that medical schools should be in densely populated, needy districts.

The practical outcome is that the university's resources are being concentrated in unified, joint, or merged schools (Guy's/St Thomas's, University College/Middlesex, Charing Cross/Westminster, and, probably, St Bartholomew's/London). At the same time diversity is being maintained by St George's completing its redevelopment at Tooting, St Mary's (with a new teaching hospital) developing a wider academic and geographical base in North-west London in a new working relationship with both the Royal Postgraduate Medical School and the Central Middlesex Hospital, King's College and King's College Hospital Medical School forming closer links, and the Royal Free going it alone at Hampstead. These rational, economical arrangements are no mean achievement and deserve a recognition more generous than "little overt progress"; change takes time but the framework is now decided and the clock is not likely to be put back.

The *BMJ* also expressed a belief that if the quality of medical education is to be maintained some medical schools should be shut, not, presumably, because they are bad (although if some are bad let us hear the evidence and take appropriate action) but in order to rob Peter to pay Paul. This, with respect, might preserve quality if the number of medical students were reduced, but the alternative of mass production in fewer schools conflicts with the very essence of the personal nature of medical education, especially at the clinical stage; there is no evidence that quality can be preserved by growing larger. On the other hand, it surely is sensible that schools should cease to be isolated islands, should work together, and share resources so as to become cost effective. Finally, this dean sees no salvation in the passing comment that one medical school might be "converted to a

private sector institution"; much better surely that private funds should continue to underwrite research and special facilities at well-established schools than that those funds should be diverted to a new private medical school.

Precarious balance

Having put down these few markers on matters which cannot wait, the many other problems can simmer for a few weeks. But as deans disappear in all directions to recharge their batteries they may quietly muse that harsh financial discipline has not been entirely without profit. No longer is much taken for granted, no longer is security regarded as a birthright, no longer does parochialism reign supreme, and a few skeletons have been cleared from cupboards.

Such good as there was in stringency has now been achieved. A further reduction in the resources of university departments of medicine will destroy the achievements of decades, will hurt patients as much as students, and harm electors even more than academics. The Social Services Committee summed up the relationship between university medicine and the NHS in these words: "University medicine can offer to the NHS a valuable impetus to innovation, research, and general professional leadership. A harmonious balance of academic and service medicine is the hallmark of good health services everywhere. To disturb this balance is to put at risk the quality of patient services"—and, of course, the quality of tomorrow's doctors. This balance is now precarious to say the least: one more push may destroy it.

(Accepted 26 July 1982)

Lesson of the Week

Non-excretory myeloma

JEAN-MICHEL CEREDA, JON AYRES, T GIBSON

When a patient presents with lytic deposits in the skeleton a diagnosis of myeloma is usually suspected and established on the basis of a raised erythrocyte sedimentation rate (ESR), a plasma paraprotein band, Bence Jones proteinuria, or an abnormal bone marrow on histological examination. Occasionally, marrow histology suggests myeloma in the absence of protein abnormalities in the blood or urine.¹ We report on a patient in whom equivocal bone histology and absent biochemical markers resulted in a mistaken diagnosis of breast carcinoma.

Patients with histological evidence of myeloma may not have any blood and urine protein abnormalities

Case report

A 54-year-old woman presented with pain in the right arm. Three months earlier she had complained of pain in the rib cage and lumbar spine. Clinical findings were confined to tenderness of the arm. All laboratory investigations were normal, including ESR, plasma protein electrophoresis, and immunoelectrophoresis of blood and urine (after ultracentrifugation). Radiographic examinations showed collapse of the third lumbar vertebra and an osteolytic area in the right humerus. A bone scan showed multiple skeletal abnormalities. Marrow examination was normal, but histology of the humeral lesion suggested

Guy's Hospital, London SE1 9RT

JEAN-MICHEL CEREDA, MD, senior house officer

JON AYRES, MB, MRCP, medical registrar

T GIBSON, MD, FRCP, consultant physician

myeloma. The Unna-Pappenheim stain for cytoplasmic RNA was negative, casting doubt on the initial histopathological interpretation. This stain is a sensitive marker for immunoglobulin-producing cells. After reconsideration the possibility of breast carcinoma was suggested. Bilateral xeromammography indicated microcalcification of the left breast. This area was excised and found to be normal. The patient was nevertheless treated on the assumption that she had metastatic breast carcinoma with tamoxifen, prednisolone, and irradiation of the arm and spine. Three months after presentation the results of plasma electrophoresis and urine immunoelectrophoresis were still normal. One month later she developed a lump in the left breast, an enlarged lymph node in the ipsilateral axilla, and spinal cord compression. Myelographic examination showed an extradural tumour, confirmed at laminectomy. Histology of the breast lump, the spinal lesions, and a second marrow aspiration showed the appearance of typical myeloma. For the first time electrophoresis of the plasma and urine showed large amounts of a monoclonal beta globulin. Immunofixation tests showed this to be IgA (kappa). She received further radiotherapy to her spine and prednisolone 40 mg and melphalan 5 mg daily. After one week of treatment she became neutropenic, developed pneumonia, and died.

Comment

At presentation this patient showed none of the usual haemato-

logical or biochemical markers of multiple myeloma. The ESR may be normal in 10% of such patients.² The absence of monoclonal globulin or globulin fragments occurs in fewer than 1%.³⁻⁴ The transition from a non-excretory myeloma to a more typical pattern, as was apparent in our patient, is exceptional.⁵ Our mistaken assumption that the patient had breast carcinoma was based on atypical marrow histopathology and was reinforced by the development of a breast lump with axillary lymph node enlargement. The correct diagnosis was established only when microscopy of marrow and extraskelatal tissue showed unequivocal myeloma in the presence of a plasma paraprotein band. The failure to demonstrate abnormalities in blood and urine protein in the presence of suggestive histological evidence should not deter acceptance of the diagnosis of multiple myeloma.

References

- Joyner MV, Cassuto JP, Dujardin P, *et al.* Non-excretory multiple myeloma. *Br J Haematol* 1979;43:559-66.
- Kyle RA. Multiple myeloma. Review of 869 cases. *Mayo Clin Proc* 1975; 50:29-40.
- Di Guglielmo R. Unusual morphologic and humoral conditions in the field of plasmacytoma and M-dysproteinemia. *Acta Med Scand* 1966; 79, suppl 445:206-11.
- Osserman EF, Takatsuki K. Plasma cell myeloma: gamma globulin synthesis and structure. *Medicine* 1963;42:357-84.
- Kim I, Harley JB, Weksgler B. Multiple myeloma without initial paraproteins. *Am J Med Sci* 1972;264:267-75.

(Accepted 15 July 1982)

A 2-year-old child has painful ingrowing toenails. What treatment is advised?

As the toenails of a 2-year-old are much softer than in the adult it is easier to apply to the ingrowing nail the treatment of tucking under the corner of it a cotton wool pledget soaked in antiseptic. (The problem is securing the co-operation of the patient.) If there is severe infection to start with warm saline soaks before the treatment are helpful. The treatment should be carried out twice a day until the edge of the nail protrudes beyond the hypertrophic skin fold. Thereafter correct cutting of the nail and correct fitting of shoes must be attended to. Cotton socks, not nylon, are advised. Only very rarely may the nail be congenitally so deformed as to require ablation of the bed.—PETER GORNALL, consultant paediatric surgeon, Birmingham.

Some foods supplied to our hospital patients—for example, commercially prepared soups—contain monosodium glutamate; these concentrations are sometimes sufficient to cause the "Chinese restaurant syndrome." Can we condone the uncontrolled administration of vasoactive drugs, particularly to patients with cardiovascular disease?

The Chinese restaurant syndrome consists of a numbness at the back of the neck radiating to arms and back with associated weakness and palpitation that occurs 15 to 20 minutes after ingestion of Chinese food.¹ Monosodium glutamate has been implicated as a likely cause of symptoms, but the results of several placebo-controlled double-blind studies have not been conclusive. In one study² there was no difference in the incidence of reactions between monosodium glutamate and placebo, and in another³ symptoms such as nausea and headache occurred more often after monosodium glutamate, but the full clinical picture of the Chinese restaurant syndrome did not occur. The pathophysiology of adverse reactions to monosodium glutamate is not known. There is no evidence to suggest that symptoms are primarily vascular or that patients with cardiovascular disease are more susceptible. Monosodium glutamate is one of the most widely used food additives. In many commercially available foods its concentration is about one gram per serving and this level rarely causes symptoms. On the basis of the evidence available there is

little basis for advocating the withdrawal of foods containing monosodium glutamate from hospitals.—EOIN O'BRIEN, consultant physician, and W G O'CALLAGHAN, research fellow, Dublin.

- Kwok RHM. Chinese restaurant syndrome. *N Engl J Med* 1968;178:796.
- Morselli PL, Garattini S. Monosodium glutamate and the Chinese restaurant syndrome. *Nature* 1970;227:611-2.
- Gore ME, Salmon PR. Chinese restaurant syndrome: fact or fiction? *Lancet* 1980;i:251-2.

A married woman of 40 with two sons has taken the pill for the past 15 years. Her present prescription is D-norgestrel 0.15 mg and ethinyl-oestradiol 0.03 µg. Is this likely to increase the risk of developing breast cancer?

As breast cancer is known to be an endocrine-related cancer, there is a natural anxiety about the risk of developing breast cancer among women taking hormone preparations over a long period. So far as the contraceptive pill is concerned, there have been two recent publications that offer some degree of reassurance.^{1,2} The Royal College of General Practitioners found no increased risk in a cohort of women followed up for a maximum period of 13 years. Again, the Oxford Family Planning Association study showed no increased risk among those taking the pill with a maximum follow-up of a similar period.³ Unfortunately, neither study could assess the risk for a woman who had taken the pill for 15 years, and both studies pointed out the paucity of data on young women starting the pill in their 20s and followed up into the peak age incidence of breast cancer, which is the middle 50s. In short, therefore, there are no data on which to base an informed answer, but theoretically the combination of an oestrogen with a progestogen should protect against carcinogenesis if we accept the hypothesis of luteal insufficiency.³ All that aside, I would have thought that of greater concern to this woman would be the increased hazard of cardiovascular and cerebrovascular problems associated with prolonged use of the pill after the age of 40.—M BAUM, professor of surgery, London.

- Royal College of General Practitioners. Breast cancer and oral contraceptives: findings in RCGP study. *Br Med J* 1981;282:2089-93.
- Vessey MP, McPherson K, Doll R. Breast cancer and oral contraceptives: findings in Oxford Family Planning Association Contraceptive Study. *Br Med J* 1981; 282:2093-4.
- Short RV, Drife JO. The aetiology of mammary cancer in man and animals. *Symposia—Zoological Society of London* 1977;41:211-30.