NEWS AND NOTES

Views

At long last, the study of blood lead concentrations in children and intelligence by Yule *et al* has been published (*Developmental Medicine and Child Neurology* 1981;**23**:567-76). This is the report widely believed to have persuaded the Government to control the lead content of petrol; its publication has been delayed, says *Nature* (1981;**292**:284), owing to "difficulties in interpreting data." Minerva's statistician friends point out that the numbers were small (166 children) and the blood lead concentrations low (mean 13·5 μg/100 ml); but the main "difficulty in interpreting data" was that the 35 children with the highest lead values were 16 months younger than the 34 with the lowest lead concentrations. How much of the differences in spelling and reading were due to age and how much to lead?

Statistical associations are, moreover, sometimes totally bewildering. For example, a study in the "Journal of Epidemiology and Community Health" (1981;35:220-3) reports that the association between atmospheric pollution and mortality from stroke is closer than the association with mortality from bronchitis.

Classic lead poisoning is still causing appalling damage to children (*Pediatrics* 1981;**68**:225-30). A poor family in North Carolina used discarded casing from lead batteries as winter fuel. Soil samples close to the house contained as much as 13% lead by weight; dust inside the house contained 41 000 ppm of lead. The baby of the family developed lead encephalopathy with a blood lead concentration of 220 g/100 ml and, despite treatment, was left severely retarded.

How many mothers who did not breast-feed have been made to feel guilty that "cot deaths, multiple sclerosis, coronary disease, mental deficiency and untold other horrors of later life" may be attributable to bottle-feeding, asks Professor John Dobbing in the "Nutrition Bulletin" (1981;6:130-2). The case for breast-feeding is not so slender that it requires such doubtful support—and it might have been more widely accepted as self-evident had not its advocates been so extravagant in their claims.

One cancer is bad luck; two may seem evidence of some predisposition to the disease. Epidemiological research shows, however (*British Journal of Cancer* 1981;**43**:623-31), that 16 out of 17 750 women who had had a breast cancer went on to develop cancer of the cervix—almost exactly the number that would have been expected in the population at large.

An outstanding collection of grisly medical photographs appears in the "New York State Journal of Medicine" (1981;81:1226-64). Among the hideous deformities and bizarre abnormalities is a postmortem picture of Cheng and Eng, the original Siamese Twins, connected by a tissue bridge only four inches in diameter.

Two grisly reports (*Annals of Internal Medicine* 1981;**95**: 380-3) of farm workers and their would-be rescuers who were asphyxiated in storage tanks are reminders that agriculture has a high accident rate. Fermenting manure or grass cuttings can replace the air in a tank with a mixture of methane and carbon dioxide, so that the victims very quickly "drown" in what looks like normal air.

As the NHS faces ever worsening financial problems the independent sector flourishes, and last week Sir Alan Parks opened the Wellington Day Surgery Centre in Harley Street. Lord Elton, making his first appearance as a Government health spokesman, drew attention to the debt that independent medicine owed the NHS, from which it drew so many nurses and other staff. The Wellington Foundation has funded a nursing lectureship at Chelsea College; more actions of that kind would be welcome.

In the hands of an expert, ultrasound scanning can give remarkably detailed and reliable information about the age, sex, and health of the fetus. Studies at Oxford (*British Journal of Obstetrics and Gynaecology* 1981;**88**:803-5) have now shown that the fetus empties its bladder at intervals of 110 minutes, usually shortly after the heart rate speeds up—which is thought to indicate a change in the sleep state.

Even non-neurologist physicians are familiar with aphasic patients whose difficulty is confined to some classes of words but not others. How many know that selective defects are also found in agraphia? A patient described in "Brain" (1981;104:413-29) could write normal words but not nonsense syllables—he could not transform sounds into letters. Bang goes the classic theory of written memory.

Most people do not realise just how bad are the problems of primary care in inner London, one delegate told a conference at the King's Fund last week. Professor David Morrell then described how he had met singlehanded doctors in Lambeth who had not spoken to another doctor for two years and others who had not had a holiday for seven. Professor Brian Abel-Smith was unhappy, however, with the Acheson report on how things might be improved. He and others thought it politically naive and pointed out that it lacked targets, a programme of implementation, and a chapter on costs.

A scholarship fund has been established to commemorate Gussy Mehigan, senior surgeon to St Vincent's Hospital, Dublin, who died earlier this year. The scholarship will support a student through medical school; an undertaking will be sought from the applicant to spend at least one year doing postgraduate work in a third-world country. Donations to Mrs Eileen Parkinson, 4 Sandford Avenue, Donnybrook, Dublin 4.

A new piece of jargon in sociological circles is "disjointed incrementalism," which means messing about on the edge of a problem without ever getting to grips with the real issues. It could be a phrase with a big future.

MINERVA

EPIDEMIOLOGY

Food poisoning and salmonellosis surveillance in England and Wales, 1980

This is the second of a new series of annual reports[1] of food poisoning and salmonella infection in England and Wales and presents a review of reports submitted by public health and hospital laboratories to the Communicable Disease Surveillance Centre. In January 1980 a system by which medical officers for environmental health and environmental health departments could report outbreaks to the centre was introduced as part of the rationalisation of food poisoning surveillance. The first year's results are also briefly reviewed.

Reports submitted by laboratories

DEFINITIONS

A case of salmonellosis is defined as a person with symptoms from whom the organism has been isolated. A case of food poisoning is a symptomatic person from whom the relevant organism has been isolated, or who is part of an outbreak of food poisoning.

An outbreak is defined as two or more related cases of food poisoning or salmonellosis. Outbreaks are classified as family outbreaks where they have occurred in one household, and general outbreaks if more widespread. Sporadic cases are those where there is no known association with another case of the same infection. An incident of food poisoning or salmonellosis refers to a sporadic case or an outbreak.

ANNUAL INCIDENCE

In 1980 there were 10 856 cases of bacterial food poisoning and salmonella infection (table I), 1025 (9%) fewer than in 1979, but similar to the number reported in 1978 (10 590). Reports of *Salmonella typhimurium* cases increased from 2582 in 1979 to 3161 in 1980, but cases due to other salmonella serotypes fell from 7330 to 6379—so that for all salmonellas there was a 4% fall from the record figure in 1979. The number of reported cases of *Clostridium perfringens* food poisoning fell from 1607 in 1979 to 1056 in 1980, and of *Staphylococcus aureus* food poisoning from 328 to 189. *Bacillus cereus* reports increased from 22 to 64 but this was still less than half the number of reports in 1978 (143).

The number of general outbreaks has remained stable but the number of family outbreaks has fallen slightly. The number of reports of sporadic cases has decreased by 6% compared with 1979, and this fall accounts for 43% of the decrease in total cases reported in 1980.

Places of outbreaks

Salmonella outbreaks outside the home occurred most commonly in restaurants and at receptions (table II), though the proportions of outbreaks in these groups fell considerably. The number of hospital salmonella outbreaks was similar to 1979 but in only three was there good evidence that food poisoning was the initial mode of infection; the remainder were probably due to cross-infection.

As in previous years, the commonest location of reported *C perfringens* outbreaks was hospitals, followed by restaurants and hotels, and *S aureus* outbreaks were mainly reported from shops, supermarkets, schools, receptions, and parties.

Type of food

The type of food associated with reported outbreaks was recorded in 150 of the 518 outbreaks. Again, in almost all *C perfringens* and *S aureus* outbreaks a vehicle of infection was recorded, usually meats other than poultry. In only 84 of the 439 salmonella outbreaks was a vehicle of infection recorded, and 50 of these (60%) were attributed to turkey (30) or chicken (20). All the *B cereus* outbreaks were attributed to fried rice.

Twenty-six incidents of scombrotoxin poisoning were reported in 1980 affecting over 75 people. Smoked, canned, or soused mackerel accounted for 11 incidents, and canned tuna for nine; the remainder were attributed to canned sardines (four incidents), pilchards (one incident), and raw tuna (one incident). In one instance 27 people were affected after eating canned Moroccan sardines.

Five outbreaks of campylobacter enteritis associated with consumption of raw milk were reported.

Salmonella serotypes

There was little change in the 20 commonest serotypes in 1980. *S typhimurium* and *S hadar* are still the first and second commonest serotypes isolated, though the proportion accounted for by *S hadar* fell from 21% in 1979 to 16% in 1980. *S typhimurium* accounted for 33% of isolations in 1980 compared with 27% in the previous four years. Of the less common serotypes, *S albany* has shown a recent sharp increase. Only two isolations were reported in the first 43 weeks of 1980, but 40 isolations were reported from weeks 44 to 53, including cases in three hospital outbreaks.

Deaths from salmonella infection and food poisoning

Reports were received of salmonellas isolated from 27 patients who died in 1980; in 14 of these the infection was considered to be the cause of, or have contributed to, death. One was a 9-month-old child with diarrhoea and vomiting; seven adults aged 47-82 years were reported to have had diarrhoea, vomiting, and dehydration only; two, aged 42 and 61 years, had bacteraemia, and the other four deaths, all in adults, followed cholecystectomy, chest infection, meningitis, and steroid treatment. Salmonella serotypes responsible were *S typhimurium* (six), *S virchow* (three), *S hadar* (two), *S enteritidis* (one), *S heidelberg* (one), and *S montevideo* (one).

Enterotoxin A-producing *S aureus* was isolated from necropsy specimens from a 2½-year-old boy with diarrhoea and vomiting who died on admission to hospital. One death occurred in a geriatric hospital outbreak caused by *C perfringens*.

TABLE I—*Bacterial food poisoning and salmonella infection in England and Wales, 1980 (1979 figures in parentheses)*

Organism	General outbreaks		Family outbreaks		Sporadic cases		All cases*†	
S typhimurium	45	(27)	102	(96)	2454	(2146)	3161	(2582)
Other salmonella sp	104	(111)	188	(221)	4502	(5258)	6379	(7330)
C perfringens	53	(53)	2	(2)	2	(—)	1056	(1607)
S aureus	7	(14)	4	(3)	6	(3)	189	(328)
B cereus	12	(4)	1	(1)	—	(2)	64	(22)
Other bacillus sp	—	(1)	—	(—)	7	(—)	7	(6)
Total	221	(210)	297	(324)	6971	(7409)	10856	(11875)

* Excluding symptomless excreters of salmonellas. † In some outbreaks total cases not known.

TABLE II—*Outbreaks of bacterial food poisoning and salmonella infection, 1980, by location and causal organism (1979 figures in parentheses)*

	Salmonella sp		*C perfringens*		*S aureus*		*B cereus*		Total	
General outbreaks										
Restaurants/hotels	27	(38)	14	(10)	—	(—)	11	(4)	52	(52)
Receptions	29	(41)	4	(3)	(3)	(3)	1	(—)	37	(47)
Hospitals	20	(24)	16	(13)	1	(—)	—	(—)	37	(37)
Institutions	9	(7)	8	(12)	—	(1)	—	(—)	17	(20)
Schools	8	(3)	2	(7)	—	(3)	—	(—)	10	(13)
Shops	3	(7)	—	(—)	2	(5)	—	(—)	5	(12)
Canteens	2	(3)	8	(6)	—	(2)	—	(—)	10	(11)
Farms	8	(8)	—	(—)	—	(—)	—	(—)	8	(8)
Infected abroad	5	(7)	—	(—)	—	(—)	—	(—)	5	(7)
Other	7*	(—)	1	(2)	1	(—)	—	(—)	9	(2)
Unspecified	31								31	
Total	149	(138)	53	(53)	7	(14)	12	(4)	221	(209)
Family outbreaks	290	(317)	2	(3)	4	(3)	1	(1)	297	(324)
Sporadic cases	6956	(7404)	2	(—)	5	(3)	—	(2)	6963	(7409)
All incidents	7395	(7859)	57	(56)	16	(20)	13	(7)	7481	(7942)

*Of the 7 other locations, 2 were on board ships, 4 were among the community, 1 was in local authority poultry meat inspectors at a broiler factory.

Outbreaks of unknown aetiology

Twenty-one outbreaks of unknown aetiology affecting over 563 patients were reported by laboratories. One outbreak affected 85 out of 180 schoolchildren who became ill with diarrhoea and vomiting 36 hours after eating salad. In another outbreak 31 out of 132 bank employees at a reception became ill with nausea, vomiting, abdominal pain, and diarrhoea 24-36 hours after eating a buffet meal which included prawns and mussels.

Comment

The trend, evident since 1972, of increasing numbers of incidents of bacterial food poisoning and salmonella infection reported by laboratories in England and Wales was not maintained in 1980. This was due to a fall in the number of cases of salmonella infection. The number of outbreaks reported has remained fairly constant, but reports of sporadic cases have fallen by 6% and total reported cases by 9%. One possible explanation for the fall is the progressive implementation of the Poultry Meat Hygiene Regulations (1976) with stricter supervision of plant hygiene and improvements in immersion chilling practices for poultry carcases. Possibly also the trend towards the sale of poultry as portions and further-processed products, which may be easier to thaw out and cook, has helped to reduce the incidence, although our data do not support this. A possibility is that the now readily available advice on the proper cooking and cooling of poultry has contributed to the decrease in incidents.

Outbreaks and sporadic cases due to *S typhimurium* and total isolations of *S typhimurium* increased in 1980, a trend evident since 1978. Nevertheless, for all other salmonellas, and particularly for *S hadar*, numbers of reported cases and isolations fell, reversing the trend of recent years.

Hospital outbreaks of salmonella infection have been reviewed by the PHLS Salmonella Subcommittee.[2] In 1980, 20 such outbreaks were reported, but in 17 of these cross-infection and not food poisoning was the most likely explanation. If food poisoning in hospitals only is considered then *C perfringens* outbreaks were five times more common than salmonella outbreaks. This agrees with the results of a survey of food poisoning in Scottish hospitals.[3]

Despite the encouraging trends in laboratory reports the sudden appearance of *S albany* in 1980 is disturbing, particularly since it has been associated with hospitals; it caused two large outbreaks in 1980 and has continued to be a problem in a few hospitals in 1981. Sporadic cases in the community have occurred, and intensive investigation of these cases would greatly help in discovering the reason for the national increase of this previously rare serotype.

Reports from medical officers for environmental health and environmental health officers

During the year under review reports of 357 outbreaks were received from medical officers for environmental health and environmental health officers. The new report forms have been particularly helpful in describing outbreaks of gastroenteritis thought to be food-borne but where no bacterial cause was found,[4] and in documenting factors contributing to outbreaks in more detail and more consistently than is possible in laboratory reports.

In the outbreaks where sufficient data were collected and recorded to incriminate a particular food, several faults were often listed. In 70 out of 227 outbreaks of salmonella infection faults were recorded. The single commonest fault was storage of the cooked food at too high a temperature (34), followed by inadequate cooling (32), too long storage (18), reheating food (13), inadequate thawing (11), and contaminated equipment (11). In 38 out of 70 outbreaks (54%) more than one fault was recorded, and in 12 outbreaks (17%) more than three faults were recorded. In one outbreak a 4 kg (9 lb) frozen capon was thawed for 18 hours at ambient temperature, cooked for three hours, and stored for three days at room temperature before consumption. Four people who ate the meat became ill with abdominal pain and diarrhoea. In another outbreak 41 out of 92 at risk became ill after attending a 21st birthday party. On the menu was boned turkey, which had been cooked for two hours at mark 4 and stored for 24 hours at room temperature before serving. *S heidelberg*, *S saint-paul*, *S indiana*, and *S newport* were cultured from stools of cases.

Of the 26 *C perfringens* outbreak reports in which details were recorded, 22 recorded more than one fault (86%). The commonest fault was storage at too warm a temperature (20), followed by inadequate reheating of food (14), and too long storage (13). In one outbreak 41 of 100 people at a handicapped persons' day centre were ill 18 hours after a turkey meal. The turkey had been thawed for 72 hours, cooked for five hours, and placed in a refrigerator for 12 hours, but then left at room temperature for several hours before reheating and serving. *C perfringens* was isolated from the turkey and from the refrigerator floor.

In one well-documented outbreak attributed to *S aureus* the food was stored for too long at too high a temperature. At a reception 98 out of 180 people attending were ill with vomiting, diarrhoea, fever, and abdominal pain two to 10 hours after eating rice and prawns. Cultures of rice were positive for *S aureus*, with 10^6 organisms/gram. The cooked food had been stored for 5½ hours at 18°C after being cooled at 4-7°C for an unknown period.

Compiled at the Communicable Disease Surveillance Centre, Public Health Laboratory Service

1 Anonymous. Food poisoning and salmonellosis surveillance in England and Wales: 1979. *Br Med J* 1980;**281**:1360-1.
2 Report from the Public Health Laboratory Service Salmonella Subcommitee. Salmonella infections in hospitals. *Journal of Hospital Infection* 1980;**1**:307-14.
3 Sharp JCM, Collier PW, Gilbert RJ. Food poisoning in hospitals in Scotland. *J Hyg* 1979;**83**:231-6.
4 Appleton H, Palmer SR, Gilbert RJ. Foodborne gastroenteritis of unknown aetiology: a virus infection? *Br Med J* 1981;**282**:1801-2.

MEDICAL NEWS

Childhood accidents—the unnecessary toll

Almost one-third of deaths between the ages of 1 and 14 years are the result of an accident, points out the Office of Health Economics in *Accidents in Childhood* (Briefing No 17), estimating that the 925 accidental childhood deaths in England and Wales in 1979 have led to a loss of some 60 000 years of potential life. In addition, 130 000 non-fatal accidents require hospital admission each year and 2 million cases are seen in accident and emergency departments. Hospital and GP treatment of childhood accidents are estimated to cost the NHS £70m. The report shows that there have been reductions in death rates over the last 20 years that have not been matched by falls in the incidence of non-fatal accidents in childhood; but recently, it says, some hopeful trends have emerged. For example, from 1975 to 1978 admissions of children under 15 years resulting from all types of injury dropped by nearly 23 000, partly because of fewer poisonings. The widely varying regional and social class rates for accidental injury, argues the OHE, suggest that there is scope for continued improvement. The highest rates are found in Wales and the Northern Region of England. The standardised mortality ratio for accidents for children of unskilled parents is almost five times as high as for children of parents in the professional groups—and for pedestrian deaths seven times as high. The report concludes that efforts to promote a safer environment (such as the creation of safe play areas and greater sensitivity to the needs of children in housing construction and design) offer the best prospects for reducing accidental injuries, with publicity campaigns and educational programmes to increase awareness of the dangers confronting children today. The report is obtainable from OHE (12 Whitehall, London SW1A 2DY) price 30p.

BMA symposia to mark IYDP

Two symposia to mark the International Year of Disabled People are being arranged by the BMA. The first, to be held at the BMA Scottish Office (7 Drumsheugh Gardens, Edinburgh EH3 7QP) on Friday, 13 November, includes lectures on handicap in the first five years of life (Professor F Cockburn); prevention of disabling diseases (Professor D C Flenley); sporting injuries (Mr D A D Macleod); assessing psychological and social adjustment in disability (Dr G P Maguire); incontinence in disability (Dr N A Hood); and rehabilitation of the physically disabled (Professor G Murdoch). The registration fee is £12. The second symposium, "Towards integration," is being arranged by the BMA Board of Science and Education and will be held in Bath during the weekend 20-22 November 1981 at the Royal United Hospital. The subjects of the lectures will include rheumatology and rehabilitation in Bath (Dr J A Cosh); a historical perspective of rehabilitation (Dr J G Sommerville); pressure sores (Dr A K Clarke); pain (Dr M Mehta); a therapist's view of some problems in rehabilitation (Miss P Jay); medical progress (Dr G Cochrane); and designing for the disabled (Mr D Penton). The cost of the symposium and social activities will be £22 for members (£27 for non-members), with £15·50 a night for hotel accommodation.

Further details from Rosemary Weston, BMA House, Tavistock Square, London WC1H 9JP.

Accident and emergency services in London

Hospital accident and emergency departments are often used in London to provide services that are not adequately provided through GPs or the primary care network, points out the fourth report of the joint study group of the Association of Community Health Councils for England and Wales and the London community health councils, which covers accident and emergency services. The group makes recommendations on accident and emergency services which it believes would remove some of the present uncertainties and lead to a more effective blend of hospital and community-centred primary care. The recommendations include: co-ordination of accident and emergency services between districts; recognition that the use of accident and emergency services, as an effective part of both primary and hospital care, should be taken into account in the planning of both; recognition of these realities in the training and job descriptions of all staff of accident and emergency departments; and a policy review by the DHSS of the treatment of accidents and emergencies. The report may be obtained from the association at 362 Euston Road, London NW1 3BL (01-388 4814).

Evaluation of breath testing devices

Three new devices for analysing the breath of drivers suspected of having a blood alcohol concentration above the legal limit are to be assessed at police stations in selected areas of Britain from 1 October. The trials will be for three months initially but may need to be extended. Drivers brought to the stations concerned will participate on a voluntary basis. The three devices are the Camic Breath Analyser, the Intoximeter 3000, and the Lion Auto-Alcolmeter. Breath tests will replace blood or urine tests for most motorists once the provisions of the Transport Act 1981 come into force.

Equal pension rights for men

At this year's Annual Representative Meeting the BMA Council was instructed to press for equal treatment for men and women doctors who are members of the NHS superannuation scheme, especially in relation to the provision of widowers' pensions as a right. The Secretary, Dr John Havard, has now written to the new Secretary of State, Mr Norman Fowler, asking for his comments and offering to meet DHSS representatives to discuss the matter. The present position is that on the death of a married woman a widower's pension is payable only where the husband is permanently incapable of earning his own living because of ill health or infirmity and is wholly or mainly dependent on her. Ministers have accepted in the past that there is little justification in these discriminatory practices and have supported the Occupational Pensions Board's view that the test of equal status between men and women should start from the premise of equal benefits—that is, identical treatment in identical circumstances.

In his letter Dr Havard said that the BMA thinks that "the Government should make a statement of intent and come forward with proposals for introducing provisions for widowers' pensions into the public service pension schemes and in particular the NHS scheme."

People in the news

Dr A Paton has been appointed regional postgraduate medical dean in the North-east Thames Region and an assistant director of the British Postgraduate Medical Federation from 1 October.

COMING EVENTS

St Mary's Hospital—Course in perinatal care, labour ward practice for obstetricians and midwives, 15-16 October, London. Details and application forms from Mrs K Newson, School of Midwifery, St Mary's Hospital, Harrow Road, London W9 3RL. (Tel 01-286 4884 ext 355.)

Royal Aeronautical Society Aviation Medicine Group—Symposium "Recent developments in aviation medicine," 21 October, London. Details from the lectures secretary of the society, 4 Hamilton Place, London W1V 0BQ. (Tel 01-499 3515.)

Royal Society of Medicine—"New perspectives: fifth forum for general practitioners," 26-30 October, London. Details from Miss N Mitchell, Conference Office, Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE.

Institute of Obstetrics and Gynaecology—Refresher course for general practitioners on modern management of obstetric and gynaecological problems in hospital and general practice, 28-30 October, London. Details from the symposium secretary of the institute, Queen Charlotte's Hospital, Goldhawk Road, London W6 0XG. (Tel 01-741 8351 ext 15.) Section 63 does not apply for this course.

Edinburgh Brook Advisory Centre—Conference "Dilemmas of teenage sexuality," 6 November, Glasgow. Details from Jean Malcolm, 2 Lower Gilmore Place, Edinburgh EH3 9NY. (Tel 031-229 5320.) Approval under Section 63 has been requested.

General Practitioner and Social Worker Workshop—Autumn conference "Whose patients? Team approach in health and social services," 7 November, London. Details from Mrs M H Lawrence, 7 Brookside, Dinas Powis, South Glamorgan.

Royal Society of Medicine—Details and copies of the 1981-2 calendar with section programmes are now available from the society, 1 Wimpole Street, London W1M 8AE. (Tel 01-580 2070.)

University of Liverpool—Details and copies of the autumn term of the course on the science and practice of orthopaedic surgery are now available from Professor George Bentley, University Department of Orthopaedic and Accident Surgery, Royal Liverpool Hospital, Prescot Street, P O Box 147, Liverpool L69 3BX. (Tel 051-709 0141 ext 2651.)

Winchester and Central Hampshire Medical and Dental Federation—Details and copies of the September to December 1981 programme are now available from the federation, Royal Hampshire County Hospital, Winchester. (Tel Winchester 63535 ext 422.)

SOCIETIES AND LECTURES

*For attending lectures marked * a fee is charged or a ticket is required. Applications should be made first to the institutions concerned.*

Monday, 5 October

BRITISH HEART FOUNDATION—At Birch Hill Hospital, Rochdale, 8 pm, Professor J R A Mitchell: Should every cow carry a Government health warning?

INSTITUTE OF OBSTETRICS AND GYNAECOLOGY—12 30 pm, project presentations, Dr V Osgood: Some aspects of twin pregnancy. Dr K Bidgood: Outcome of pregnancy associated with malignant disease.

Wednesday, 7 October

BRITISH HEART FOUNDATION—At Worsley Building, Leeds University, 5 30 pm, Professor Edmund Sonnenblick: New concepts in myocardial failure.

INSTITUTE OF ORTHOPAEDICS—6 pm, Mr D H R Jenkins: Use of carbon fibre for tendon replacement; 7 pm, Mr R S M Ling: Implant fixation with special reference to the hip.

ROYAL COLLEGE OF PHYSICIANS OF LONDON—5 40 pm, Goulstonian lecture by Dr R A C Hughes: Immunological disorders of peripheral nerves.

ROYAL COLLEGE OF SURGEONS OF EDINBURGH—2 pm, Mr Ian Kennedy: Rethinking medical ethics.

ROYAL COLLEGE OF SURGEONS OF ENGLAND—5 pm, Arris and Gale lecture by Mr G Davies: A new approach to the identification of tumour specific antibodies in patients with pancreatic and colonic cancer.

ROYAL FREE HOSPITAL SCHOOL OF MEDICINE—5 pm, guest lecture by Professor J Ch Bode (Marburg): Alcoholic liver disease.

Thursday, 8 October

WEST OF SCOTLAND COMMITTEE FOR POSTGRADUATE MEDICAL EDUCATION—9 30 for 9 45 am, Professor Rona MacKie: Recent advances in dermatology.

Friday, 9 October

INSTITUTE OF UROLOGY—12 30 pm, Surgeon Commander C Buck: Glucagon antiprostaglandins and stones.

NUFFIELD ORTHOPAEDIC CENTRE, OXFORD—6 30 pm, Dr P Dieppe: Inflammatory component in osteoarthrosis.

UNIVERSITY OF LIVERPOOL—At Royal Liverpool Hospital, 5 pm, Mr E Somerville: Contemporary treatment of congenital hip dislocation.

Saturday, 10 October

NUFFIELD ORTHOPAEDIC CENTRE, OXFORD—8 30 am, Dr P Dieppe: Particle induced inflammation; 9 30 am, Dr M J O Francis: Prostaglandins and inflammation in bone.

BMA NOTICES

Central Meetings

OCTOBER

6 Tues Scottish Joint Consultants Committee (7 Drumsheugh Gardens, Edinburgh EH3 7QP), 10 15 am.
7 Wed **Council,** 10 am.
9 Fri Ophthalmic Group Committee, 2 15 pm.
13 Tues Joint Consultants Committee, 9 30 am.
15 Thurs General Medical Services Committee, 10 am.

Division Meetings

*Members proposing to attend meetings marked * are asked to notify in advance the honorary secretary concerned.*

Barnsley—At Keresforth Hall Hotel, Thursday, 8 October, 7 30 pm, illustrated talk by Dr I McK Thompson on the new NHS.*

Brighton and Cuckfield—At Sussex Postgraduate Medical Centre, Brighton, Tuesday, 6 October, 8 30 pm, agm. (Preceded by buffet supper, 7 for 7 30 pm.*)

Chesterfield—At Royal Hospital, Wednesday, 7 October, 7 30 pm, Dr I McKim Thompson: "Reorganisation."* (Buffet supper provided.)

Halifax—At Hipperholme and Lightcliffe Conservative Club, Lightcliffe, Saturday, 3 October, 8 pm, snooker and social evening, spouses invited.*

Hastings—At Postgraduate Centre, Tuesday, 6 October, 8 15 pm, Mr P D Trevor-Roper: "The influence of eye disorders on the artist."* (Preceded by buffet supper 7 15 pm. Spouses invited.)

North Birmingham, Lichfield, and Tamworth—At the Belfry, Friday, 9 October, 8 pm, dinner dance.* (Guests invited.)

Mid Essex—At Chelmsford and Essex Hospital, Friday, 9 October, 12 30 pm, agm.

North Warwickshire—At Chase Hotel, Nuneaton, Tuesday, 6 October, 8 for 8 30 pm, valedictory dinner and lecture by Mr J A Jordan: "Litigation in medicine today."* (Guests and wives welcome.)

North-west Regional Office—At Boyd House, Wednesday, 7 October, open evening with free buffet.* Contact Sue Hickenbottom on 061 224 2382/3.

Solihull—At St John's Hotel, Thursday, 8 October, 7 30 pm, dinner, speaker Mr A W Goode: "The history and development of medical findings in manned space flights, its application to clinical medicine, and where we go in future with space laboratories and space shuttle."*

South-east Kent—At Royal Victoria Hospital, Folkestone, Tuesday, 6 October, 8 pm, agm.

South Glamorgan—At Whitchurch Postgraduate Centre, Tuesday, 6 October, 8 15 pm, Professor N C Wickramasinghe: "Life as a cosmic phenomenon." (Preceded by buffet supper 7 30 pm.*)

Regional Meetings

North-east Thames Regional Committee for Community Medicine—At London Hospital Medical College, Tuesday, 6 October, 4 30 pm.

Trent Regional Council—At City Hospital, Nottingham, Sunday, 11 October, 11 am.

CONSULTANT APPOINTMENTS

BIRMINGHAM AHA(T)—Miss E E Kritzinger (ophthalmologist).

NORTH WESTERN RHA—Dr G L Bhan (physician in geriatric medicine); Dr M E Eltoft, Dr B R Puddy (anaesthetists); Dr R F Stevens (haematologist).