$\frac{1}{8}$ in. (0.3 cm.) under the left leg appeared to level up the pelvis. It seems, therefore, that a raise of $\frac{1}{8}$ in. can be detected, and $\frac{1}{8}$ in. (0.9 cm.) was observed with an accuracy of 82%—I am, etc.,

J. D. MILLER.

Welling, Kent.

Fat Embolism

SIR,—In your article on fat embolism (29 August, p. 476) you mention tracheostomy, hypothermia, low-molecular-weight dextran and vasodilatation, clofibrate, and antibiotics. You then suggest that intravenous hydrocortisone is sometimes useful to reduce inflammatory oedema of the lungs. In this connexion you point to the paper by A. P. J. Ross¹ in which he argues that cerebral damage and death in cerebral fat embolism are usually due to hypoxia caused by pulmonary alveolar oedema.

I suggest that if corticosteroids are effective in this respect they should be used in large doses at the earliest possible opportunity in order to prevent this complication. A more suitable preparation would be dexamethasone 10 mg. intravenously followed by 4 mg. 4-hourly intramuscularly.

Since this treatment could do no harm it is worth a trial.—I am, etc.,

A. W. FOWLER.

Bridgend General Hospital,
Bridgend, Glam.

REFERENCE

- ¹ Ross, A. P. J., *Annals of the Royal College of Surgeons of England*, 1970, **46**, 159

Electrocardiography and the Family Doctor

SIR,—After reading Dr. D. Short's article on electrocardiography and the family doctor (28 February, p. 560), we decided to send a questionnaire to all the general practitioners in East Suffolk to ask them whether they would like to be able to refer their patients to Ipswich for an E.C.G. One hundred and twenty letters were sent and 79 replies received.

Seventy-eight per cent. of those replying wanted open access to an E.C.G. service, 9% did not at all, and a further 13% did not because they owned their own E.C.G. machine. Most doctors wanted the result quickly—within three days—and only six thought a reply within seven days would suffice. Nearly all wanted the report in the form of the tracing plus a cardiologist's comment. Ninety-two per cent. thought that if they could use the E.C.G. service they would ask for fewer outpatient and domiciliary consultations. More than half, however, thought that they would use the service once a month or less; only three reckoned on needing it more than once a week. These results appeared to be largely uninfluenced by the doctor's age, his practice size, and number of partners and his distance from Ipswich—which might be up to 35 miles (56 km.).

There is no doubt that as medical screening and health checks become more popular and as patients and doctors become more knowledgeable the need for all doctors to

have E.C.G.s done will increase. Our results show that most doctors are aware of this; it remains to solve the logistical problems of having good quality tracings made quickly and economically which can then be read accurately.

We are very grateful to the doctors who replied for filling in yet another form about themselves, and to Dr. Ian Tait for his helpful comments.—We are, etc.,

C. F. TREDGOLD.

S. L. BARLEY.

Ipswich and East Suffolk Hospital,
Ipswich, Suffolk.

Cancer and the Pill

SIR,—Dr. P. Strickland (18 July, p. 165) expresses concern over the possibility that the use of oral contraceptives may be causing an increased incidence of breast cancer. While I agree that we must keep a careful watch for evidence of increased neoplastic disease among women using the pill, a recent study of mortality trends in Ontario women of child-bearing age has revealed no increase in the mortality from breast cancer during the past few years, despite the widespread use of oral contraceptives.¹

It is, of course, possible that improvements in the treatment of breast cancer have prevented the death rate from rising despite an increased incidence of the disease, but this seems unlikely in view of the depressing stability of the death rate from this disease over the past few decades.²—I am, etc.,

T. W. ANDERSON.

School of Hygiene,
University of Toronto, Canada.

REFERENCES

- ¹ Anderson, T. W., *Canadian Medical Association Journal*, 1970, **102**, 1156.
² McKinnon, N. E., *Canadian Medical Association Journal*, 1955, **73**, 614.

Upgrading V.D. Departments

SIR,—Apocryphal of the recent correspondence on this subject (1, 15, and 29 August, pp. 286, 408, and 529; and 5 September, p. 589) may I point out that mooted the change of the name of venerology to genitourinary medicine is not a new one.

On 15 May 1914 Sir William Osler was one of the witnesses called to give evidence to the Royal Commission on Venereal Diseases.¹ He was questioned by Lord Sydenham of Combe. During the course of being examined he quoted his famous aphorism: "There is only one disease you require to know thoroughly. Medicine is a very easy art and an easier science. It is the only one in which you have to know a single disease. If you know syphilis and know it thoroughly you get all the rest on the way. . . ."

Then quoting from the minutes: Q. "As far as the routine of the curriculum existing in this country is concerned, do you think there is sufficient as regards these diseases?" A. "No." Q. "But you think it would be impossible on account of the overloading of subjects to increase the time?" A. "Yes for special subjects, but the difficulty is that these diseases have been more or less tabooed in our general hospitals to which

the students go. If each medical student had to pass through a venereal or genitourinary outpatients clinic and had to serve in the syphilitic department, he would get his education in those diseases very thoroughly and very practically."

Q. "Do you think that every general hospital should establish an outpatient clinic for dealing with these diseases?" A. "Yes; but I would not have it specially for venereal diseases. I would have it a genitourinary clinic. There are certain advantages in that, because then you do not taboo it. A great many people who would not go to a special venereal clinic would go willingly to a genitourinary clinic."—I am, etc.,

M. A. WAUGH.

Department of Venereology,
West London Hospital,
London W.6.

REFERENCE

- ¹ Royal Commission on Venereal Diseases. *Appendix to Final Report*, p. 58. London, H.M.S.O., 1916.

G.P.s in the Hospital

SIR,—I have every sympathy with Dr. W. A. Roxburgh (5 September, p. 589). The Royal College of Obstetricians and Gynaecologists has devised a petard and the regional boards are hoist with it. In one metropolitan regional hospital board there are three brand new maternity hospitals which are threatened with closure because they are remote from the district hospital. They could all be staffed by general practitioners provided that the said general practitioners have got the Diploma of Obstetrics, which ensures that they have done a resident house appointment with all that that implies. Consultant cover in some areas could be difficult, but surely it is not beyond the wit of the Department to devise some scheme for making cover in emergencies attractive to the consultant.—I am, etc.,

C. KEITH VARTAN.

London S.E.3.

Alcohol and Phenformin in Diabetes

SIR,—I have recently seen a patient with phenformin-induced acidosis whose presentation so resembled that of Drs. G. G. Shirriffs and P. D. Bewsher's case (29 August, p. 506) that I think it worth reporting.

The patient was a 67-year-old retired seaman, a habitual whisky drinker and known to be diabetic for 10 years. At first controlled by diet alone, he had later been given phenformin and was taking 50 mg. three times a day at the time of his illness.

One evening he went to a party after skipping his tea but taking his usual 50 mg. of phenformin. "Several whiskies and a few beers" later he was seized with a sudden and severe abdominal pain, felt cold and sweaty, and immediately left for home. Taking to his bed, he then felt pain across the lower chest and later in the back. He spent a restless night, moaning and complaining of blurred vision. The next morning he was seen by his general practitioner, who arranged his emergency admission to hospital. The patient meanwhile insisted on a