often unfairly, for the unsatisfactory circumstances in which many overseas doctors now find themselves on arrival, and some have only themselves to blame. It might, however, be felt that a degree of cruelty is sometimes shown towards the plight and peculiar needs of some, if not all, overseas doctors that is scarcely excusable in any circumstances. Nor should knowledge of this be longer withheld from influential lay opinion, whose insistence, if the true facts were widely known, would surely urge better postgraduate facilities generally than now exist. There can be no reasonable argument against the proposal that once the legitimate needs of our own graduates are ordinarily met those overseas graduates who apply to the Department of Health for compulsory clinical attachment should, wherever possible, be given their first post if the "attachment" is favourable, without having to apply for it. Nothing can be more evasive than that the Department of Health should refuse to act as an employment bureau, since among its other functions this is precisely what the Department does do, though admittedly this function is normally delegated to regional boards or to boards of governors. It would, of course, be difficult, indeed impossible, to guarantee doctors from abroad arriving for attachment continuous employment throughout their stay here, but since the first post seems by far the most difficult to obtain, especially if temporary registration is also needed, then it would seem wholly fair we should at least help this type of immigrant to that extent. Anything less is surely a blatant and soulless denial of our overall responsibility.

Clearly the habit of reaching facile conclusions on many aspects relating to immigrant doctors must be resisted, but a few definitive conclusions now seem inescapable. Furthermore, deliberate refusal by the Department of Health actively to invite overseas governments purely on humanitarian grounds, if on no other, to recall their own doctors for service at home after an absence in this country on postgraduate study of about five years, seems a violation of basic human rights as applied to the great mass of peoples within the underdeveloped countries, whose access at present to the full benefits of modern, scientific medicine is a lot less than it should be. Preliminary discussion on this important aspect might well be considered a useful item on the Agenda (if it is not already on it) for the fifth meeting of the council of the Commonwealth Medical Association being held soon in South-east Asia.—I am, etc.,

H. VINCENT CORBETT.

Liverpool 1.

Deadly Diapers

SIR,—In your leading article "Deadly Diapers" (9 May, p. 314), a hazard to infants is attributed to dusting powders containing boric acid, whereas it is well established that the danger arises from the use of undiluted boric acid as a dusting powder in place of a borated talcum powder. It is important that the difference between these two should be realized.

Though R. B. Goldbloom and A. Goldbloom[1] reported a case of non-fatal boric acid poisoning from the use of a commercial borated baby powder applied liberally to an infant's excoriated buttocks, R. B. Goldbloom later[2] published a statement that pure boric acid powder had also been applied to the infected umbilical cord of the infant and added ". . . the borated baby powder cannot be implicated *per se* as the sole cause of intoxication in this infant." Similarly in the cases you refer to reported by J. Ducey and D. B. Williams,[3] a borated talcum powder had been used on one infant, but this had been followed by undiluted boric acid powder. There was no case of a borated talcum powder alone causing poisoning.

The safety of borated talcum powders for use with infants is well documented.[4 5]—I am, etc.,

DORA L. SAMUEL.

Borax Consolidated Ltd.,
London S.W.1.

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Depressive Illness and Menstruation

SIR,—Dr. M. J. Wooldridge (18 April, p. 174) is surprised that Dr. A. M. W. Porter's paper (28 March, p. 773) on depressive illnesses in general practice did not reveal an increased frequency during the premenstruum. Dr. Porter in his letter (9 May, p. 363) shares equal concern, and states that he was correlating the time women "reported sick" with the time of the menstrual cycle.

This is only a partial explanation of the puzzle; a vitally important point has been overlooked. There is an appointment system operating in Dr. Porter's practice. An appointment system makes nonsense of any attempt to correlate the time of a woman's first attendance with the onset of an illness. Many extraneous factors are involved in finding a mutually convenient time for an appointment, such as the social and other commitments of patient and doctor, the proximity to a week-end, and the patient's working hours. The delay between a patient asking for an appointment and waiting only one to four days for a convenient time is quite sufficient to bring the time of first consultation into a different phase of the menstrual cycle. Therefore, an arbitrary time of an appointment cannot provide a datum line for correlating an illness with the menstrual cycle.

An increasing number of doctors with appointment systems are conducting studies into illness and menstruation; therefore, it is of paramount importance that the fallacy of using the first appointment as the time of onset of the illness is fully appreciated. Thus in the analysis of menstruation in relation to hospital admissions to psychiatric, accident, medical, and surgical wards, and even for children's admissions in relation to their mothers' menstruation,[1-4] the surveys were specifically limited to emergency admissions, thus excluding cases admitted *by appointment* from outpatients or when a bed was available.

An illness starts when an illness starts, not when the patient attends by appointment.—I am, etc.,

KATHARINA DALTON.

London W.1.

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Sickle Cell Trait and Leg Ulceration

SIR,—The findings and the conclusion in the letter by Dr. G. R. Serjeant and Mr. M. Gueri (28 March, p. 820) that "there would appear to be a definite relationship between leg ulceration and sickle cell trait" are surprising.

We have recently reviewed 34 Nigerian patients with osteomas due to "tropical ulcers." These ulcers are of a defined clinico-pathological nature and quite distinct from those due to varicose veins, yaws, syphilis, and open traumatic wounds, which we have assumed were included in the survey reported. None of our patients had the sickle cell trait even though over 25% of Nigerians carry the S gene.[1]

We respect the findings of Dr. Serjeant and Mr. Gueri and eagerly await a non-statistical explanation for this relationship, remembering that leg ulcers are not a feature of all anaemias—for example, pernicious anaemia—and that the histology of these ulcers, especially the absence of thrombosis, does not differ from other chronic ulcers such as in chronic haemolytic jaundice.[2]—We are, etc.,

T. M. KOLAWOLE.
S. P. BOHRER.

Department of Radiology,
University College Hospital,
Ibadan, Nigeria.

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New Bronchodilator Aerosol Preparations

SIR,—I would agree with the letters of Dr. J. H. Clarke (9 May, p. 367) and Dr. I. W. B. Grant (16 May, p. 421) suggesting that the advertising of Medihaler-duo as preventing a fall in Pa_{O_2} in various lung conditions including asthma is, perhaps, a little premature being based on two letters to you (29 November, 1969, p. 557 and 17 January, p. 173) and, I should also add, a paper presented to the Societas Europaea Physiologiae Clinicae Respiratoriae at Bochum which is to be published shortly. However, I believe it is reasonable to expect that bronchodilator therapy should improve the function of the respiratory system which defined by E. J. M. Campbell[1] ". . . is to secure gas exchange between blood and ambient air so that arterial blood gas pressures are kept within certain limits." The same author, in the article referred to by Dr. Clarke,[2] warns against a sudden fall in Pa_{O_2} in hypoxic patients which, in our experience, often happens in chronic obstructive lung disease after the use of bronchodilator aerosols.

I think, therefore, it is desirable that firms making these substances, while main-