for some weeks. When it is thought the outbreak has subsided and all the investigations have been completed a detailed account will be submitted.—We are, etc.,

E. W. HARDMAN.
R. LYNN H. JONES.
A. H. DAVIES.
O. H. WATKINS.

Chepstow, Mon.

** See also epidemiological report at p. 63.—Ed., *B.M.J.*

Incentive to Specialize

SIR,—Capital earnings during the first 20 years of general practice now so outstrip the earnings of the trainee consultant that by the time the registrar is appointed to his consultancy he is usually heavily in debt, and sees little prospect of becoming financially viable within the next 10 years. There is nothing of that slight whiff of affluence which in his more optimistic, if not actually hallucinated moments, he had come to anticipate.

There is one just and simple solution to this. When a registrar becomes a consultant he should receive a tax-free gratuity of at least £2,000. This would make the achievement worthwhile materially as well as psychologically. It would also give him the incentive to persevere with specialist training, and help him to begin his consultant career relieved of some of the financial tension which has bedevilled his registrar existence.—I am, etc.,

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W. C. WATSON.

Admissions Through a Booking Clinic

SIR,—The Metropolitan Hospital is a small busy general hospital with a large outpatient department in relation to its size, and the resident staff have always found life busy and working hours long. The problem of admitting, clerking, and investigating booked cases always presented difficulties, particularly to the house surgeons, as each one worked for several consultants and had casualty duties in the evenings in addition. It was found that patients who had been admitted during the day were not examined until late in the evening, when x-ray and pathology services were only available for emergency use, and this clashed with the necessity to give house staff free evenings.

In 1967, because of reconstruction work in the hospital, a system was instituted of bringing patients to the hospital to attend a "booking clinic" a few days before their admission to the wards. The clinic is held on three afternoons a week, each of the house surgeons choosing a suitable day when he is not otherwise committed. All the cases which are to be admitted under his care are seen, and the clinic is conducted with one of the nurses from the ward to which the patient is likely to be admitted. A full clinical examination is made, urine is examined, routine investigations such as haemoglobin and other blood tests are done, and appro-

priate x-ray investigations are made. If the patient is found to be unfit for any reason for operation, then arrangements are made to postpone the admission and another patient is called to come in.

There can be no doubt that the chief people to gain are the resident medical staff, but in addition there are co-lateral benefits to the x-ray department and the pathology department, which arrange their work so that they are in a position to make their investigations during ordinary hours. No patient has complained at having to attend an extra time in the outpatient department, and over a thousand patients each year are handled in this way. In general the consultant staff find this service useful, although one out of ten has expressed a preference for the work to be done in the ordinary outpatient clinic at the time of first attendance or decision to admit, where time permits.

Any measures which tend to make the house surgeon's life more regular and less rushed can only be of benefit to his patients, and it may well be that other hospitals may wish to try out a booking clinic. They will, we believe, find that the benefit is greatest when the waiting-list is long.—We are, etc.,

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Social Awareness

SIR,—The "Personal View" of Dr. D. M. Ross (7 June, p. 629) was particularly interesting. He stated that for the medical students of his day "Politics had no interest for us simply because it made no difference to our lives which particular party was in power. As for marching about protesting about something which was no concern of ours, we had other things to do which we considered more important." It appears that these thoughts express the attitudes of many students and young doctors today.

Surely in the long run the most potent defence against injustice is public opinion; in other words the collected social consciences of the population. Doctors have a greater opportunity than most to play a part in strengthening this cornerstone of a free society. They have natural ability and a good school education. They have spent five or six years in a medical school attached to a university. By the nature of their work they are brought into contact with people of all walks of life and are given a chance to become aware of their problems. Some doctors are very aware of the troubles of our times, but many have succeeded in closing their minds to them.

In the "Personal View" of the week (31 May, p. 571) before doubts were expressed that medical training was too narrow. In an ideal world one of the functions of a medical school curriculum and a junior hospital training post would be to allow time for, and encourage, men to develop a sense of social awareness and responsibility. The present system is unlikely to produce any one like Bertrand Russell. This is a pity.—I am, etc.,

London W.5.

D. H. HOWE.

Reading and Learning

SIR,—From studies in 1966 of doctors registering in 1964 and 1965 after qualifying in Edinburgh, Drs. H. J. Walton and J. M. Last (21 June, p. 752) conclude that "While women do better academically at medical school than men, they do much less medical reading subsequently. This implies that soon after graduating women are already falling behind in the theoretical part of their professional programme, a finding that has obvious implications for postgraduate education of women doctors."

Time spent reading cannot be a measure of learning. Their observations will equally bear the interpretation that the young women, being more able, require much less time to select and apprehend necessary facts than the men. May not the "obvious implication" be that the postgraduate education of men doctors should include the dictum that time spent mulling over books is not necessarily time spent learning?

Perhaps a comparison of the pass rate of male and female candidates in higher examinations would be enlightening.—I am, etc.,

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An Explanation for Addiction

SIR,—The addiction phenomenon may be considered as a form of oscillation in which drug-taking constitutes the feedback. One can regard the mood centres in the main as self-regulating mechanisms tending to maintain mood at a constant level, so that the euphoria produced by a drug tends to be corrected by a subsequent depression. This in turn requires the administration of the drug to relieve the rebound depression. If the time constants of the drug and the mood centres are about the same—in other words, a few hours—and the drug is sufficiently potent, oscillations can be built up which would be reinforced by conditioned reflex formation. This would explain why potent drugs having rapid action—for example, heroin or the amphetamines—are likely to produce addiction while longer-acting drugs—for example, monoamine-oxidase inhibitors—apparently do not cause addiction.

It would seem likely, therefore, that addiction might be treated by establishing the patient adequately on a long-acting antidepressant before the drug of addiction is withdrawn.—I am, etc.,

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Sudden Death in a Young Asthmatic

SIR,—The discussion of Drs. Ian Gregg and John Batten's patient (5 April, p. 29) again raises the question of the use of peak expiratory flow rate (P.E.F.) measurements to assess airway obstruction. This patient was treated inadequately because he had little subjective distress, and the functional evidence pointing to airway obstruction was not accorded its due importance in the clinical management.

It is regrettable that P.E.F. measurements continue to be popular among clinicians,¹ despite warnings about their relative lack of sensitivity in assessing airway obstruction published in your columns years ago.^{2,3} More recent studies which have clarified the relationship between lung volume, expiratory flow rate, and alveolar pressure^{4,5} substantiate the view that "The measurement of the maximal expiratory flow rate . . . cannot be recommended as a single lung function test."⁶ Maximum expiratory flow rates depend on lung volume, and flow rates at small lung volumes are more depressed under conditions of peripheral airway obstruction than P.E.F.^{7,8} Leuallen and Fowler⁹ realized this fact long ago, when they introduced the measurement of mid-expiratory flow rate.

Measurement of spirometric values such as the F.E.V.₁ or mid-expiratory flow rate, or recordings of maximum expiratory flow-volume curves, all include, directly or indirectly, information on maximum flows occurring at smaller lung volumes than that at which P.E.F. is reached. Any one of these methods would have indicated the severity of the persistent airway obstruction in the patient of Dr. Gregg and Dr. Batten more adequately than P.E.F., and this would have called for suitable measures, such as bronchoscopy and active physiotherapy, to clear the patient's airways.—I am, etc.,

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Thrombosis and Fibrinogen Degradation Products

SIR,—Dr. J. D. Cash and others (31 May, p. 576) suggest a possible relationship between a high concentration of fibrinogen/fibrin degradation products (F.D.P.) in the serum and the occurrence of certain types of thromboembolic disease. However, as the authors indicate, this relationship is by no means invariable, as only two of four patients

with high serum concentration of F.D.P. had evidence of thromboembolism. Nevertheless, failure to detect thrombosis by clinical methods does not necessarily exclude its presence. It is generally accepted that phlebothrombosis in the pelvic veins (which may follow gynaecological operations) is difficult to diagnose by clinical means. Studies with radioactive fibrinogen (¹²⁵I) suggested that the incidence of phlebothrombosis in the postoperative period may be as high as 35%,¹ although only half of these patients had clinical signs.

We have assayed F.D.P. in the serum by the haemagglutination inhibition method during the first eight days of the puerperium in 30 women following normal delivery (62 samples) and in 16 women following caesarean section (63 samples). In two women, following caesarean section (but none in the other group), the serum concentrations of F.D.P. were considerably higher than those in the remaining patients. The results are shown in the Table.

Clinical evidence of phlebothrombosis was present in only one case (Case 1), but there were no features suggestive of pulmonary embolism. It is possible that high levels of F.D.P. in the serum may be due not only to increased production (following intravascular coagulation) but also to retarded elimination.

In some cases raised haemagglutination inhibition titres may be due not only to F.D.P. but also to fibrin monomer. Addition of protamine sulphate (to a final concentration of 1 mg./ml.) to sera with high concentrations of F.D.P. obtained from the two patients reported above gave an increased degree of flocculation. This phenomenon of "paracoagulation" is said to indicate the presence of soluble fibrin monomer—F.D.P. complexes.² As thrombin does not precipitate these complexes, they are likely to react in the immunoassay. Furthermore, samples of plasma from both these patients showed the presence of cryofibrinogen, which suggested the presence of fibrin monomer in soluble form under physiological conditions.^{2,3} Thus, it is reasonable to assume that at least in some cases fibrin monomer rather than F.D.P. is the important link between intravascular coagulation and an increased concentration in the serum of substances reacting immunologically with an antifibrinogen serum. These preliminary results suggest the need for further study in this field.—We are, etc.,

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Gangrene in Behçet's Syndrome

SIR,—The case reported by Drs. A. G. Mowat and T. E. Hothersall (7 June, p. 636) of gangrene of the forefoot in a patient with Behçet's syndrome is of considerable interest, and I would like to draw attention to experience of two further cases in which arterial lesions were a prominent feature.

In 1967, a 24-year-old milkman with Behçet's syndrome was admitted under the care of Dr. I. B. Sneddon in the Rupert Hallam Department of Dermatology at the Sheffield Royal Infirmary. Gangrene of both the patient's feet occurred and both legs had to be amputated below the knee. Histological studies showed thrombotic occlusion of the major arteries and veins, which were the seat of an acute non-specific arteritis and phlebitis involving all layers of the vessels.¹ Thus, in contrast to the Edinburgh patient, this patient's gangrene resulted from inflammatory disease of the large vessels.

The number of cases of Behçet's syndrome in which lesions of large arteries have been described is very few.²⁻⁵ The fact that a bruit was audible over the femoral artery in the patient described by Drs. Mowat and Hothersall raises the possibility of an underlying arterial aneurysm at this site and may be considered an indication for angiography and definitive surgery as prophylaxis against further complications. The histological nature of such a lesion had not been documented until recently, when I and others described the development of spontaneous bilateral popliteal artery aneurysms in a 16-year-old boy with Behçet's syndrome.⁶ We were able to show that a non-specific primary acute arteritis had resulted in aneurysm formation and rupture. Attempts at reconstructive surgery were not wholly successful, but we were fortunate in that adequate collateral circulation developed to ensure viability of the limb distal to the aneurysm.—I am, etc.,

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Iatrogenic Septicaemia

SIR,—We were interested in the article by Dr. J. H. Darrell and Professor L. P. Garrod (24 May, p. 481) but not surprised by their findings or conclusions. In 1962 we demonstrated a strong correlation between bacterial contamination of "cut-down" sites and the development of infective thrombophlebitis, and showed that both could be reduced by improved aseptic and antiseptic technique.¹

While we are, of course, disappointed that neither Dr. Darrell and Professor Garrod nor your leading article (p. 462) referred to our work, we would be even more distressed if we thought that it had also escaped the attention of clinical chiefs responsible for the

Day of puerperium	Serum F.D.P. (μg./ml.)									
	1	2	3	4	5	6	7	8	9	10
Case 1	—	—	192	160	24	8	12	8	8	6
Case 2	—	10	—	—	128	80	12	4	4	4
30 women following vaginal delivery (mean and S.D.)	10.0 ± 6.4 (n=19)		11.2 ± 3.6 (n=12)		11.3 ± 5.1 (n=15)		7.3 ± 3.9 (n=16)		—	
14 women following caesarean section (mean and S.D.)	16.3 ± 5.8 (n=14)		20.3 ± 9.8 (n=12)		17.5 ± 0.9 (n=11)		12.0 ± 4.0 (n=11)		—	