aware in a dream-like way of cramming goods which she did not need from the shelves into her own shopping basket with no attempt to conceal them. Having done this she rushed to the cash desk, paid for the goods in the wire carrier, but carrying out the other goods exposed in her own shopping bag. As soon as she had passed through the cash barrier she was stopped and subsequently charged with shoplifting. After she arrived home her husband concluded that her state of mind was due to the drug and she stopped taking it for the second time. As a result of the charge she was referred for psychiatric opinion, and when seen two weeks later her mental state was normal. It was concluded that her depression and confusional state had been due to the effects of fenfluramine.

Similar cases have been reported previously^{1,2} and are presumably due to the psycho-active nature of the drug. Fenfluramine seems to possess a complex mixture of activities related to its amphetamine-like structure. It is known to interact with monoamine oxidase inhibitors,³ and cause facial dyskinesia^{2,4} as do other amphetamine derivatives. In therapeutic doses fenfluramine may cause sedation⁵ or, in some cases, confusion as above, but in elevated doses the drug seems to show stimulant properties as reflected by recent animal work,⁶ temporary mood depression on stopping the drug therapy,⁷ anxiety, agitation, and convulsions noted on overdose,⁴ and the inhibition and rebound of R.E.M. sleep. Oswald⁸ states that the last is an indication of a dependence liability of the amphetamine type. The sedative action on the other hand could give rise to abuse commonly seen with this category of drug.

Fenfluramine exhibits in one molecule a wide spectrum of psycho-mimetic activity ranging from sedation to stimulation, which is reminiscent of the barbiturate/amphetamine mixtures. It should, therefore, be given with care so that its dependence-producing potential can be properly evaluated.—I am, etc.,

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Self-examination of the Breast

SIR,—In your leading article on the treatment of primary cancer of the breast (7 March, p. 579) you rightly mention first as influencing prognosis "the biological behaviour of the tumour and its host." May I make some observations and a suggestion arising out of the other prognostic factor you mention—"the extent of the disease at the time of presentation."

All examinations for carcinoma of the breast suffer from the weakness as screening procedures that a negative finding is valid only for the time of the examination. The position is quite different from that of cervical smears, in which the biological potentialities of the cells can be assessed.

The logistics and economics of medical care are such that this weakness cannot be overcome by the frequency of examinations. This leaves self-examination as the only practical large scale screening procedure at the present time. Training in and adoption of regular monthly self-examination of the breasts, as has been advocated in the United States, are unlikely for a variety of reasons to find favour except with a small minority of women.

Under these circumstances may I mention a simple but efficient method of self-examination of the breasts. If a woman washes her breasts with the soaped hands rather than with a flannel or sponge, the pulps of the fingers are automatically placed at a right angle to the chest wall, the correct position for determining any pathological deviation from the normal in the consistency of any part of the breasts. Being a routine hygienic measure, it is free from the psychological overtones, and the consequent errors, of conscious examination of the breasts for a dreaded disease, while its simplicity makes it a practicable large scale screening procedure. Women adopting this practice and reporting to their doctor if they notice any abnormality will have the satisfaction of knowing that they have done all that is possible on their part to secure a favourable outcome to treatment.—I am, etc.,

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Unusual Cause of Inguinal Mass

SIR,—A female patient, aged 80, was admitted as an emergency with a mass in the left inguinal region which had appeared two days previously and had become progressively more tender. Six years previously she had had a left inguinal herniorrhaphy, and six months previously she had attended hospital with lower abdominal pain. On the latter occasion a diagnosis of diverticulitis was made clinically, and confirmed radiologically. At the time of her admission, however, she was free from bowel symptoms.

On examination, a swelling was found in the left inguinal region extending across to the mid-line. The mass was 2 in. × 2 in. (5 cm. × 5 cm.) in size, apparently localized, of firm, smooth consistency, and appeared to arise from the external inguinal ring. The

overlying skin was red and inflamed, and the whole mass was tender. There were no symptoms or signs of intestinal obstruction or peritonitis apart from nausea. A diagnosis of an irreducible recurrent inguinal hernia, probably containing strangulated omentum, was made.

At operation, the cause of the swelling was found to be a segment of varicose vein which was the site of a thrombophlebitis (Fig.). The vein originated from the long saphenous just proximal to the point at which it penetrated the deep fascia. Its path ran through the subcutaneous tissue superficial to the membranous layer. It followed a course in an upward and medial direction, across the suprapubic region and was traced to the opposite side where it joined the right long saphenous in the same manner.

Preoperatively, it had been noted that the patient had extensive varicose veins of both legs. Her wound healed without difficulty, but her postoperative course was complicated by an episode of severe superficial thrombophlebitis and possibly co-existent deep vein thrombosis which was treated by bed rest, local support, and ampicillin. After her herniorrhaphy six years previously she also had a superficial thrombophlebitis. In view of this history and the extensive varicose veins in both legs, we did not pursue investigations in search of a more obscure cause of phlebitis in an elderly patient.

We are grateful to Mr. A. I. S. Macpherson for his permission to publish this case.—We are, etc.,

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Council Election of R.C.S.

SIR,—We have received the usual notice of the impending election to fill two vacancies on the council of the Royal College of Surgeons of England.

The present membership of the council is listed on the reverse of the notice and one cannot fail to observe the preponderance of Fellows from the London teaching hospitals. Excluding representatives elected by other faculties, of the 24 places on the council no fewer than 18 are at present held by Fellows on the staff of the London teaching hospitals (in which we include the Royal Postgraduate Medical School and St. Peter's and St. Paul's Hospitals). There is one member of council from Edinburgh, one from a non-teaching hospital, and only three from provincial teaching hospitals. Wales is completely unrepresented.

If one considers the distribution of population in the country and of the Fellows of

the College it would seem reasonable that approximately half of the council should come from the London hospitals—both teaching and non-teaching—and that the other half should come from the provinces, again from both the teaching and non undergraduate teaching hospitals.

While it is clear that the over-riding consideration in the impending election should be the suitability of Fellows for service on the council, we would like to suggest that the forthcoming election gives an opportunity to improve the balance of the council.—We are, etc.,

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M. W. F. DUNNING.
J. A. RUSSELL JOHNSON.
D. LINCOLN LEWIS.
G. K. ROSE.

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