old, and both she and her sister-in-law were clear that difficulty in swallowing was her main problem.

The patient looked ill and wasted, and was admitted as an emergency, with a probable diagnosis of carcinoma of the oesophagus. Alternatively, it was considered that she may have had enlarged nodes compressing her oesophagus and causing the dysphagia. In the ward she admitted to frequency, as she had been drinking a lot to try to wash her food down. She also had nocturia. Her pulse was regular at 92 and her blood pressure was 150/80. Apart from wasting there were no abnormal signs. A barium meal report stated, "the oesophagus showed no evidence of obstruction and had normal peristaltic movements, but there is a slight irregularity of the margin extending throughout the whole length—? significance. The duodenal cap appeared normal. There is a small pouch arising from the lesser curve border of the antrum just proximal to the pyloric canal; this may represent ectopic pancreatic tissue," and the chest x-ray was normal.

There was no evidence of diabetic retinopathy or neuropathy. However, she was found to have glycosuria and ketonuria on routine ward testing. Blood sugars were 350 mg./100 ml. and 540 mg./100 ml., and her E.S.R. was 12 mm. in one hour. The rest of her blood picture was normal, as was a midstream urine specimen. Her blood urea was 41 mg./100 ml., bicarbonate 24 mEq/l., potassium 3.9 mEq/l., and sodium 134 mEq/l. A diagnosis of diabetic ketosis was made, and she was started on soluble insulin. Her dysphagia disappeared within hours of controlling her diabetes.

This case is therefore reported as a most unusual presentation of diabetes mellitus.

I am grateful to Dr. H. E. Webb for allowing me to report this case.

—I am, etc.,

L. HERZBERG.

St. Thomas's Hospital,
London S.E.1.

Androgens and Growth

SIR,—The caution displayed by your author in his review of androgens and anabolic steroids (19 April, p. 165) is well founded. I do not share Dr. R. Greene's (10 May, p. 379) optimistic view of the effects of such treatment. That androgens promote skeletal maturation to a greater extent than linear growth has been oft repeated but is not a fallacy. How would Dr. Greene explain the reduction in adult height which is commonly seen in constitutional sexual precocity, or in the simple virilizing form of congenital adrenal hyperplasia which is untreated or inadequately treated?

Many eminent paediatric endocrinologists¹⁻⁴ have expressed reservation about the benefit of androgen therapy in growth disorders. Laron⁵ finds that the degree of response of children to various anabolic steroids varies in an unpredictable manner. Children with primordial or constitutional dwarfism, chondrodysplasia, and gonadal dysgenesis respond poorly. While psychological benefit may be produced by inducing a growth spurt or signs of sexual maturation in a short male with delayed puberty, therapy

should be given only in short 3–6-month courses and treatment should be interrupted for periods of 6–12 months to allow an adequate period of time in which to observe the effects on skeletal maturation.—I am, etc.,

P. H. W. RAYNER.

Department of Paediatrics
and Child Health,
University of Birmingham,
Birmingham 16.

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Sexual Mores and V.D.

SIR,—The reviewer of *Sex and Society in Sweden* (31 May, p. 564), after noting with approval the "enlightened" and "liberal" sexual mores of Swedish society, seems perplexed by the increasing incidence of syphilis and gonorrhoea, especially in teenagers, and also by the increase in illegitimate births and requests for abortion. As an explanation he suggests that "some sort of devil" must be frustrating the good work, or that the above and other disturbing features of Swedish society, such as the high incidence of alcoholism and the highest suicide rate in the world, are merely external manifestations of "hidden internal conflicts." Is not the simpler explanation of some causal interrelation between the various phenomena worthy at any rate of consideration?—I am, etc.,

London W.1.

D. H. PATEY.

Disodium Cromoglycate and Induced Asthma

SIR,—In their letter (10 May, p. 382) Professor J. Pepys and Dr. F. E. Hargreave criticize the (mostly negative) results of Miss Helga Bewersdorff and myself (26 April, p. 220) in our attempt to protect patients against allergen-provoked asthma with disodium cromoglycate. They say our cases F and G should not have been included according to our own standards. We have included attacks lowering the vital capacity by 10 to 20% or the peak flow by 30 to 40%, not "and," as was said erroneously in our paper. We felt justified including these patients, particularly as they became audibly wheezy during their attacks. The variations in our cases I, J, and L, which Professor Pepys and Dr. Hargreave mistakenly regard as evidence of protection, are often seen in bronchial provocation tests. I have carried out such tests since 1948 and regard these variations as normal. The difficulty of judging this is illustrated by our patient D, who seemed to show definite partial protection when given 16.8 mg. cromoglycate, but none when given 8.4 or 33.6 mg. Despite this rather doubtful result we listed him as partially protected.

In the matter of the F.E.V. as a standard measurement of lung function we had referred to an earlier paper.¹ My scepticism is based on the fact that in the asthmatic every forced expiration starting from maximum inspiration is likely to increase bronchial spasm. I have illustrated this phenomenon with a spirometric recording.² Moreover, as is well known, in an asthmatic the forced expiration of coughing usually increases bronchial spasm. The same phenomenon occurs when the forced vital capacity is recorded, and also, to some extent, with the F.E.V. Both are therefore often reduced in asthmatics after the first measurement. Thereafter, they may seem well reproducible, and this is presumably the example Professor Pepys and Dr. Hargreave refer to. But the trouble is that the degree of spasm provoked may change from subject to subject and from day to day. I therefore regard the F.E.V. as a poor lung function test in asthmatics, almost as poor as the maximum ventilatory capacity which was fashionable some years ago but has now been abandoned in the main. The F.E.V. fashion deserves the same fate. In any case, Professor Pepys and Dr. Hargreave would have done well to use a second method as a safeguard—for instance, the peak flow.

Their statement that the coarse-particle powder of cromoglycate they used had, in their hands, a potent inhibitory effect (and therefore must have been working) begs the question and needs no discussion. Both Professor Pepys and Dr. M. C. S. Kennedy (24 May, p. 511) ask for more details of our observations on the five chronic asthmatics. In these patients we attempted to improve lung function with single or repeated doses of cromoglycate aerosol, but had completely negative results in three or four experiments with each subject. We reported this negative result very briefly in order to save space. Whatever results may be obtained with cromoglycate used for several weeks, it seems clear that a beneficial effect cannot be demonstrated in an acute experiment in chronic asthma.

To sum up: The reasons for the differences between our results and those of Professor Pepys and his colleagues are not clear. They found "complete" protection in nine out of 10 patients and partial protection in the tenth. We found complete protection in only two out of 13 and partial protection in one and possibly in two others. There were important differences in the methods of administration, methods of testing, and (except in one patient) different allergens. Other sources of error may be hidden in our ignorance about the mechanism of action of the cromoglycate. It may have been a little disconcerting for Professor Pepys and his colleagues to find that we have had different results, but in the circumstances we must agree to disagree. I hope that this disagreement will lead to a more sober appreciation of this new and interesting substance.

To Dr. J. M. Smith (31 May, p. 574) we reply that patients with mild asthma, who form a great proportion in his investigation, are not suitable for drug trials, as their asthma too often spontaneously improves. As to the coarseness of the cromoglycate particles (Dr. J. S. G. Cox and others, 7 June, p. 634), we have sucked the powder through the spinhaler on to a cover slip and have found microscopically about the same amount of very large conglomerates as when we examined the contents of the cromoglycate capsules. The spinhaler therefore breaks up hardly any of these conglomerates which cannot penetrate into the finer airways. I am not surprised that only 8% of the total amount inhaled is excreted. In contrast, the

aqueous cromoglycate solution which we used in ambulant patients can penetrate as aerosol into the finest airways, and it has blocked the bronchial-provoked reaction in a few cases, as Altounyan³ and we have shown. The aqueous solution is therefore a more reliable means of achieving a blocking effect, if any, and it ought to be used in further trials.—I am, etc.,

Free University,
West Berlin.

H. HERXHEIMER.

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Drug Resistance of Bowel Bacteria

SIR,—In my paper on drug resistance and R factors in the bowel bacteria of London patients before and after admission to hospital (17 May, p. 407) one of the aims was to show whether or not resistant intestinal bacteria are acquired by patients in hospital. No very great change was found in patients' bowel bacteria after admission, but a tendency to acquire a more resistant flora was noted. I did not give any statistical evaluation of this effect and would be glad if you would allow me to do so here.

I showed (Table I) that 28 of 100 patients before admission to hospital were excreting enormous numbers of resistant *Escherichia coli* (25–100% of the bacteria cultured). The proportion of hospitalized patients excreting large numbers of resistant *E. coli* was higher, but the difference in the groups of patients I studied just failed to reach statistical significance ($P=0.08$). Nevertheless, significant acquisition of resistant *E. coli* in hospital was demonstrated in another way. In Table V patients were classified according to whether their bowel bacteria, and *E. coli* in particular, became more resistant, less resistant, or showed no change in this respect after admission to hospital. The increase in resistance here was statistically significant ($P=0.04$ for all "coliforms," $P=0.02$ for *E. coli*). It seems worth stressing this point as evidence that the use of antibacterial drugs in medicine has exerted a selective pressure in the dissemination of R factors in the normal bowel flora.—I am, etc.,

NAOMI DATTA.

Department of Pathology,
Royal Postgraduate
Medical School,
London W.12.

"Cure" of Coeliac Disease

SIR,—We hope that Sir Wilfrid Sheldon's article on coeliac disease (17 May, p. 401), endorsing the view that the gluten-free diet should be lifelong, will help to dispel the conflicting advice that has been given to parents hitherto. Since the formation of this society a year ago we have received many letters from parents who have been confused by the promise of an expected "cure" in childhood which did not materialize. Neither parents nor children have difficulty in adapting to a strict gluten-free regimen, but the physical as well as psychological harm resulting from a "stop—go—stop" approach to the diet should not be underrated.

We believe that once a diagnosis of coeliac disease has been firmly established in a child

the necessity to keep to the gluten-free diet permanently should be explained in detail to the parents.—We are, etc.,

ELIZABETH SEGALL.

PETER BENENSON.

Trustees, The Coeliac Society.

London N.W.8.

Research in Otosclerosis

SIR,—May I appeal through your columns for post-mortem specimens of petrous temporal bone from otosclerotics and their relatives? Such specimens are rarely avail-

able for histopathological study, for otosclerosis does not assume importance during a terminal illness, and thus much essential material is lost.

Where there is any evidence of perceptive or inner-ear deafness in otosclerosis, there is particular need for rapid fixation. Injection of any good fixative through the oval window could be done as soon as possible after death by an E.N.T. registrar, so that preservation of sensory cells and nerves is completed before necropsy, when the petrous temporal bones may be removed in the usual way.—I am, etc.,

MARY INGLE WRIGHT.

Department of Oto-Laryngology,
University of Manchester.

Inconsistent Salaries

SIR,—It was most intriguing to read the two letters under the above heading (24 May, p. 516). The fragmented partisan approach of the profession to the problem of money can be very depressing at times.

Mr. A. Henry Millard feels aggrieved at the unfair pay differential in favour of the general practitioner as against the hospital consultant. We in general practice can sympathize with his feelings, as a few years ago the seesaw made us extremely sensitive over what appeared bias the other way. However, he cannot expect too much support from us if he uses the rock bottom of a consultant's salary scale as starting "at least equal to that of the average general practitioner." After all, it is the general practitioner's misfortune that he is wedded to a structure which scarcely recognizes hard work or medical qualifications, and where the most senior now frequently finds himself on an equal pay and work basis with the latest recruit. There is no haven of seniority for him from the chores, no way of getting out of the rut; if there was, then Mr. Millard's suggestion might not sound so objectionable.

Dr. G. M. C. Watts states baldly that "... it is money that really counts," and, although it is not clear whether he means money in the general practitioner's pocket or money pumped into the practitioner service, his later remarks on increased basic practice allowances, etc., seem to leave little doubt. It is disappointing, at a time when recruitment to general practice remains at a low ebb, to see money pinpointed as the major deterrent. In a country where salary scales generally do not compete with the new world and our tax system defies the industrious, I do not see our present level of remuneration as of paramount importance. To many of us, in fact, any marked increase in income would have to be considered carefully, and the shrewd may decide to axe their unremunerative work-load rather than swell the Inland Revenue's coffers.

There can be no denying, however, that money really matters to some of us. Division meetings see faces never previously seen and never seen again until the next monetary crisis—but these are men with their careers set, their dreams behind them. Fortunately, this is not so with the young, on whom the future of medicine depends. Ludicrous as it may seem, after the relatively barren years we knew, many of the young men find it intellectually degrading to be in receipt of consultant-type salaries from the outset with-

out a further hand's turn of specialization or vocational training. This abysmal career structure linked to the increasing work-load of the most routine kind and the snail's pace advancement in general practitioner thinking turns them away. The Todd report¹ gives us hope, but these reasons and the demoralizing state of the country's economy, I am certain, combine far more than simply money to cloud the future.—I am, etc.,

F. L. P. FOUIN.

Peterculter,
Aberdeenshire.

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Regional Hospital Consultants and the Royal Colleges

SIR,—As president of the Regional Hospitals' Consultants and Specialists Association I have been asked to ventilate the question of representation of regional consultants on the councils of the royal colleges, and in particular the Royal College of Surgeons of England.

It would appear that among the 24 council members of this college there is only one surgeon whose contract is in a regional hospital.

Nowadays the bright young men from teaching hospitals do not all stay there. Most come out to regional hospitals and lose none of their intelligence or ability by so doing. They only lose their chance of being on the council of their college. As most of the surgical work in England is done in regional hospitals—I have heard 85% mentioned—this discrepancy of representation is even more unjustified. They do the work but cannot participate in planning the education of their successors.

The remedy is in their own hands. At the annual election of the Royal College of Surgeons three new council members are chosen each year. If surgeons from regional hospitals are nominated they will receive the support of our association.—I am, etc.,

DONALD YOUNG,
President, Regional Hospitals' Consultants
and Specialists Association.

Royal College of Surgeons,
London W.C.2.