time a mitral systolic murmur maximal at the apex was noted. Blood cultures were persistently negative. More recently there has been an exacerbation of her SLE with fever and arthritis. Her steroid dosage has been increased and azathioprine added to her therapeutic regimen.

In our patient there seems little doubt that the aortic incompetence is a complication of her SLE. She has never had rheumatic fever or syphilis and does not have ankylosing spondylitis. It is of interest that her aortic reflux developed during a stage when the SLE appeared to be controlled satisfactorily with steroid therapy. It is only in recent weeks that we have detected evidence of an associated mitral valve lesion. This case closely parallels that described by Dr El-Ghobarey and his colleagues, who noted aortic incompetence developing despite apparent control of the SLE with steroid therapy. They reinforced suggestions that steroids might play a part in the evolution of the valvular defect, but others have reported aortic reflux in untreated SLE.¹

Our problem is that of a patient with active SLE who has developed heart failure secondary to aortic valvular disease. There have been reports of successful valve replacement with Starr-Edwards prostheses,^{1,2} but these were performed on patients with quiescent disease assessed by clinical and immunological criteria. In our patient current active systemic disease would seem to preclude cardiac surgery, but we feel that this must be considered at some stage. It may well be that serial measurements of DNA-binding activity and serum complement levels will allow a more accurate assessment of disease activity to be made.

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¹ Oh, W M C, Taylor, R T, and Olsen, E G J, *British Heart Journal*, 1974, **36**, 413.
² Schulman, H J, and Christian, C L, *Arthritis and Rheumatism*, 1969, **12**, 138.

Cigarette smoking and chronic bronchitis

SIR,—There is a current belief that cigarette smoking causes chronic bronchitis. I would like to question this belief.

Firstly, it is not true that all patients with chronic bronchitis are smokers or ex-smokers; there must therefore be some other cause for the condition. Secondly, I think the proponents of this belief are victims of the generally used MRC definition of chronic bronchitis,¹ which is a clinical one of chronic cough and the production of sputum with or without evidence of airways obstruction. While it is true that cigarettes cause cough and hypersecretion and even airways obstruction, this is not the same condition as that of chronic bronchitis, which is irreversible, often with a progressive downhill course and with attendant complications such as cor pulmonale. If cigarette smoking is stopped the cough and hypersecretion often disappear and spirometric tests of obstruction may improve. This is therefore a reversible condition due to irritation of the airways by cigarette smoke and a condition which might be called "cigarette lung" or "smoker's lung."

There are thus two syndromes characterised by the productive cough of the definition which lead to confusion of thought about chronic

bronchitis and which are both encompassed by the MRC definition of chronic bronchitis, but one is a reversible condition and the other is not. These two conditions may of course coexist and if patients with chronic bronchitis who are smokers stop smoking some of their symptoms and signs may be reversed, but only partially. In attempting to establish the nature and course of chronic bronchitis the two conditions should be separated. Cigarettes therefore may "damage your health" but they do not necessarily cause the disease of established chronic bronchitis, which is a different syndrome. The MRC definition of chronic bronchitis has been of great value, but I would like to suggest an amendment of it to exclude conditions maintained by continuing aggravating causes such as cigarette smoke.

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¹ Medical Research Council, *Lancet*, 1965, **2**, 775.

Unpopular specialties

SIR,—I can offer a crumb of comfort to Dr S B Datta (9 October, p 883). In our sample of 1974 graduates there were in fact four who gave geriatrics as a first choice of career and one other who tied it with psychiatry as a first choice. The error in table V in our paper (11 September, p 630) resulted from a problem in sorting for individual "medical" and "surgical" choices. I had written to point this out by the time Dr Datta's letter appeared and I welcome the opportunity to apologise both for the mistake and any additional grey hairs it may have caused among geriatric colleagues. Our other figures have been rechecked.

In response to Dr F M Lanigan-O'Keefe (6 November, p 1136), venereology was included among "other medical specialties" but actually there was only one graduate who showed interest and this was as an equal first choice with obstetrics and gynaecology and general practice.

It is obviously impossible to give all details in a published report, but we may well be able to supply more specific information in response to individual inquiries and should be pleased to receive these. An analysis of 1975 graduates' choices of career is at present being completed.

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Hospital practitioner grade

SIR,—I was astonished to receive in today's post the following memorandum addressed to "all general practitioners":

Hospital Practitioner Grade

At a meeting of the Consultant Medical Staff Committee of the Swindon District Hospitals held on Monday, 1 November, the committee, having discussed this grade, as presently defined, decided to reject any introduction of the grade as it stands into these hospitals. It was felt that you should be informed of this decision and the reasons for it.

The committee in no way wishes to exclude general practitioners from working in the hospital service and indeed already enjoys the assistance of over 30 local general practitioners in this district. It did, however, feel very strongly that the grade is discriminatory against many doctors, notably married women, well qualified and ex-

perienced to fill such posts except that they are not principals in general practice. Generally, the committee accepted that a career grade of this type should be introduced but also felt some concern that it should not be allowed to provide a substitute for an increasing inability to fill consultant posts. Accordingly, they felt unable to give support to any such appointments until the grade has been suitably renegotiated and modified to remove its unfair features and include all suitably qualified doctors as acceptable applicants.

Although I agree with its basic point that the grade is discriminatory, I otherwise object most strongly to it on the following grounds:

(1) This is discrimination not against one group but in favour of another. Nobody actually loses.

(2) This grade has already been negotiated by the General Medical Services Committee and the Joint Consultants Committee with the Government and was hailed by the BMA, with some fanfares, as a great success. Why try to obstruct it locally now?

(3) The above agreement was reached a year ago, with implementation to start last January. Why wait till now?

(4) This is playing right into the Government's hands. The longer the introduction of this expensive grade is delayed the happier they will be, especially if we are seen to be divided the while.

(5) If we want to fight against discrimination let us fight for those who are left behind, not against those who are advanced. A good socialist ideal, surely?

(6) This is not the way for professional people to behave. It is obstructive politics of the worst degree and we should have no part of it.

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Consultants' increments

SIR,—We, the undersigned, as consultants at this hospital, are affected by the Government's counterinflation policy of 1975-6 and have been following the correspondence on this subject in your columns. All agree that this policy is immoral and unjust because the Government has unilaterally and arbitrarily withheld our contractual salary increments and has thereby created an anomalous situation in pay structure. Furthermore, the NHS consultants' pay, as the 1975 Review Body acknowledged, has failed to keep pace with that of others in comparable walks of life. Our sacrifice of an annual increment—that is, £800 approximately—is equal to or more than the total amount to be withheld from other grades of medical and administrative staff in the NHS with incomes of £8500 per annum or more (with the exception of senior hospital dental and community medical staff) even if they were to forfeit one increment all the way up to the top of their scale. Accordingly we would like to challenge the statement by the Secretary of State (25 September, p 771), "the consultants are not being treated worse . . . than other groups affected by [the £8500 cut-off]," particularly in the NHS. It is obvious that, although the treatment is the same for all groups, the financial outcome of that treatment is worse for the consultants. Moreover, the Secretary of State admits that this principle of the £8500 cut-off has created anomalies and has been unjust to some groups, so surely it is the duty of the Government to rectify the anomalies unless otherwise prevented by its