African rural population (10 July, p. 111) will come as a shock to those who may have changed from moderate cigarette smoking to pipe smoking as a preventive measure. Contrasting the relative lung-cancer death rates for (1) smokers of up to 20 cigarettes a day and (2) pipe smokers in his survey and that of Hammond and Horn[1] in America gives the following results:

	Lung-cancer Mortality Compared with that of Non-smokers		Lung-cancer Mortality Compared with that of the Total Average	
	Cigarettes 1–20 a Day	Pipe Only	Cigarettes 1–20 a Day	Pipe Only
Hammond and Horn's study of white Americans aged 50–69 (1952–5)[1] ..	793%	301%	149%	57%
Dean's study of white South Africans aged 45–64 (1947–60)	186%	486%	43%	113%

The South African pipe smoker's risk works out at 261% of that of the moderate cigarette smoker, whereas in America it is only 38%. Incidentally, Dr. Dean's figures only show mortalities of smokers of up to 20 cigarettes a day and of smokers of 25 or more. Unless this is a misprint it leaves an astonishing loophole.

In view of this and many other contradictions in the published statistics of the relationship between smoking and lung cancer may I renew my urgent plea for a fresh retrospective investigation of all the possible factors involved in every recorded case of lung cancer in this country? This can only be carried out by a programme of research under official auspices, and should record not only the smoking habits but details of residence and occupation so as to provide a means of estimating the patient's exposure to diesel fumes and other forms of air pollution as well as to various types of tobacco smoke. Carcinogens in urban atmosphere must be analysed and traced quantitatively to their sources.

The present controversy over the cause of the increase in lung cancer is based on speculative evidence, and one can prove almost anything by selecting the right set of figures. The only reliable conclusion that can be drawn at the moment is that those who breathe air unpolluted by either tobacco smoke, diesel fumes, or other forms of atmospheric contamination seem to have a relative immunity from the disease, and the only justifiable recommendation to the public would be to avoid them all as far as possible.

Propaganda against the cigarette has been on a gigantic scale—with very little result—whereas warnings about the dangers of diesel exhaust have been suppressed or ignored. The death rate from lung cancer is still rising inexorably, and the responsibility of those in control of our national public health policy cannot be evaded.—I am, etc.,

GEOFFREY MYDDELTON.

Henley on Thames, Oxon.

REFERENCE

1. Hammond, E. C. and Horn, D., *J. Amer. med. Ass.*, 1958, **166**, 1294.

Phenindione Toxicity

SIR,—An eczematous reaction to drug therapy is unusual but probably is seen most often with gold, penicillin, and streptomycin. From Dr. E. K. M. Smith's report (3 July, p. 24) and from my own recent observations it might seem that phenindione should be added to this list—although other skin manifestations of toxicity, including pruritus without rash, urticaria, purpura, and necrotic lesions, are better known.[1]

I have seen three women in-patients aged 32, 45, and 60 who had an itchy eczema of sudden onset with obvious erythema and scaling that affected predominantly the scalp, ears, eyelids, axillae, groins, and natal cleft. None had a past or family history of eczema. In spite of stopping phenindione in two of them, the eruption persisted and was only partly suppressed by topical corticosteroids.

Eczema may be an important early sign of phenindione toxicity, because the rash may precede other toxic manifestations, such as those due to damage to kidney, liver, and bone-marrow. For example, the woman aged 45 had had the rash for a week in hospital before the "drug fever" appeared. The drug was stopped a few days later. After a further week oliguric renal failure was diagnosed.—I am, etc.,

P. W. MONCKTON COPEMAN.

Skin Department,
Westminster Hospital,
London S.W.1.

REFERENCE

1. Perkins, J., *Lancet*, 1962, **1**, 125, 127.

Africa's Needs

SIR,—Dr. S. McClatchie (10 July, p. 109) is right to stress the need for doctors of any specialty or in general practice to do basic work under difficult conditions; re-orientation of training of African students to their special needs and increasing supply of technicians are beyond dispute.

The need for medical care is so great that it may never be met, but there must surely be room for any doctor or specialist for any reasonable time, doing any type of medicine, sent by any organization; and any one, particularly the young, helping in this manner will benefit and mature from meeting Africa's challenge, however humble his efforts.—I am, etc.,

Windsor, Berks. ROY MAUDSLEY.

SIR,—As one who has spent the whole of his professional life in Africa, I have with some interest read the contributions in the *B.M.J.* on Africa's needs.

First may I endorse the practical approach of Dr. S. McClatchie (10 July, p. 109), especially his plea that the flying visits of experts be replaced by more practical visits. As one who has benefited from overseas visitors may I say how very useful their visits are, but only if the expert is willing to stay a while. Much of "Africa's medicine" is carried on in small rural hospitals, often under almost primitive conditions—it is to these places that experts should come and show in a practical way how their skills can be used and applied.

Having said this, it must, of course, be added that "the short-term doctor," be it even for a year or two, is not the real answer to Africa's needs—we need men and women who will devote their professional life to the service of Africa. The spirit of service, sacrifice, and adventure has always been one that has been associated with the British way of life and its expression more particularly in Christian service. There is unlimited opportunity in the medical field in Africa now, as there has always been, if we can match it with the men and women to respond to the challenge.

There are no branches of medical skill that cannot be used to the full and there are many fascinating medical problems that are waiting to be investigated. Burkitt in his classical studies on lymphoma has shown the way, and there are many other similar problems which need only the application of a ready mind to be brought to light.

The standards of medical practice are going to be set in Africa in the next 10 years, and the lead of devoted men is needed to see that what has been begun by men of the past is not lost now that the reaping time has come.

The Government and mission medical services in Africa realize that perhaps the most urgent needs are those of training, and here, too, are needed men of talent, skill, and devotion. We have many fine institutions in Africa, but the training of medical, nursing, and technical personnel may well fall below standard if we fail to supply the teachers of highest quality that are so urgently needed.—I am, etc.,

Mvumi Hospital, Dodoma, Tanzania. JOSEPH TAYLOR.

"Medical Directory"

SIR,—The posting of the annual schedule for the *Medical Directory 1966* has now been completed.

It is desired to include in the book the names of all fully and provisionally registered medical practitioners living or working in the British Isles, and also the names of British-qualified doctors living or working abroad. All such practitioners who have not received the annual schedule are asked to communicate at once with the Editor, the *Medical Directory*, 104 Gloucester Place, London W.1, stating full name and year of qualification.—I am, etc.,

Medical Directory, London W.1. B. STANTON.

Points from Letters

"Wriggling Reflex"

Dr. J. LIEBER (London W.1) writes: I was interested in the article "Query Appendix" (17 July, p. 124) and particularly concerning young women where there might be an emotional cause. The late Mr. Ewart, of St. George's Hospital, often demonstrated that in young women where there was an emotional cause, when the abdomen was first palpated, they wriggled. He gave it the name "Ewart's wriggling reflex."

Charges for Patients

Dr. S. SHUBSACHS (Manchester 16) writes: Can anyone tell me why a dentist claiming a N.H.S. fee for treating a tooth with a root abscess, or an N.H.S. optician for glasses, is more in keeping with all the principles of "social justice" than is charging a fee for a boil or a sprained ankle? Does the longer period of shortage of dentists justify the barrier?