$\frac{1}{8}$ 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 venereology 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

further "dram" before entering the ambulance.

On admission he was confused and in pain with noticeably cold extremities. Oral temperature was 97° F. (36° C.). Blood pressure 140/80, pulse 72 and small volume. The abdomen was distended and diffusely tender. There was some guarding, and bowel sounds were faint and infrequent. The pupils were unequal, moderately dilated, and did not react to light. Tendon jerks were brisk and the plantar responses flexor. Urine: some albumin and trace of acetone, but no sugar. Blood pH 7.08, PCO_2 44, PO_2 80 mm. Hg, standard bicarbonate 12.2 mEq/l., base deficit -15 mEq/l., serum sodium 134, potassium 6.4, chloride 100, CO_2 <10 mEq/l., blood sugar 164, urea 66 mg./100 ml. Haemoglobin 14 g./100 ml. The E.C.G. showed changes of hyperkalaemia. Other investigations were normal.

The acidosis was corrected with 400 mEq sodium bicarbonate intravenously. The next day he felt quite well, the blood biochemistry, E.C.G., and temperature having returned to normal. The diabetes was easily controlled with small doses of insulin.

In this case, as in that of Drs. Shirriffs

and Bewsher, acidosis followed alcohol ingestion by a diabetic on phenformin. It would seem advisable for patients taking this drug to avoid alcohol, and for their doctors to be aware of yet another "metabolic" cause of the acute abdomen.

I am obliged to Dr. A. W. Johnston for permission to report details of this case.

—I am, etc.,

PETER ISAACS.

Woodend General Hospital,
Aberdeen.

Report on Health Services Financing

SIR,—I have just returned to Australia from a world tour on behalf of the Australian Medical Association, and I find the Australian press featuring news items concerning the pay dispute between the United Kingdom doctors and the British Government.

I believe, Sir, that the British Medical Association and its advisory planning panel, under the chairmanship of Dr. Ivor Jones, are to be congratulated on a magnificent effort, not only for producing the Health Services Financing report,¹ but in the speed

with which they were able to complete their task. The report is detailed and factual and the conclusions reached quite unarguable. In short, Sir, this report should be on the compulsory reading list of every doctor and politician in the United Kingdom, and the same might well be said for doctors and politicians in Australia, where controversy is currently raging about methods of financing health services.

I firmly believe that this report will, in time, be recognized for what it is—an historic contribution to the world-wide problem of financing health care. It is only by freeing themselves from sole dependence on the Treasury as a source of finance that doctors will be able to rid themselves of the continuing arguments regarding their pay and incomes, which have bedevilled the National Health Service in Britain since its inception.—I am, etc.,

LIONEL L. WILSON.

Connells Point,
N.S.W., Australia.

REFERENCE

- 1 Advisory Panel of the British Medical Association, *Health Services Financing*, London, British Medical Association, 1970.

Points from Letters

Paronychia and Nailbed Infection

DR. K. H. TRIGG (Merstham, Surrey) writes: Is it not high time that the misleading use of the term paronychia be abandoned when applied to fungal and monilial infection of the nailfold? In the past the condition has been called "potman's disease" and my old chief used to describe it as the disease duchesses don't get on account of the predisposition to it of those whose hands are immersed frequently in the washing-up. Paronychia ought to be reserved for the bacterial infection, usually staphylococcal, commonly called a whitlow. . . .

Race and Commonwealth

DR. B. LEWIS (St. Mark's Hospital, London E.C.1) writes: May I congratulate you on the leading article on this subject (29 August, p. 475), which makes Dr. B. Beach's (12 September, p. 648) sense of tragedy concerning the expulsion of the Rhodesian Medical Association from the Commonwealth Medical Association a somewhat inappropriate reaction. In nine years of contact with Rhodesia I heard nothing to support his view that the Rhodesian medical profession "forms one of the largest liberal minded groups of people in that country." Though I have met individual members of the R.M.A. with antiracist views, commanding great respect for their integrity . . . it has made no effective protest at the innumerable ways in which racial discrimination in Rhodesia influences medical practice.

The shortened life expectation of Africans in contrast to White Rhodesians is largely due to infective and nutritional disorders. That these eminently preventable diseases persist in a country which offers an unrivalled standard of living for Whites is a measure of the economic inequality between the races. I believe this to be a matter of medical concern. Another instance of racial discrimination is the entrance of Africans into the medical profession: not one Rhodesian African was among the first 16 graduates from the Medical School in Salisbury.

. . . . I heard no protest, and found little awareness, that bed occupancy in an African rural hospital may exceed 700%. . . . But the most telling comment on Rhodesian medicine, during my stay in Salisbury, was a silent one: of the 15 African medical students then at the University College, seven fled the country before graduating. When racial issues are as clearcut as in Southern Africa, not to protest is to acquiesce.

George III and the Mad-business

DR. M. M. SALZMANN (Park Prewett Hospital, Basingstoke, Hants) writes: I had hoped that my letter (15 August, p. 406) on the subject of poor old George III's illness might have stimulated some porphyriologists or psychiatrists to indicate whether they fully accepted the much-publicized and currently popular "it-was-only-porphyria" hypothesis. So far the only reaction has been from a radiologist, Dr. P. Jacobs (5 September, p. 586), who seizes on my use of the word "slur" to berate the "non-sense" of the irrational prejudice which he assumes I share. My phrase was prompted by the statement in the booklet *Porphyria—a Royal Malady* that "this diagnosis clears the House of Hanover of an 'hereditary taint of madness' imputed to it". . . . I had realized in retrospect that I might have been wiser to put "supposed slur" to indicate that I did not personally share this prejudice, lest some critical reader jumped to the wrong conclusion. . . .

REFERENCE

- 1 Macalpine, I., and Hunter, R., in *Porphyria—a Royal Malady*, p. 16. London, B.M.A. 1968.

Shortage of Casualty Officers

DR. D. K. GUHA-RAY (Royal Free Hospital, London W.C.1) writes: Casualty departments deal with the acute emergencies of every branch of medicine. Perhaps this is the most difficult job in medical practice, and demands a great deal of knowledge and practical skill and responsi-

bility. It goes without saying that there is immense value in casualty training. This applies to every practising doctor. Perhaps casualty training should be made compulsory for all medical practitioners whether they want to specialize in any branch of medicine or go to general practice in future. A minimum period should be decided upon according to the demand. The training should be started preferably after full registration with the G.M.C. This will offer better training to the future medical practitioner and better service to the population in general.

Toxaemia and Intravascular Coagulation

MR. J. SOPHIAN (Worthing, Sussex) writes: Dr. A. H. Henderson and others (5 September, p. 545) advance the thesis that disseminated intravascular coagulation occurs in toxæmia, and further that it gives rise to the syndrome. Their own "evidence" is merely an inference and apart from that of Brain¹ no visualized evidence has been produced, while in this case the patient suffered also with severe diabetic ketosis and acute pancreatitis. In the group of clinical states infection has preceded² the intravascular coagulation. In the others the fibrin deposition is in the glomerular wall.³ . . . It is evident that since eclampsia, toxæmia, and early anuria can subside on rupture of the membranes and conduction anaesthesia that intravascular coagulation, which is an organic change, cannot be present in these states for recovery is dramatic. It certainly occurs at delivery, further emphasizing its non-structural aetiology, and that it depends entirely on spasm of the cortical glomerular blood supply.

REFERENCES

- 1 Brain, M. C., Kuah, K.-B., and Dixon, H. G., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1967, **74**, 702.
- 2 Rosenmann, E., Kanter, A., Bacani, R. A., Pirani, C. L., and Pollak, V. E., *American Journal of the Medical Sciences*, 1969, **257**, 259.
- 3 Morris, R. H., Vassalli, P., Beller, F. K., and McCluskey, R. T., *Obstetrics and Gynaecology*, 1964, **24**, 32.