could find no other major social or environmental change that occurred in the population we served which might have explained these striking findings.

We agree with Dr Platt that it would have been advantageous to compare our experience with that of similar districts in England. Despite strenuous efforts, however, we could not obtain comparable data of this type. The experience in the Edinburgh poisons unit has apparently been different from our own, but several factors may explain this. In contrast to our own policy during the period of study, we understand that in Edinburgh, particularly during the latter years of the review described by Dr Platt, the admission policy has changed in that only some of the patients reaching the accident and emergency department are admitted to the poisoning centre. Also, from the data presented, it is clear that the percentage of Edinburgh patients who took alcohol with their overdose before the change in the licensing laws was more than twice that in our own series. This may well have obscured and at least reduced any impact which the change in the law may have caused in the Edinburgh admission rate. As far as poisoning is concerned, it is well established that patients from capital cities and other dense conurbations behave differently from those in a mixed urban and rural community.

We would suggest, therefore, that the data presented by Dr Platt are not necessarily strictly comparable with our own. Clearly it is difficult to provide any proof of the association which we suggested and we would be most interested to learn of others' experience, particularly from comparable district general hospitals.

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simply consist of part trained consultants ill supported by resources (secretary, office, junior staff) who will be expected to do the real consultants' night duty for them?

(7) Has anyone considered the wisdom of a system which effectively abolishes all competition above SHO grade? Future consultants will be chosen within two or three years of graduation, long before their suitability for such posts can be assessed.

(8) Does the BMA understand the problems implicit in a reduction in clinical research? The distinction drawn between training in research methods and in clinical research is nonsense. To suggest that a research registrar should be drawn from the overall quota of acute service registrars is also nonsense—unless there are to be more registrars allocated than there is clinical work to be done.

In summary, we are deeply disturbed about both the fundamental principles and the details of this report. We believe the solutions proposed for the problems of the hospital medical career structure are ill considered. We suggest, moreover, that the whole problem has been approached in the wrong way. Matching the number of registrar posts to the expected number of consultant vacancies is a very blinkered way of planning medical staffing of the health service. How much better to begin by matching the numbers of the different grades of staff to the work to be done. Then we might know whether the system could support a pyramidal career structure without undue wastage or whether a wholesale change in this historic pattern might be better.

Achieving a Balance may solve some of the problems of medical career structure but as a package deal we believe it has so many flaws that it would be best to reject it completely and to have no deal at all.

A MORGAN and W JEFFCOATE
and 104 other doctors

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received any steroids. This cannot therefore be said to constitute a trial of steroid therapy in an unselected series of patients.

The other papers³⁻⁵ quoted by Mr Thomas and others and by Dr C E Fadul and others (p 1015) concern randomisation of patients who had survived major surgery for two to four weeks and who were "fit enough" to withstand radiotherapy or chemotherapy. The criteria for major surgery were not given and we do not know what happened to those who did not undergo major resection. The patients admitted to these surgical trials were, as Dr Fadul and colleagues acknowledge, a different cohort from those assessed in our clinical audit. Each trial showed that radiotherapy did prolong life in these selected cases and that any additional effect of chemotherapy was marginal. Indeed, each paper pleaded for a more effective management regimen.

We would emphasise again that our report was a clinical audit of an unselected group of patients presenting consecutively to different consultants in a regional neurosciences unit. Many of the patients would not have been considered suitable for entry into the surgical series discussed by your correspondents. This does not mean that we refuse to pursue an aggressive management policy in those patients in whom this is appropriate. Unfortunately such patients represent an all too small proportion of the population presenting to us. We will, as we have in the past, continue to join multicentre trials, usually in conjunction with our colleagues in radiotherapy and oncology.

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Manpower

SIR,—We recently received the communication from the chairmen of the Central Committee for Hospital Medical Services and the Hospital Junior Staff Committee about hospital medical staffing. We are worried about the implications of the report *Achieving a Balance* and feel that agreements have been reached on our behalf with which we are not in accord. The consultation process adopted by the BMA leadership has not successfully informed the leaders of what their members think.

The circular attempting to explain *Achieving a Balance* leaves many questions unanswered.

(1) Why is there such a need to rush into restructuring junior hospital doctors' jobs?

(2) How can expansion of the consultant grade be accommodated "within existing facilities"? How can a surgeon operate without theatre space or without an anaesthetist? How can a physician run a clinic when there is no clinic space?

(3) What is the good of simply shifting the bottleneck in junior posts down to senior house officer grade? The competition for hospital SHO posts and for vocational training scheme posts is already bad enough.

(4) The BMA has not explained how a reduction in quality of patient care can be avoided in those districts in which there is a reduction in numbers not only of registrars but also of SHOs and senior registrars. In one paragraph the crucial service role of the registrar is acknowledged, yet the basis of this report is that the numbers of registrar posts should be reduced.

(5) How is it possible to avoid creating two types of registrar who provide different levels of care? District registrar posts will be essential for service needs, but is it right for the National Health Service to depend on a supply of foreign graduates on short term contracts?

(6) Will not the new intermediate service grade

Neurological and neurosurgical approaches in the management of malignant brain tumours

SIR,—In our original paper (18 October, p 1015) we perhaps did not make it clear that the 18 cases in the text referred only to those of a proved glioma (excluding ependymoma) for the diagnosis of malignant glioma was certainly not proved in the remaining cases, which were also recorded in table V. Certainly the great majority of patients submitted to radiotherapy had undergone surgery, but in most cases this was a burr hole biopsy alone. There is no evidence to support the contention that patients who did not undergo surgery included a greater proportion with low grade tumours or no tumours than the group who underwent biopsy. Indeed, as judged by the other criteria the groups were broadly similar.

Mr D G T Thomas and others (10 January, p 123) correctly quote from the discussion in Salcman's paper,¹ but the data in that paper showed that the median survival in glioblastoma multiforme was 4 months with operation alone and 9.25 months when radiotherapy was added. Whether this represents an improvement other than marginal, once time has been allowed for treatment and its effects, is a matter of opinion.

Mr Thomas and his colleagues quote the trial of Walker *et al*² as one in which steroids alone were used in one arm. Ninety five per cent of patients admitted to that trial had undergone a major resection, and all had to have a projected survival of at least two months postoperatively and to have received steroids for less than one month before they could be admitted to one of the four arms of that trial. Only 76% of the patients actually

- 1 Salcman M. Survival in glioblastoma multiforme: historical perspective. *Neurosurgery* 1980;7:435-9.
- 2 Walker MD, Alexander E Jr, Hunt WE, *et al*. Evaluation of BCNU and/or radiotherapy in the treatment of anaplastic gliomas. *J Neurosurg* 1978;49:333-43.
- 3 Walker MD, Green SB, Byar DP, *et al*. Randomized comparisons of radiotherapy and nitrosoureas for the treatment of malignant glioma after surgery. *N Engl J Med* 1980;303:1323-9.
- 4 Kristiansen K, Hagen S, Kollevold T, *et al*. Combined modality therapy of operated astrocytomas grade III and IV. Confirmation of the value of postoperative irradiation and lack of potentiation of bleomycin on survival time: a prospective multicenter trial of the Scandinavian Glioblastoma Study Group. *Cancer* 1981;47:649-52.
- 5 Green SB, Byar DP, Walker MD, *et al*. Comparisons of carmustine, procarbazine and high-dose methylprednisolone as additions to surgery and radiotherapy for the treatment of malignant glioma. *Cancer Treat Rep* 1983;67:121-32.

* This correspondence is now closed.—ED, BMJ.

Dialysis arthropathy: amyloid or iron?

SIR,—We investigated 10 patients undergoing regular haemodialysis treatment (duration 4-18 years) who underwent a carpal tunnel release operation (bilateral in two patients). The synovial tissue was histologically examined for iron, aluminium, amyloid, and β_2 microglobulin. Of these eight had amyloid and their synovial tissue stained positively for β_2 microglobulin using an immunoperoxidase method. Aluminium was not detected in any of these specimens, and only one patient had deposits of haemosiderin but her serum ferritin concentration was 39 $\mu\text{g/l}$. Another patient who was anephric had received 130 units of blood transfusions; her serum ferritin concentration was 8030 $\mu\text{g/l}$ and she showed no evidence of iron in the synovial tissue. However, in this patient excess iron was present at the osteoid mineralisation

junction.¹ The serum ferritin concentration in the remaining eight patients ranged from 19 to 251 µg/l and they had not received any abnormal amounts of blood transfusion. Large joints were not affected in these patients. Six of the 10 patients had evidence of renal osteodystrophy and underwent parathyroidectomy.

We concur with Dr N R Cary and coworkers (29 November, p 1392) that amyloid deposits are a feature of carpal tunnel syndrome in patients undergoing regular haemodialysis treatment and are related to β_2 microglobulin accumulation. However, we did not observe iron overload in these patients. We wonder whether the haemosiderin deposits they found in the synovial tissue of joints could result from minor haemorrhages for mechanical reasons in these susceptible patients.

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1 Ahmad R, Ackrill P, Day JP, et al. Reversal of osteomalacia in chronic dialysis patients with heavy iron and aluminium loading. *Mineral Electrolyte Metabolism* 1985;11:1.

Day surgery: does it add to or replace inpatient surgery?

SIR,—To answer Dr E A Howarth's and Dr R Balarajan's question (10 January, p 133), it is self evident that if day surgery is set up as a unit in addition to the existing facilities then it will add to them. Should a day unit be set up with a calculated removal of inpatient facilities then it will replace them.

The Kingston day unit was set up in addition to existing facilities so it was bound to result in a greater total volume of work. This reflects only the huge unmet need, which is pressing at all times. Surgeons live with this every day. Although the authors say "The critical or irreducible surgical rate for a given population is not known," it would seem to many of us that we live with a basic critical level all the time. They go on to show that the New York level of provision is over twice that in England and Wales. Even if New York is over-provided by 10%, 20%, or even 30% that still leaves us significantly underprovided, whatever the politicians may claim. We do not seek over-provision of facilities and surgeons but just ask that they be adequate.

Of course we could, and should, change to treating more patients in day case units but even if these facilities are additional they will barely get us above the present disgraceful level of provision in surgery.

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Macrocytic anaemia in patients treated with sulphasalazine for rheumatoid arthritis

SIR,—We note that the seven patients of Dr P J Prowse and colleagues who developed macrocytosis were from a group of 50 receiving sulphasalazine for progressive erosive rheumatoid disease. The authors infer from the data presented that the development of macrocytic anaemia due to sulphasalazine therapy in this situation is therefore quite common. We do not, however, think that this conclusion is entirely justified from their data.

Of the seven cases described, four had an important potential cause of folate deficiency quite

separate from sulphasalazine therapy. Thus one had malabsorption with bacterial overgrowth, a second coeliac disease, a third a "poor diet," and a fourth chronic haemolysis. In none of these patients can sulphasalazine be concluded to be the cause of macrocytosis. Of the other three patients reported, none appeared to have undergone bone marrow examination, and therefore megaloblastic anaemia was not confirmed. Also the increase in mean corpuscular volume while taking sulphasalazine was at most modest in one of the subjects (case 7). In all three cases the red cell folate value was below the lower limit of normal, but no data were given on red cell folate before sulphasalazine therapy. Modest increases in mean cell volume in the absence of folate deficiency have been reported in patients with rheumatoid arthritis taking sulphasalazine¹ and we have seen a number of cases in which a modest increase in mean cell volume occurred during sulphasalazine therapy, with a subsequent spontaneous fall and no evidence of folate deficiency or haemolysis.

The data presented are not adequate to justify a diagnosis of sulphasalazine induced folate deficiency in most of these patients. Indeed our own experience in 350 patients would suggest that this is an uncommon complication of sulphasalazine treatment in rheumatoid arthritis. The authors correctly point out that sulphasalazine need not be discontinued if anaemia occurs, but we would suggest from their data that a more reasonable conclusion would be that macrocytic anaemia occurring during sulphasalazine therapy should trigger a search for some other cause of folate deficiency.

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1 Grindulis KA, McConkey B. Does sulphasalazine cause folate deficiency in rheumatoid arthritis? *Scand J Rheum* 1985;14: 265-70.

The debasing of medicine in the Soviet Union

SIR,—Dr Stewart Britten may be sincere when he says he is against sin (17 January, p 180) but unlike the Royal College of Psychiatrists he does not see it when it occurs. He insinuates that the royal college has been guilty of "coercing" the Russian people, and his intellectual gymnastics complete a 180° turn by complaining that we should not fête released dissidents because this would serve as a "disincentive" in granting exit visas to other dissidents.

No doubt Dr Britten would not occupy his present post as honorary secretary of the UK/USSR Medical Exchange Programme if he did not, on occasion, release a defensive smoke screen about the situation in the Soviet Union. Psychiatric detention as a means of political repression is a proved fact quite irrespective of whether the "patient" is mentally completely normal or whether he shows mental abnormalities: even in the latter case the decisive factor is the expression of views unacceptable to the Soviet establishment.

The views of ordinary Soviet psychiatrists are totally immaterial as far as the practice of this type of abuse is concerned. They have no voice in formulating psychiatric policies let alone policies entailing political decisions. Their views probably encompass the whole range from strong secret disapproval to uncritical acceptance of these

practices. What is relevant is that we cannot meet ordinary Soviet psychiatrists unless they are chosen by the staff of the Soviet embassy in London. This was made very clear to the royal college when this question was discussed with a representative of the Soviet embassy.

I hope Mr Britten's sanguine view of better times to come is based on something more relevant than the publication of infant mortality figures. What concerns us psychiatrists and, I am sure, many other doctors is, for instance, the continued detention of Dr Anatoly Koryagin in conditions of the utmost severity in a labour camp for no reason other than his insistence on drawing attention to the existence of psychiatric abuse as a means of political repression. His psychiatric reports on specific cases are in the possession of the Royal College of Psychiatrists and show a perversion of a humane discipline that was surpassed only by the fascist dictatorship in Germany. Dr Britten's letter would have carried at least a grain of conviction if he had, for instance, joined the royal college in its insistent demands for Dr Koryagin's immediate release.

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The increase in molluscum contagiosum

SIR,—Dr J D Oriel brings to our attention the increase in the incidence of molluscum contagiosum (10 January, p 74). I would like to add a few points about its management.

Identification of the lesions is not as easy as it may seem, and they are often mistaken for condylomata acuminata. When a patient presents with lesions of molluscum contagiosum in a busy clinic their removal will probably be time consuming, each one needing to be removed individually.

The standard descriptions mention phenol, but this might be considered unsafe, especially if the operator's hands are unsteady. Tincture of iodine introduced into the tumour with the pointed end of a wooden stick is probably safer.¹ The removal of the lesions is usually done in the outpatient department with the operator having to press on the lesion with his thumb nail, usually ungloved (in fact they are not easy to remove in gloves). There is usually some oozing of blood. In homosexuals molluscum contagiosum is often found on the face and around the natal cleft. The lesions are often worse and more widespread in individuals who are infected with the human immunodeficiency virus,² who are often also positive for hepatitis B surface antigen. Is it not about time that physicians' standard procedures in the treatment of this condition were reconsidered?

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1 Radcliffe-Crocker H. *Molluscum contagiosum in disease of the skin*. London: H K Lewis, 1903:674-82.

2 Farthing CF, Brown SE, Staughton RCD, Cream JJ, Mühlemann M. *A Colour atlas of AIDS*. London: Wolfe Medical Publications, 1986:66.

Prognosis for infants born at 23 to 28 weeks' gestation

SIR,—The question raised by Drs C Skeoh and P Galea (17 January, p 178) is obviously relevant in these straitened times. I must, however, confess to some unease at the recent debates concerning what amounts to selective non-treatment of extremely low birthweight infants.