ovulation. Since the mean prolactin concentration in this group (44 $\mu\text{g/l}$) was several times lower than that in the pituitary tumour group and no other cause of hypoprolactinaemia could be found we speculated³ that these patients had microtumours of the pituitary.⁴ This hypothesis is clearly consistent with the relationship of prolactin to fossa size published by Dr. Child and his colleagues since a prolactin level of 44 $\mu\text{g/l}$ would be associated with a fossa size of below 50 mm², which is apparently normal.

Finally, in a study of prolactin concentrations in acromegaly⁵ we found that hyperprolactinaemia, which occurred in 17% of 40 patients, was usually associated with hypogonadism. Furthermore, reduction of prolactin levels by effective surgical treatment⁶ led in one patient to an improvement of libido and potency such that after hypophysectomy treatment with androgens could be withdrawn.

We found no correlation of prolactin and growth hormone concentrations in patients with acromegaly, but since five of the seven hyperprolactinaemic patients had upward extension of their tumours we consider an elevated basal serum prolactin concentration to be an indication for air encephalography even in patients in whom the acromegaly itself is not sufficiently severe to warrant hypophysectomy.—We are, etc.,

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Imported Sterile Water

SIR,—Recently I sat on a committee commissioning a new district hospital in the South-west. We argued with the regional administration to provide money to allow water to be sterilized and bottled locally for use in the operating theatres and wards of our hospital. The Department of Health and the regional authorities refused this, with the result that all sterile water used in the hospital is now manufactured and bottled in Illinois, U.S.A., and then transported across the Atlantic to be used in Britain.

It surely cannot be beyond the ability of the natives of this country to sterilize and bottle water. It would be interesting to know how much the taxpayer is paying to have this water imported from America. I would not be surprised if for sheer idiocy it deserved a place in the *Guinness Book of Records*. Cannot the Department of Health, with their large administrative organization, do something about this, set up local facilities for sterilizing water, and thereby save many hundreds of thousands of pounds.—I am, etc.,

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Gastrin Heterogeneity: Simple or Complex?

SIR,—Your leading article about gastrin heterogeneity (18 January, p. 112) draws attention to this rapidly expanding field of study and interest. However, a rather troublesome point about the terminology of tissue and serum immunoreactive gastrin molecules was not mentioned.

Gastrin components have been purified and characterized chemically from antral and Zollinger-Ellison tumour tissue^{1,2}; these characterized tissue components can be classified by their number of amino-acids.³ Extracts of human antral and duodenal tissue contain mainly "little" gastrin,^{4,5} while human serum contains mainly "big" gastrin.⁶ This inconsistency cannot be explained satisfactorily by differences in clearance rates in dogs³ and accentuates the following troublesome point. The fact that serum or plasma contains immunoreactive components which elute in comparable positions to those of the characterized tissue components does not justify their classification by the amino-acid nomenclature. One reason for this is that the tissue and serum component distributions suggest that "little" gastrin once secreted may be modified in the blood or by passage through some organ and then circulate as seemingly larger gastrin molecules.

Extreme caution must be exercised in the interpretation of the relationship between tissue and serum immunoreactive gastrin components until further information is available about the precise character of the serum components.—We are, etc.,

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Falling Standards and Sagging Morale

SIR,—It was almost a relief to read the article on "Falling Standards and Sagging Morale" (22 March, p. 675) and Dr. C. H. C. Thomas's Personal View on geriatric admissions (p. 678).

The fact that hospital care today is often poor and ill-supervised and hospitals dirty has been known to us for a long time, and it says little for us as a profession that we have not said so boldly long ago, possibly out of deference to a nursing service that we used to know and to porters and cleaners who were known to and respected by all of us in our time.

It is also a disgrace to us that we have condoned, and some senior hospital staff have helped to forge, a system which refuses urgent and necessary care to the sick on grounds of age alone. Had we always insisted that all patients needing nursing should be admitted on request earlier Governments would have had to provide adequate acute and chronic beds and decent

old people's homes and housing. Apart from considerations of humanity it is dishonest to expect a citizen to pay health insurance to the age of 65 and then to say that he is too old to reap full benefits.

I personally would like to hear a good deal less of "returning people to the community," to squalid conditions, one meal on wheels a day, and an occasional bath when nurse has time.—I am, etc.,

MAY DOWNIE

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The Trainee Year

SIR,—The paper by Dr. J. B. Donald (22 March, p. 672) is a welcome addition to the limited material available on the subject of postgraduate training in general practice. It contains a number of comments which are of concern to all who organize or teach in training courses.

The Committee for Postgraduate Training in General Practice, which has as its main responsibility the quality of training schemes, has already been helped by the critical comments of trainees. It gives considerable weight to the confidential discussions which have already been held with groups of trainees during the visits so far carried out in five regions.

Dr. Donald is not correct in saying that there are only 178 places available on vocational training schemes. His error is understandable since the reference he gives is five years old. In fact, on 1 October 1974 there were not less than 460 places available in recognized three-year "package" schemes. There were also 100 trainees in post in three-year programmes which they had constructed themselves with the approval of the postgraduate dean and which made them eligible for the vocational training allowance and the M.R.C.G.P. examination.

Dr. Donald has also not quite correctly stated the attitude of the Royal College of General Practitioners about who is eligible to take the membership examination. He rightly quotes the regulations—"either four years as a fully registered medical practitioner, or three years if the candidate has completed a special course of vocational training recognized by the college." The college does allow self-constructed rotations lasting three years as "special courses" provided they have been approved by a postgraduate dean.—I am, etc.,

J. P. HORDER

Secretary,
Committee for Postgraduate Training in
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SIR,—As one who has been recently approved as a trainer and who has his first trainee in post I read Dr. J. B. Donald's paper (22 March, p. 672) with interest. He is to be congratulated on it. He states that 70% of trainees "thought they should be reimbursed for full locum duties, night visits, insurance examinations, and pill prescriptions." I feel sure that many insurance companies would feel that the trainer rather than the trainee should be doing their medical examinations because, generally, these companies are most discriminating in their appointment of medical examiners, who are usually expected to have had at least 10 years' experience.