in males. It is for this reason that the wait-and-see policy referred to in your leading article (28 August, p 490) needs to be compared with radiotherapy in younger men with localised disease.

However, old habits are not easily discarded and a non-investigative approach to the management of these patients has become widespread. The TNM classification provides a good "shorthand" system of tumour characterisation but requires moderately sophisticated, and certainly expensive, techniques. We cannot share Dr Rostom's confidence in the accuracy of lymphography. Pedal lymphography does not opacify the obturator and internal iliac group of nodes, which are the most common site of nodal deposits. Moreover, in a recent study we have shown a 25% error rate, mainly false-negative, in the interpretation of opacified nodes. Thus a negative lymphogram has no value in staging, and pelvic lymphadenectomy should be considered for improving the accuracy of staging in selected younger patients. If the proposed clinical trials for localised prostatic carcinoma are to yield meaningful results, then detailed investigation to fulfil the TNM requirements must be accepted.

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[1] Bailar, J C, III, and Byar, D C, *Cancer*, 1970, **26**, 257.
[2] Blackard, C E, *Cancer Chemotherapy Reports*, 1975, **59**, 225.

Student health

SIR,—I was interested to note in your leading article (13 November, p 1160) that the *BMJ* is to provide a short series of articles on student health. I hope that some attention will be paid to the health problems of the student nurse population. The case of such students is far from uniform, in spite of centres of excellence. Indeed, one might go farther and inquire about the vexed question of the care of the health of hospital staff in general.

Whatever became of the Tunbridge Report of 1968?[1]

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[1] Ministry of Health, *The Care of the Health of Hospital Staff*, Report of the Joint Committee. London, HMSO, 1968.

Promotion of new drugs on television

SIR,—I was shocked at the blatant advertising of the new histamine H_2 receptor antagonist cimetidine (marketed by Smith, Kline, and French under the trade name of Tagamet). This occurred on the 9 pm news on BBC 1 on Thursday 18 November. The trade name of this no doubt excellent product was clearly visible to viewers in at least two shots.

In general practice we had received the literature (plus statutory data sheet) only on Wednesday 17 November; in my case it was the first I had heard about this new drug, now freely prescribable on an FP 10 (price not mentioned in the literature).

I understand that I am by no means alone in my concern over this trap into which the BBC reporters fell. By all means let us have authoritative information put over on or in the media by the responsible medical authorities, but this occasion cannot be allowed to pass without protest. I understand that an official protest is to be made to the Association of British Pharmaceutical Industry over this matter.

H M WHITE

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Aortic incompetence in systemic lupus erythematosus

SIR,—With reference to my letter on this subject (20 November, p 1260) I should like to make it clear that this was a follow-up report of the patient originally described in more detail by Oh *et al*[1] and does not represent a new case.

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[1] Oh, W M C, Taylor, R T, and Olsen, E G J, *British Heart Journal*, 1974, **36**, 413.

Appointments in community medicine

SIR,—I have waited with interest for some public response from the Faculty of Community Medicine to my earlier letter (28 August, p 523). An unexpectedly silent watchdog may be highly significant.[1] Some who were appropriately qualified, trained, and experienced to be appointed specialists at the time of reorganisation have been seriously and permanently affected by failure then to separate personal specialist grading from appointment to specific posts. They have resented the arbitrary and seemingly uncontrolled way in which the career grade continues to be conferred. It would be revealing to know the criteria (other than expediency) advised for adoption by faculty representatives on specialist appointment committees and to have confirmation that the Faculty, in refusing to recognise subspecialties, regards all specialists so far appointed as generalists within the broad specialty.

If community medicine is to be regarded as allied to clinical medicine and therefore to achieve the exemption not so far granted from the current review of management costs, it is essential for the faculty to demonstrate that standards for appointment to the permanent career grade have been, and continue to be, no less demanding than those for clinical consultants. The available evidence is largely anecdotal but not reassuring. Since much stress is laid on the need for evaluation in health services[2] and the specialty is that branch of medicine which deals with the health of populations or groups, it is particularly appropriate to inquire: (*a*) the proportion of founder fellows or members not meeting the full and specific criteria originally established under standing order 6; (*b*) the number of specialist community physicians already appointed who were not currently fellows or members of the faculty; and (*c*) the number of appointments made to the subspecialist grade as a proportion of all appointments made to specialist posts.

It may well be that the creation of the proposed new grade of hospital specialist (a permanent subconsultant grade) could provide a fortunate opportunity for a review of all existing specialists in community medicine on a personal basis, those with appropriate qualifications and experience being regraded as consultants in community medicine. Meanwhile, the faculty board should carefully reconsider their continued silence on these matters, and reflect whether this furthers the consolidation and development of the emerging specialty.

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[1] Doyle, A C, *Silver Blaze*. London, Murray, 1890.
[2] Horner, J S, *British Medical Journal*, 1976, **2**, 827.

General practitioners and coronary care

SIR,—The implication that the general practitioner cannot play a useful role in the operation of prehospital coronary care schemes because calls from general practitioners for an ambulance in Nottingham are usually long delayed (Drs J D Hill and J R Hampton, 30 October, p 1035) cannot go unchallenged. Since its inception in 1966 the majority of calls for the Belfast mobile unit have come from general practitioners. The median delay between onset of symptoms and intensive care has been 100 min.[1] Over a quarter of the patients have been reached during the first 60 min.

In drawing their conclusions the authors assume, wrongly, that the response of an individual to the development of symptoms and the delay on the part of the general practitioner are innate and immutable. Adaptation is usually possible when necessary. As James Russell Lowell said in 1889, "New occasions teach new duties: time makes ancient good uncouth".

Activation of a mobile unit from whatever source at the earliest possible moment is, of course, to be encouraged. Nevertheless, exclusion of the general practitioner from this area of acute medicine is in the interests of neither the patients nor their doctors. Rumination over the obstacles does nothing to save lives. Drs Hill and Hampton will do a better service if they will now direct their energies toward bringing treatments of proved value to the maximum number of patients at the time of greatest risk, whether medical advice is sought through a general practitioner or the emergency ambulance service.

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[1] Pantridge, J F, *et al*, *The Acute Coronary Attack*. Tunbridge Wells, Pitman Medical, 1975.

The elderly in a coronary unit

SIR,—Dr F F Thompson (2 October, p 814) is indignant at the attitude of Dr B O Williams and his colleagues (21 August, p 451) concerning the admission of elderly patients, mainly over the age of 70, to a coronary care unit, and his sentiments are shared to some extent by Dr M S Pathy (18 September, p 696).

I must say that I find the comments of Dr Williams and his co-authors sensible and humane: "Keeping them at home when possible, at the expense of a few lives in the mild group not saved by immediate defibrillation, may often be kinder, sounder from the psychological point of view, and beneficial therapeutically"—that is quite apart from obvious practical and economical considera-