

One would expect a little more independence and fairness from a leading medical journal with a very high standard.—I am, etc.,

Birmingham 13.

D. R. PREM.

\* \* Dr. Prem is mistaken in thinking we criticized (July 14) the "A.M.A. for their opposition to socialized medicine." What we criticized was the "vulgarity and cheapness of its past and present attacks on the National Health Service" and the "misrepresentation of what is happening in Britain." But we questioned whether admitted abuses in the U.S.A. "call for such a violent corrective as 'socialized medicine.' . . ." Our Canadian colleagues will be interested to note that Dr. Prem regards the Saskatchewan scheme as "socialized medicine." The decision not to advertise in the *B.M.J.* medical vacancies in Saskatchewan was taken by the British Medical Association.—ED., *B.M.J.*

### Steroid Therapy

SIR,—In order to evaluate the effect of steroid therapy in any disease state it is necessary to know both the name of the steroid and the dose that has been given. Everyone is aware of this, yet hardly a week passes without someone transgressing in our weekly journals. This week's example is from Dr. B. S. Smith (July 7, p. 55), who attributes a failure to diagnose pyoarthrosis and multiple fractures to the administration of methyl prednisolone (no dose) and quotes others as saying that fractures may be painless when associated with steroid therapy (neither name nor dose). There are now more than seven classes of steroids in clinical use, and to evaluate therapy in each class it is essential to know the precise compound used and the dose (quantity, duration, and route of administration). Family planning clinics are now giving steroid therapy and issuing steroid cards.

At this centre, using maintenance doses of prednisolone of 7½ mg. to 10 mg. daily, we find fractures and infected joints both painful and very tender.—I am, etc.,

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### Sarcoma from Iron Injections

SIR,—I read Dr. J. Fielding's paper (June 30, p. 1800) with interest and pleasure. However, he criticizes some of my ideas on the origin of these sarcomas, and while this is a minor point, perhaps I may be allowed to reply to him.

He states that any views on pathogenesis should include an adequate explanation of the distribution of iron in the tumours, and contradicts my suggestion that the cells containing iron at the site of injection are those responsible for subsequent tumour formation.<sup>1,2</sup> My own interpretation is perhaps too simple, but I attribute the scarcity of iron in the tumour cells to the continued division of neoplastic iron-containing cells with subsequent sharing of the iron content by their progeny, and consequent diminution or loss of iron-staining. In the early stages of iron-dextran-induced sarcoma electron microscopy<sup>3</sup> has shown the presence of small amounts of iron in the cytoplasm of the neoplastic spindle cells which develop in the masses of siderophages, a finding which is quite compatible with my interpretation. The histiocytes no longer interest themselves in the uptake of iron when malignancy is established,<sup>4</sup> a change which is also seen in the malignant liver cells in hepatoma supervening on haemochromatosis. Miller and Miller<sup>5</sup>

drew attention to a similar occurrence in the liver cells of rats receiving the carcinogenic azo-dye, butter yellow; the binding power of the liver falls as tumours are about to develop, and the tumours themselves cannot bind the dye. Is it not possible that the malignant histiocytes in experimental sarcomas induced by iron-carbohydrate lose their ability to bind and store iron in a similar fashion?

The use of the term "histiocyte" may be wrong, as it is employed here only as a convenient label for iron-containing cells at the site of injection in this particular experiment. Many different types of cell fed with iron-dextran in tissue-culture can be made to store iron in their cytoplasm.<sup>6</sup>

It may be fair to point out that my histological observations in favour of tumour origin in cells heavily overloaded with iron were based on the study of 40 tumours, and included biopsy material on animals which subsequently developed sarcoma. The observations in Dr. Fielding's paper are based on five tumours at the site of injection.—I am, etc.,

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### REFERENCES

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- 2 ——— *Cancer Progr.*, 1960, p. 24.
- 3 Muir, A. R., and Golberg, L., *J. Path. Bact.*, 1961, **82**, 471.
- 4 Richmond, H. G., M.D. Thesis, University of Aberdeen, 1958.
- 5 Miller, J. A., and Miller, E. C., *Advanc. Cancer Res.*, 1953, **1**, 340.
- 6 Richmond, H. G., *Brit. J. Cancer*, 1961, **15**, 594.

### Old Folk in Wet Beds

SIR,—Dr. J. L. Newman's paper (June 30, p. 1824) is a stimulating contribution to the understanding of urinary incontinence in the elderly.

Any geriatrician of experience (I do not refer to those who "don't have any problem with incontinence") will be able to confirm Dr. Newman's views that incontinence is often apparent rather than real, and that when it is real it is due to an organic lesion, to psychological stress, or to severe dementia. Psychological stress of one sort or another would appear to account for a high proportion of cases, and it is in enumerating the types of stress, and in pointing to the possible psychological mechanism involved, that Dr. Newman's paper is so valuable.

Old people become "set in their ways" and tolerate change badly. We accept this. Do we accept that life in hospital differs in a quite extraordinary way from life outside the hospital? Or have we become so used to it that we have forgotten? If we have forgotten, then we cannot appreciate the stress suffered by an old person in being transported abruptly from the one to the other.

To be cynical, one might feel that some geriatric long-stay wards were designed specifically to produce the social degradation which Dr. Newman suggests is so important. Patients are attired in clothes drawn, presumably, from some inexhaustible stock inherited from the Victorian workhouses and thus conform to a voluminous and sloppy uniformity. Lest they should soil these garments with food, each is adorned with a bib well in advance of each meal, and as some may not have the full use of both hands, all are provided with spoons and bowls so that they may shovel their food into their mouths with safety. Some years ago a psychiatrist suggested to me that incontinence in many