

your attention to a press denial by the trustees that the centre is to close. This is a decision which still has to be discussed by the trustees in the light of the resignation of Dr. Shaldon, which is to take effect from 1 July 1968. Obviously, if a suitable replacement for Dr. Shaldon could be found within a reasonable period of time the centre could continue to function, but if perchance this is not possible inevitably and regretfully it would have to close.

On 9 May last a meeting took place with representatives of the Minister of Health to discuss a Ministry of Health circular, No. H/A 190/14, where the Minister advised chairmen of medical committees of teaching hospitals and senior administrative officers that, while regional hospital boards have the power to refer patients to the National Kidney Centre and pay for treatment outside the N.H.S., it was the unanimous recommendation of the meeting that patients should not be referred, as this form of treatment should be based only on hospitals with full supporting facilities. At this meeting a plan to provide chronic dialysis in the United Kingdom based on the use of home haemodialysis, which would integrate the National Kidney Centre within the National Health Service, thereby making all the medical equipment and financial resources available to the National Health Service, was submitted for consideration, and to date no reply to this plan has been received.

The attitude of the trustees of the National Kidney Centre and its medical director has always been an unselfish one, and the result of Dr. Shaldon's research into home dialysis was quite staggering in its potential in the terms of numbers which could be treated. We therefore feel that by integration with the N.H.S. the maximum number of people suffering from this disease in the United Kingdom could receive benefit.

Regretfully, it is the complete lack of interest and approach to this matter which has developed cumulative frustration in our medical director which now results in his resignation. I would have thought that from a national point of view there must be a strong case for the retention of the National Kidney Centre until such time as a better form of development could be substituted in its place. Should the train of events now result in the eventual closure of the National Kidney Centre it would be a national tragedy.

The result during the last seven weeks has already proved disastrous, as the programme of the centre was to accept 60 patients by the end of the year. During the past three weeks any patients referred have not been accepted. By the end of the year, if the situation continues, some 30 prospective patients will die needlessly.

The National Kidney Centre has been established as a charitable, non-profit-making organization to provide artificial kidney treatment to as many patients as possible. The centre is concerned with providing treatment under ideal circumstances—one unit, one patient, at home and freed from the need for repeated hospital attendance, involving travel and pressure on bed space and nursing staff in the already overburdened Health Service hospitals. Though the effectiveness of artificial kidney treatment for those with incurably diseased or damaged kidneys is medically accepted beyond dispute, the National Health Service will be unable to provide this form of treatment for more than

5 to 10% of those who could benefit in the next few years. This means that 5,000 to 10,000 sufferers in this country will die unnecessarily in that time.

The National Kidney Centre was set up by a group of individuals who were dissatisfied with the Health Service plan and who wished to demonstrate an alternative approach—home dialysis—which would, through private funds, provide hope for the majority who are doomed to die and for whom no Government help is foreseeable.—I am, etc.,

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. See leading article at p. 631.—Ed., *B.M.J.*

Amphetamine

SIR,—I have been most pleased to see in "Today's Drugs" on the prevention of motion sickness (12 August, p. 422) that you and your expert contributors say that any drug combination containing amphetamine is of itself open to objection. On turning overleaf (p. xii) I was dismayed to see an advertisement for an anti-obesity drug containing just such a combination.—I am, etc.,

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T. G. REAH.

The "Pill" and Deep-venous Thrombosis

SIR,—Mr. K. Hæger and colleagues (19 August, p. 493) query the reliability of diagnosis of venous thrombosis in the Royal College of General Practitioners series of non-fatal cases discussed in the Medical Research Council report (6 May, p. 355) and other reported non-fatal cases. Their remarks do not apply to any of the reported deaths, all of which have come to necropsy, as will have most of those studied by the Dunlop Committee. Even in the Royal College of General Practitioners cases, as the same practitioners were caring for both patients and controls, an increased incidence of *something* (pseudothrombosis?) has been found. Conversely, about 66% of deep-venous thromboses are not diagnosed in life¹ (my own observations agree) and it is as likely that the incidence is understated as overstated.

Interpreting broadly the term "coagulation patterns" in their last sentence, many studies have revealed a variety of changes in oral contraceptive users. To take one line of thought, your leading article (19 August, p. 449) says: "Platelet adhesiveness . . . has been shown to be increased in . . . venous thromboembolism." Puerperal venous thromboses are commonest about the tenth day, when both platelet count and platelet adhesiveness are maximal.² Platelet adhesiveness in the presence of cephalotogenic factor is increased in users.³

The platelet count in users is not increased.^{4,5} This was claimed as evidence against any thrombotic risk, but Dr. J. L. Burton (22 July, p. 214) suggests that agglomerins (notably fibrinogen) cause rouleaux formation and raised erythrocyte sedimentation rate in users. Very likely they play a part in thrombosis. If, as your leading article suggests, platelet adhesiveness is an

index of other blood changes it may in users connote a liability to thrombosis.—I am, etc.,

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REFERENCES

- Richards, R. L., *Brit. med. J.*, 1966, 2, 217.
- Carroll, J. D., Leak, D., and Lee, H. A., *Quart. J. Med.*, 1966, 35, 347.
- Caspary, E. A., and Peberdy, M., *Lancet*, 1965, 1, 1142.
- Pepper, H., and Lindsay, S., *Amer. J. Obst. Gynec.*, 1963, 86, 737.
- Hetherington, R. J., *Lancet*, 1967, 1, 1385.

Surgery in Acquired Cardiac Disease

SIR,—Perhaps I may draw attention to an error in the report on my communication on the place of surgery in acquired cardiac disease at the Annual Meeting in Bristol in July (22 July, p. 233). I am reported as saying that: "Patients with mitral incompetence tended to run a more rapid downhill course after the *arrest* of symptoms . . ." This should of course read "after the *onset* of symptoms . . ." The change in the word of course completely alters the sense of the message.

I was anxious to point out that, since operations for mitral incompetence are more complex and hazardous than mitral valvotomy, patients should not be advised to have open operations unless the symptoms due to mitral incompetence were demanding. Thus I stated that many patients with mitral incompetence were capable of managing satisfactorily without surgery for a number of years and in them operation could often be postponed.—I am, etc.,

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Protective Helmets and Traumatic Epilepsy

SIR,—I am very grateful for Mr. W. Bryan Jennett's helpful comments and information on traumatic epilepsy (29 July, p. 308). The following information may be of interest to him regarding his request for data on the incidence of head injuries in men wearing helmets.¹

During a period of six months in a coal mining area where 16,732 were employed 324 men voluntarily reported to the colliery medical treatment centres injuries which had occurred to that area of the head normally covered by the helmet. Of these, 299 accidents occurred underground and 34 on the surface. The wearing of helmets was virtually 100% in underground workers; it was the exception rather than the rule for those working on the surface. The distribution of accidents which occurred at the underground working place, according to the site of the head injury, was 60% frontal, 17% side, 8% back, and 16% top of the head. Surface workers had a different distribution—namely, 24% frontal, 9% side, and 68% top.

These figures demonstrate the efficiency of the helmet in protecting the top of the head. Unfortunately, the design and wearing fashion of the helmet did not give the same degree of protection to the front of the head in