individual transport by car or ambulance or private coaches from the university. One cannot foresee any other form of transport becoming available. It is almost inconceivable that any planning authority other than the Ministry of Health could have failed to make adequate proper provision of this basic essential. The new Poole General Hospital provides an object lesson, if any was needed. Recently completed, it is not yet in full swing, but already the car-parking is grossly inadequate. As in Southampton, street-parking is impossible, and the distances from public parking places make their use impracticable.

I hope that this letter will bring this particular Ministerial folly to wider notice than is possible through the devious routes of planning committees, and that it will be corrected before it is too late to do so. For a teaching hospital complex of over 1,000 beds, car-parking for 1,000 cars is as essential as the beds themselves.—I am, etc.,

KENNETH S. MULLARD.
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Local Use of Progestogen in Cancer

SIR,—Although systemic progestogens are accepted as an additional means of therapy for recurrent and metastatic uterine cancer, local use of these agents has been largely restricted to accounts of intrauterine instillation.[1] Their injection into the pleural cavity in an attempt to destroy tumour cells on the pleura and thereby limit effusion has not been previously reported, and it is suggested that the favourable response described here merits further attention.

A 36-year-old woman was admitted to hospital on 4 June 1968 with recent progressive dyspnoea. On examination there were signs of a large left pleural effusion, which was confirmed by chest *x*-ray (Fig. 1). Several metastases were seen in the right lung field. Cytological examination of fluid removed at diagnostic aspiration showed the presence of adenocarcinoma cells. At the age of 32 she had an extended hysterectomy for a poorly differentiated adenocarcinoma of the corpus uteri. This was preceded by external irradiation, as the tumour extended right down the cervical canal. Histology of the specimen revealed no residual tumour or metastases. Following operation she remained well until development of dyspnoea described above.

Because of the dissemination of the disease an oral progestogen, medroxyprogesterone 300

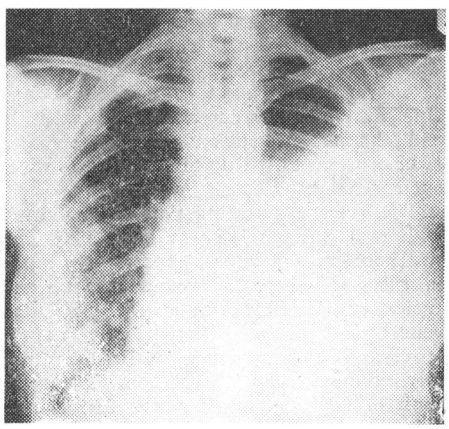

FIG. 1.—Chest *x*-ray prior to treatment—large effusion and pulmonary metastases.

mg. daily, was started on 7 June 1968. Aspiration of 3·1 l. of fluid from the left pleural cavity was effected, and subsequent *x*-ray showed deposits in the lung field. The pleural cavity was emptied four times, and on the last occasion 250 mg. medroxyprogesterone in 10 ml. sterile water was instilled. A small right-sided effusion developed immediately after admission, and 10 ml. of fluid was aspirated from this side prior to instillation of further medroxyprogesterone in the same dosage.

The patient has remained well since her discharge but has slight dyspnoea on exertion. The latest chest *x*-ray taken 11 months after her admission shows no reaccumulation of the effusions but an increase in size of pulmonary metastases (Fig. 2). The maintenance dose of oral medroxyprogesterone was increased to 600 mg. daily six months after commencement of therapy in an attempt to achieve regression of pulmonary metastases.

There is evidence to support a direct action of progestogens on tumour cells. A necrotic

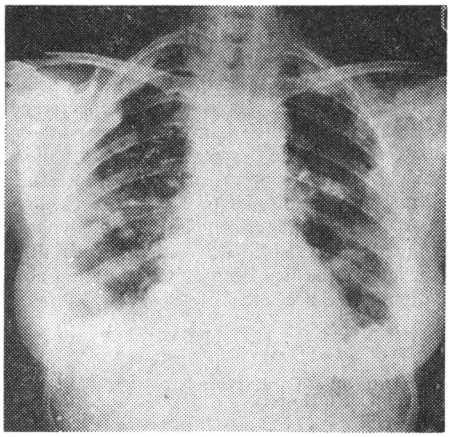

FIG. 2.—Eleven months after treatment with intrapleural and oral medroxyprogesterone.

effect on endometrial carcinoma cells grown in tissue culture has been reported,[2] and the favourable clinical response of effusions, as opposed to pulmonary metastases in this patient, suggests a local action. It is impossible to exclude that systemic therapy may have helped prevent further effusions developing. As local progestogens are without the systemic side-effects of conventional oxytoxics they could be a treatment of choice for malignant effusions from endometrial cancer.—I am, etc.,

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[1] Wentz, W. B., *Obstetrics and Gynecology*, 1964, **24**, 370.
[2] Kohorn, E. I., and Tchao, R., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1968, **75**, 1262.

Oral Contraceptives and Thromboembolic Disease

SIR,—Drs. M. P. Vessey and Richard Doll are to be congratulated on their interesting study of this problem (14 June, p. 651), but I am puzzled by one aspect of their investigation. It would appear that they excluded from their series those female patients aged 16 to 40 years who had been on oral contraceptives but who "could not be interviewed because they had died during their stay in hospital." I think I must understand this wrongly otherwise it would mean that they excluded from their study any who had suffered fatal pulmonary embolism; and I could hardly think that they would have done that.

As they say, it is clear that the figures do not serve to suggest a connexion between the use of oral contraceptives and the occurrence of coronary thrombosis; but, as stated, this might suggest a frank denial of such association, and it is doubtful whether their findings justify that. For example, at one point they say "three other patients died from coronary thrombosis while in hospital and were excluded from the special study because they could not be interviewed." Although they go on to say that "none was recorded in the hospital case notes as having taken oral contraceptives," yet this seems to show a somewhat optimistic degree of confidence in the quality of routine hospital case notes. A further point is that the investigation was necessarily limited to patients who had been admitted to hospital, but it is well known that many patients who develop coronary thrombosis die of the condition before reaching hospital, and there is no reason to suppose that females aged 16 to 40 years behave differently in this respect.

For these reasons (and also because the numbers were small) it would seem impossible, on the basis of this study, to draw any sound conclusion about the liability to coronary thrombosis in women taking oral contraceptives.—I am, etc.,

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Payment by Colour

SIR,—Your leading article "Payment by Colour" (7 June, p. 586) was very misleading in at least two respects:

Your use of the word "Bantu" without comment suggests it is a term widely accepted and in common use. It is in fact a term imposed by the South African Government in an attempt to replace the term "African." This latter term has been preferred by the black people of South Africa whenever there has been an opportunity for them to express an opinion.

You have presented the South African Medical Association (S.A.M.A.) as being the standard-bearers of opposition to race discrimination in medicine. It would have been more accurate to have stated that their opposition has been reserved to the point of silence and sporadic to the point of rarity. Let me suggest that there are certain matters on which the S.A.M.A. has been, and will continue to be, silent:

(i) The medical schools of Cape Town and the Witwatersrand were closed to Africans 10 years ago. Other non-white medical students require special permits to attend.

(ii) White doctors can unreservedly treat non-white patients in and out of hospital. The reverse is not true. Black medical students are not permitted to examine white patients nor even to attend post-mortems on whites.

(iii) The Group Areas Act prohibits black (including all who are not white) doctors from opening consulting-rooms in the populous urban areas.

(iv) Black doctors cannot give instruction to white sisters.

(v) The race of every doctor in the country must now be entered in the *Medical Register*.

Differential wage scales have existed for a long time, and it was the brave action of the