malignant processes did develop, by contrast, in others of their patients, who had received irradiation alone or in combination with various other multiple-agent chemotherapy regimens, in conformity with data presented by several other investigators.[1-3]

A possible explanation for these results lies in the observation reported by the Late Effects Study Group, which found that actinomycin D appeared to decrease the risk of radiation-associated second malignant neoplasms by a factor of 7.[4] Adriamycin, one of the agents in ABVD, resembles actinomycin D in certain fundamental and clinical ways. Both are antibiotics that intercalate in the DNA molecule and both are radiation enhancers and reactivators.[5 6] Thus it is possible that adriamycin is acting like actinomycin D in protecting against radiation-associated cancers. This possibility is given some credence in view of the fact that 2·6% of the patients reported by Mr Valagussa and his colleagues who received only irradiation developed second tumours within five years and 14·9% did so within 10 years.

Of additional interest is the fact that second tumours were observed in irradiated patients given the five-drug regimen MABOP. The latter contains adriamycin, but also includes nitrogen mustard and procarbazine. The latter two alkylating agents have been widely held to be oncogenic in their own right.[7 8] This suggests that adriamycin—if it does act like actinomycin D in protecting against second tumours following irradiation—is not efficient for this purpose when alkylating agents are concerned.

It will be important to see whether the experience accumulated in other groups of irradiated patients who receive adriamycin with or without alkylating agents with high oncogenic potential duplicate the very interesting and thought-provoking results reported by the Milan investigators. The implications regarding choice of treatment for patients requiring combined chemotherapy and radiation therapy are obvious.

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Spironolactone prophylaxis in mountain sickness

SIR,—Recently I accompanied an RAF climbing expedition to Mount Kenya (5200 m) as team doctor. Reading up about "mountain sickness" I rediscovered your leading article "Proteinuria at high altitude" (24 February 1979, p 508), from which sprang the idea of assessing spironolactone as a prophylactic agent, as mentioned in that article, on our climb.

Regrettably, time did not permit the organisation of a formal trial. The best solution, to avoid wasting the opportunity, seemed to be random allocation of half the team to a spironolactone-taking group and the formation of a clinical impression, which would become the basis for further studies. The reported incidence of non-lethal high-altitude problems during acclimatisation approached 100%, which increased the validity of such an uncontrolled pilot study.

There were 12 team members (nine male, three female). Of the six who were assigned to the group of spironolactone takers there were four males and two females. The remaining six took no drugs except proguanil. Dosage was fixed at 25 mg twice daily. The drug was taken for three days before moving into the highlands (over 3050 m), where altitude symptoms are commonly first felt, to avoid problems of drug intolerance. There were no side effects. We acclimatised slowly, spending one day at 3050 m, six days at 4150-4570 m and a further six days (and nights) in the high range, at 4725-5200 m.

Results agree with the impression "on the hill." Minor altitude symptoms (said often to herald more serious manifestations if protracted) occurred with equal frequency in spironolactone takers and the "control" group. The incidence was 100% for one or a combination of the following (over the entire 13 days): recurrent headaches, persistent insomnia, malaise, dyspnoea on exertion, and lightheadedness. Two members developed severe symptoms, both without signs. The first had severe headache, vomiting, and confusion (day 2). Interestingly, he was our only heavy smoker, and he recovered within three hours of being moved to a lower altitude (3050 m). The second developed very severe headache and confusion, and "collapsed" (day 10). Interestingly, she was the fittest team member. Both were taking spironolactone.

Such evidence is anecdotal but suggests that a formal trial would be useful in which the starting dose of spironolactone should be greater than 50 mg daily. As greater numbers of people take to the hills to ski and climb at altitude, often only for a few days, problems of mountain sickness will become commoner. Perhaps a prophylactic is required when short trips do not permit acclimatisation—analogous to seasickness pills?

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Cimetidine and thrombocytopenia

SIR,—Dr A J Isaacs (2 February, p 294) reported a patient who developed isolated thrombocytopenia following cimetidine therapy. We have recently had a patient who developed thrombocytopenia and also generalised psoriasis while on this drug.

The patient, a 72-year-old man, whose psoriasis had followed a stable course over the past 30 years, required hospitalisation following the acute onset of generalised psoriasis. Over the five weeks prior to admission he had been taking cimetidine 200 mg three times daily for an endoscopically proved duodenal ulcer. His only other medication had been chloridiazepoxide 10 mg taken intermittently. Examination confirmed generalised exfoliative psoriasis with ankle oedema, the latter being associated with hypoproteinaemia. There was no splenomegaly or lymphadenopathy. His platelet count on admission was 13×10^9/l (13 000/μl), haemoglobin concentration 11·1 g/dl, and white cell count $10{\cdot}1 \times 10^9$/l (10 100/μl)—distribution 63% polymorphs, 29% lymphocytes, 3% eosinophils, 4% monocytes. Examination of the bone marrow showed increased numbers of megakaryocytes with some younger forms. Cimetidine was discontinued and a spontaneous rise in platelet count occurred after five days, a value of 350×10^9/l (350 000/μl) being achieved after 10 days. The acute phase of his psoriasis also settled dramatically over the same period, during which his topical therapy was yellow soft paraffin, complete clearance of his psoriasis taking place over the next two to three weeks with increasing strengths of tar ointment.

We feel confident that both the thrombocytopenia and the generalised psoriasis were cimetidine induced in our patient, who differs from both Dr Isaacs's patient and others reported to have cimetidine-induced thrombocytopenia[1-2] in having no obvious factors predisposing to thrombocytopenia. Rate *et al*[3] suggested that the potential toxicity of cimetidine is enhanced when other factors, such as cirrhosis, cancer, cytotoxic drugs, systemic lupus erythematosus, and septicaemia, are present. Perhaps sarcoidosis, which itself can be associated with thrombocytopenia, should be added to this list.

Cimetidine has not previously been incriminated in precipitating acute generalised psoriasis, although one case of pustular psoriasis of the hands has been reported.[4] In fact, beneficial effects of this drug in psoriasis have been claimed.[5] We feel that careful monitoring of patients on this drug is obviously still very necessary, particularly from a haematological point of view and in those patients with psoriasis.

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Pyogenic liver abscess

SIR,—Your leading article (10 May, p 1155) rightly emphasises the poor prognosis of those patients with multiple small abscesses, but makes no mention of their medical management. In a recent review of 19 patients with pyogenic liver abscesses in Leicester (unpublished data) we found that two out of three survivors with multiple small abscesses responded to long-term antibiotic therapy without surgical drainage; and in the third case, where a large abscess was drained at laparotomy, the associated smaller abscesses also resolved with antibiotics. Maher *et al*[1] recently treated six cases with multiple or single liver abscesses with antibiotics and no surgery; all their patients survived. They included an anti-anaerobe drug, usually clindamycin, in five out of the six regimens.

Although McFadzean[2] reported good results from percutaneous aspiration of single abscesses with local and systemic antibiotics in 14 patients, all of whom survived, this method has not been widely adopted. A recent study, reported by D R Osborne and L Berger at a recent meeting of the British Society of Gastroenterology, using ultrasound-directed percutaneous needle aspiration showed excellent results in nine patients with single or multiple abscesses when combined with antibiotics. We feel that there is a place for percutaneous aspiration plus antibiotics in the management of those cases where there is no

underlying abdominal pathology needing surgical intervention.

Liver function tests are often abnormal in patients with sepsis anywhere; an elevated serum vitamin B_{12} level is a useful pointer to a source in the liver.[3] In the three Leicester patients in whom vitamin B_{12} was measured, two had grossly elevated levels and the third was at the upper limit of normal. We recommend vitamin B_{12} estimation in patients with unexplained pyrexia as delay in the diagnosis of a liver abscess, as you point out, is usually fatal.

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Surgical treatment of prolapsed lumbar discs

SIR,—I would certainly agree with Mr Keith Norcross (26 April, p 1123) that radiography should be reserved for certain well-defined indications in apparent "prolapsed lumbar disc". However, I would like to take further issue with your leading article "Surgical treatment of prolapsed lumbar discs" (22 March, p 814).

Firstly, not all back pains with sciatica originate from prolapsed lumbar discs.[1-3] Irritant fluid injection into the lumbar facet joints gives pain indistinguishable from sciatica.[4 5] Secondly, positive neurological signs do not necessarily indicate pressure on a nerve root.[4] Weakness, for instance, of hip abductors or foot dorsiflexors may often occur as a pain-inhibition reflex. Thirdly, "lifting with a bent back" is quoted by you as the important origin of back injury. Careful history in acute back pain often elicits a twisting component in the injury. This is important with regard to management. Lastly, you advocate "strict bed rest" as the mainstay of conservative therapy. No one doubts the value of rest but is bed rest alone the first-line routine treatment?

In a twisting injury of the spine those facet joints able to take up the rotational strain—that is, mainly the thoracic posterior spinal joints—do so. The continuation of the injurious strain, especially when weak or unexpecting muscles are improperly protective, tends to twist the next most vulnerable site. It is biomechanically and anatomically sound to suggest that this may be a lower lumbar facet joint. Mild subluxation may be locked in that position by muscle spasms, and neurological signs and symptoms may ensue for reasons already stated. If this argument is valid, then reduction of the subluxation may be expected to produce an immediate alteration of signs and symptoms. My experience as a junior at Warrington was to see a large majority of acute "prolapsed-lumbar-disc-like" back pains miraculously cured, with a loud and satisfying clunk, by a twisting type of manipulation.

My scepticism vanished at my first successful manipulation, half an hour after being shown the technique. I find it incredible that the majority of orthopaedic consultants still regard manipulation as quackery. NHS financial resources can no longer afford such obstinacy.

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Anglo-French contrasts in medical practice

SIR,—Having spent two months in Grenoble Medical School, I was interested to read Dr A W M and J M T Porter's observations on French medicine (26 April, p 1109). Whereas I would agree with many of their observations, I would like to offer different interpretations.

Fiscal factors not only determine the style of practice, but also keep waiting lists to a minimum. The mechanism for the latter is quite simple: if a specialist cannot offer treatment within a week, the patient will find one who can. The specialist who offers a delay will soon acquire a poor reputation and his business will decline accordingly. The waiting list for surgery in Grenoble was one week.

Table II exposes the burden of committee meetings carried by British specialists. When viewed in the light of our disgraceful waiting list it must be a strong point in favour of ambitious pruning of the rambling NHS administration.

The doctor-patient relationship is mentioned on page 1110. The authors may have noticed that Provence is about 1000 miles south of London and often enjoys hot weather. Indeed, this may have been a significant factor ($p \leqslant 0{\cdot}001$?) in choosing the location for this study. The wearing of three-piece suits and ties would prompt cries of "Mad dogs and Englishmen . . ." from the waiting room. We have a lot to learn from our neighbours across the channel.

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Community medicine and community physicians

SIR,—It is sad to learn from Drs K M Parry and Helen E Zealley (10 May, p 1193) that community physicians in Scotland are facing formidable difficulties, and lack the sympathy of and an understanding of their role by colleagues in other specialties.

I would beg such community physicians (1) to get on with their job—to look *behind* the statistics, to provoke other doctors, nurses, lay administrators, the health authorities or boards, the DHSS, and the community they serve; (2) to stop building their own empires; (3) to curb their own verbosity; (4) to stop looking for love and adoration; (5) to manage —if they are on management teams jointly, otherwise individually.

Perhaps some community physicians in England too suffer from the Scottish disease? Not too many, I hope. As district community physician, I do not expect to be loved by everyone all the time. I hurl brickbats and hand out bouquets. I am bound to be treated similarly.

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Reimbursement for ancillary help by relatives

SIR,—If reports are correct, then GPs who employ their wives or husbands who are nurses are to be given the £925 allowance, as are single-handed rural GPs. This is insulting to GPs and their spouses. How dare the GMSC and DHSS negotiators insult professional men and women?

I am worth £6024 a year to our practice and the GMSC and DHSS come to an agreement to allow our practice £925. Not 70% (that is, £4216), which is paid for one of our other practice nurses, doing exactly the same work. This is blatant discrimination. It is outrageous.

My husband, at present a BMA member, hopes the LMC Conference members will show their anger and displeasure by passing overwhelmingly a motion this month that SFA 52·2 be changed so that *all* staff are included in the scheme for 70% reimbursement.

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The BMA division

SIR,—The *BMJ* being an irregular arriver lately, I have only just read Mr Norman Ellis's interesting note (3 May, p 1151) on how he finds divisions: very varied, it seems. He goes on to ask some questions about what should be done to maintain a viable local unit but—very wisely—offers no single cure. Having observed, both as an observer at the centre and as an attender locally, the general (for there are exceptions) slow asthenia of divisions, I would like to throw this idea at the Organisation Committee.

All the GPs of a county have a common interest—but rarely do they meet all together; they elect a representative LMC by post. All the consultants, HJS doctors, and community physicians in a region have a similar common interest—and serve it by electing a representative committee, not by general meetings. Indeed the same pattern exists throughout civic and parochial life as well.

Is it not time that we abandon (save where its members really want it and will support it) the division per se as a continuing presence—a body with rules which require it to meet quarterly, and so on? Instead, let the members resident in its area elect—possibly biennially or triennially—a representative committee. This should be done by post, and by a single transferable vote; this latter would probably obviate any need for craft-reserved seats, but if such "sheep and goatery" is thought desirable, it can be built into a single transferable vote ballot count. The executive committee would have a continuing responsibility both to its electorate and to the Council. Like the other representative committees mentioned, it would call full general meetings of members when there was need; it could, as now, organise educational meetings and social gatherings, if that were the clear desire of the electorate.

Surely such a restructuring—even if some would see it as a council of despair (though I do not)—is to be preferred to the farce of the AGM attended by the members of the