with which they drive off in their cars each morning without investigating oil and water levels. The mistake described did not have dangerous consequences but shows how careful it is necessary to be. If there had been an accident the anaesthetist would have faced H.M. Coroner.—I am, etc.,

Bramhall. R. N. SIDEBOTHAM.

Pseudo-medical Advertising

SIR,—As medical adviser to an advertising agency, I was very interested to read Dr. R. E. Dawson's comments in your correspondence columns on "pseudo-medical advertisements" (*Journal*, June 21, p. 1482). I think that he is being unnecessarily harsh on advertisers. Most large advertising agencies employ a medical adviser, who is consulted whenever the question of claims in the medical field for any product arises in connexion with advertising. Most manufacturers of medical or semi-medical products also have their own scientific advisers, and, very frequently, qualified medical advisers as well. Moreover, there are bodies whose job it is to examine claims made by advertisers, and these bodies have laid down strict rules and codes of standards which are accepted by the majority of newspapers, magazines, and other publications, as well as television interests and by far the majority of service advertising agencies. It is therefore practically impossible for exaggerated benefits to be claimed in normal advertising channels for "useless products." In addition, in the highly competitive commercial conditions applying to-day, such products would not be handled by reputable advertising agents nor would responsible retail outlets accept them for sale.

In my opinion, the public will always buy tonics, vitamins, pain-killers, and indigestion remedies because they would rather pay for them than queue in their doctors' overcrowded surgeries. If they were not aware of the availability of these products, I would hate to think what number of extra patients would waste their G.P.'s time for minor ailments. It is of course quite natural and surely not unreasonable that a manufacturer should, in his advertising, seek to bring before the public the advantages which his product enjoys over those manufactured by his competitors.—I am, etc.,

Guildford. DICK GLOVER.

Calcium and Phosphorus Metabolism

SIR,—There are several points in the article by Dr. G. L. Mouzas (*Journal*, June 14, p. 1385) which conflict with my experience of calcium and phosphorus metabolism in 230 patients with renal calculi.[1 2]

Dr. Mouzas states that only four of his patients had parathyroid dysplasia. He apparently requires to have both an elevated serum calcium and a low serum phosphorus, and hypercalciuria, to make the diagnosis of hyperparathyroidism. I have found no single test which is a satisfactory test of parathyroid function, but this does not mean that hyperparathyroidism cannot be present unless all these abnormalities are found, as Dr. Mouzas seems to imply. I have observed patients with hyperparathyroidism in whom only one of these abnormalities was present. Hypercalciuria disappears and the serum phosphorus rises again with the onset of renal failure, and in these patients a raised serum calcium may be the only biochemical sign of hyperparathyroidism. In almost all patients with hyperparathyroidism who are followed up for a sufficiently long period before operation both the serum calcium and serum phosphorus values fluctuate, the lower values often falling within the normal range. Dr. Mouzas regards a raised serum calcium alone as being of no significance. An elevated serum calcium is always pathological and deserves the most careful investigation to discover its cause. Quite apart from the tendency for these patients to form calculi again, the hypercalcaemia causes renal damage. I also have noticed the frequency with which a low serum phosphorus occurs amongst calculus patients. Occasionally a low serum phosphorus may be the only sign of hyperparathyroidism, although there are other causes of disturbed phosphate metabolism.

It is difficult to interpret Dr. Mouzas' figures for phosphate/creatinine and calcium/creatinine ratios, because the headings of his Table III appear to be transposed. He has shown by 24-hour calcium excretion studies that all patients with a calcium/creatinine ratio above 0.3 had hypercalciuria. It cannot be claimed that this ratio is an effective screening test unless it can also be shown that values below this figure were not associated with hypercalciuria. I note that in seven of his patients the value of the serum alkaline phosphatase is above the upper 1% range, although he states in the text that all were within normal limits.

I think that his interesting group of patients merit further study.—I am, etc.,

Belfast. MARY G. MCGEOWN.

REFERENCES

[1] McGeown, M. G., and Bull, G. M., *Brit. med. Bull.*, 1957, **13**, 53.
[2] —— *Clin. Sci.*, 1957, **16**, 297.

*** It is regretted that in the headings of the ninth and tenth columns of Dr. Mouzas' Table III Ca/Cr and PO_4/Cr were accidentally transposed, as Dr. McGeown points out. —ED., *B.M.J.*

Rheumatology as a Whole-time Specialty

SIR,—Dr. L. Mandel (*Journal*, June 21, p. 1482), referring to the treatment of the rheumatic diseases, stresses that the doctor must be trained "to treat the patient as a whole, and not the disease or local disability." His conclusion that treatment should be organized by a system of dual control seems, however, unlikely to achieve this object.

This approach to the problem is absurd, in this country at any rate. Consultants in physical medicine are now required to hold a higher medical degree in addition to the specialist diploma. A long training in both general medicine and physical medicine is necessary before senior status is attained. In fact, whether Dr. Mandel likes it or not, physical medicine is the specialty best suited to deal with the rheumatic diseases under the N.H.S., and, in view of the magnitude of the problem, it is hoped that the establishment of physical medicine specialists will soon be increased in order to provide adequate cover for the whole country.—I am, etc.,

Broadstairs, Kent. R. W. BARTER.

Undescended Testicles

SIR,—I was extremely interested in the paper on the results of hormonal treatment of the undescended testis by Drs. J. Brunet, R. R. de Mowbray, and P. M. F. Bishop (*Journal*, June 14, p. 1367). At the time of passage of the testis through the inguinal canal in normal descent a marked lengthening takes place in the cord without which the vas deferens would be too short to permit such a movement. The remaining testicular descent process—i.e., from the neck of the scrotum to its floor—is brought about by lengthening of the cord, particularly of the vas deferens and cauda epididymis, and of the pars vaginalis gubernaculi (which includes the cremaster muscle). These changes would appear to be under the influence of gonadotrophic hormones, either directly, or indirectly through the testis due to its androsteroid production, and the clinical results published in this paper are essentially in agreement with these views. So long as the mesenchyme of the gubernaculum testis has not been involved by fibrous tissue, which would prevent normal growth changes and anchor the testis or its covering in an abnormal manner, there seems no anatomical reason why hormone treatment should not produce the results quoted.

Mr. Denis Browne's objections to hormone treatment (*Journal*, June 28, p. 1541) do not appear to be based on the anatomy of normal testicular descent. It is unfortunate,

therefore, that he should accuse the endocrinologists of just such a lack of knowledge. As I commented last year on certain of Mr. Browne's anatomical views (*Journal*, June 15, 1957, p. 1420) I do not propose to repeat myself needlessly. I would, however, in all fairness to Mr. Browne, agree that the anatomical criteria put forward by Dr. Brunet and his co-workers would sometimes be difficult to substantiate, as they themselves admit. I would suggest that the important criteria for hormonal treatment of testicular maldescent are that the testis should be somewhere on the track of normal descent and not anchored peripherally. A testis found in Browne's "superficial inguinal pouch" is off the normal course of descent and therefore not likely to descend under the influence of hormones. The difficulty, however, appears to be that of diagnosing accurately when a testis is or is not on the correct line of testicular descent when in the external inguinal region.—I am, etc.,

London, W.C.2. K. M. BACKHOUSE.

Fatal Haemorrhage from Superficial Varix

SIR,—In our local newspaper recently a 30-year-old mother of five children was reported to have bled to death from a varicose vein in her leg. This recalled a similar death of which I had heard years ago. A tourniquet in that instance had been applied by a lay person between the heart and the hole in the vein. On hearing of another fatality, I wondered if the same mistake had again been made. By courtesy of Dr. L. Manoim, the coroner's pathologist, I was able to see the necropsy.

The body was that of a young woman about seven months' pregnant. The pale skin, pale mucous membranes, and pale organs made plain that blood loss had been severe. Her left leg was swollen. Both her lower limbs showed varicose veins, and many of these varicosities were particularly superficial, even protuberant. About 8 in. (20 cm.) above the left lateral malleolus there was a small opening into one of these extremely superficial varicosities. This opening was only of about one-tenth of an inch (2.5 mm.) in diameter. From a vein above and below it the pathologist expressed blood on to the skin through the hole. Microscopy gave evidence of ulceration at this site.

Her husband and her friends had said that through this small venous opening she had bled to death. They had applied some home-found tourniquets, towels, handkerchiefs, even bed sheeting around the leg above the hole in the vein. They thought this was the correct site for tourniquets, but, no matter how hard they had tried to compress the leg with their tourniquets, the bleeding had continued until she died.

To return to the consulting-room, patients sometimes ask if their varicosities will bleed. The chance of this is usually so small that mostly the medical attendant will be justified in giving an assurance: but, while operation is being arranged for those who require it, any who have particularly vulnerable veins can be told what to do if bleeding should occur. They should *apply pressure directly to the bleeding point*. The danger of ignorance in this matter is shown by the fate of two persons. To each a tourniquet had been applied between the heart and the hole in the vein. Such "first-aid" measures by part-trained or untrained persons are understandable, but so are the fatal results.—I am, etc.,

Launceston, Tasmania. W. W. WOODWARD.

Male Homosexuality

SIR,—I was most interested in the excellent article entitled "A Factual Study of Male Homosexuality" by Dr. R. E. Hemphill, Dr. A. Leitch, and Dr. J. R. Stuart (*Journal*, June 7, p. 1317). It was encouraging to find that others had quite independently come to almost the same conclusions as I had myself. As the authors state that "there is surprisingly little factual literature dealing with homosexuality," it would seem that my paper,[1] which would come into this category, has escaped the notice of those interested in psychological and social medicine, no doubt owing to its title, "Venereal Disease and the Homosexual," and to the fact that it was published in a journal mainly concerned with venereal diseases. In it, among other things, I analysed the life histories and sexual *mores* of 54 male homosexuals attending a V.D. clinic. My patients differed from those of Dr. Hemphill and his colleagues in that they were free young men-about-town who were contented with their mode of life and were not in any legal or psychiatric trouble. The only significant difference between their findings and mine seems to be that my patients were attracted to adult or adolescent consorts and were not interested in having sexual relations with small boys.—I am, etc.,

London, W.2. F. J. G. JEFFERISS.

REFERENCE

[1] Jefferiss, F. J. G., *Brit. J. vener. Dis.*, 1956, 32, 17.

Occupational Diseases of Musicians

SIR,—In reply to the letter by Dr. M. Anderson (*Journal*, July 5, p. 51) and for the information of others who may be interested, there is a good deal of literature on the occupational diseases of musicians. There is indeed a monograph by Kurt Singer, who was both a specialist in neurology and the music critic for the *Berlin Vorwärts* and who lectured regularly at the Academy of Music in Berlin on the diseases of professional musicians. This was translated from the German by Vladimir Lakond and published by Greenberg in New York in 1932 with the title "Diseases of the Musical Profession: A Systematic Presentation of Their Causes, Symptoms, and Methods of Treatment." There are also numerous articles, the references for which can be obtained from the *Index-Catalogue of the Surgeon-General's Library* and from the *Quarterly Cumulative Index Medicus*.—I am, etc.,

London, N.W.1. F. N. L. POYNTER.

Iatrogenic Disease

SIR,—Your issue of June 21 opens with an article by Dr. John W. Dundee entitled "Iatrogenic Disease and Anaesthesia (*Journal*, June 21, p. 1433). I supposed that I was to read of asthma, say, or rheumatoid arthritis or some other disease that by its length and refractoriness provides sustenance for honest doctors, for iatrogenic means "doctor-begetting," just as carcinogenic means "cancer-begetting," and erogenic "love-begetting." But the learned author defines his word as a malady or an abnormal state produced by physicians. A similar mistake, for such I suppose it to be, is made with the word psychogenic, which means "soul-begetting," not "soul-begotten," as usually intended. I suggest that the word γεννητός (gennētos) is the right suffix, meaning "begotten of"—for example, "Among those born of women (ἐν γεννητοῖς γυναικῶν) there hath not risen a greater than John the Baptist."

For a disease, then, born of a doctor we may write iatrogennete, but we should not write iatrogenic nor yet iatrogenetic.—I am, etc.,

Orpington, Kent. H. ST. H. VERTUE.

Mortality and Morbidity of Steroid Therapy

SIR,—Dr. Michael Kelly in his letter to you (*Journal*, July 5, p. 50) condemns steroid therapy for arthritis, and to prove his case quotes a number of references, including one from myself. I am misquoted as reporting 6 deaths in 90 patients as due to steroid therapy, whereas I commented that one death followed a car accident and two were from carcinoma. One wonders whether his other references are equally inaccurate.—I am, etc.,

London, S.W.1. OSWALD SAVAGE.

Alfred Russel Wallace

SIR,—Dr. F. N. L. Poynter's article on the centenary of the Darwin–Wallace paper on natural selection (*Journal*, June 28, p. 1538) appeals to me, as I have always been an admirer of these two. The following is a note of a visit I made to Alfred Russel Wallace on March 1, 1905.

While doing a locum at Broadstone I was called to the house to see a servant. Asked Mrs. Wallace if they did not once live