SIR,—Drs. I. W. Delamore and C. G. Geary (26 June, p. 743) describe four patients who developed acute myeloblastic leukaemia after treatment of a hypoplastic anaemia with oxymetholone. I should like to report a similar case.

A 51-year-old man presented in April 1969. The blood count was: haemoglobin 9.4 g/100 ml, white cells 2,800/mm³ (neutrophils 44%, lymphocytes 50%), platelets 58,000, and reticulocytes 0.8%. The marrow aspirate was markedly hypoplastic, and there were no atypical cells. A transfusion was given but in July a similar blood count was found and treatment was thereafter with oxymetholone 5 mg thrice daily and prednisone continuously, together with frequent blood transfusions. The total dosage of oxymetholone over the next 2 years was no more than 11 g.

In July 1971 a rapid deterioration in the patient's health was observed and myeloblasts appeared in the peripheral blood. These rapidly reached a total of 51% of the white cells and the diagnosis of acute myeloblastic leukaemia was confirmed by marrow aspiration. A trephine biopsy failed to yield any marrow. Cytosine arabinoside and daunorubicin were given in five-day cycles removing the blast cells from the blood but not from the marrow, and the patient died early in September, two years and five months after the primary diagnosis of hypoplastic anaemia.—I am, etc.,

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Disposing of the Undisposable

SIR,—I am glad to see that Dr. Rex Binning (21 August, p. 476) defends the use of glass bottles against the plastic variety on the score that the latter are virtually indestructible and thus pollute the environment. I would go further and suggest that the general adoption of "disposable" syringes by the medical profession not only pollutes the environment but increases the incidence of drug addiction.

A few years ago, the consumption of glass syringes in hospitals was comparatively small and mostly limited to the replacement of cracked ones. At the present time the number of plastic syringes used by large hospitals is enormous. It is true that doctors, nurses, and theatre orderlies know that such syringes and their needles should be rendered useless before disposal, but how many escape unscathed? From limited personal observation I would say that at least half of the plastic syringes could be used again. It is all very well to say that the nozzles of all syringes should be snapped off but there is at least one make in which this is almost impossible. Under pressure, the nozzles bend right back and on release, gradually straighten out again. If placed in an incinerator, plastic syringes melt and form a sticky coating which eventually ruins the destructor. In practice, therefore, many syringes go into the rubbish bin intact and their further fate is ignored. Unfortunately, attached to many large hospitals there are unscrupulous characters who by one means or another will gain access to the daily waste. They then extract the syringes and needles and sell them to addicts for about 37p each.¹ Even if the wretched buyers

realized the importance of sterilization, they could not achieve it properly with these syringes, with the result that sepsis often adds to the misery.

In view of these facts I would suggest that the whole question of using plastic products in medicine might be investigated.—I am, etc.,

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¹ *Anaesthesia*, 1970, 25, 163.

Addiction or Dependence?

SIR,—Dr. Ian Oswald and others (10 July, p. 70) illustrate how the new terminology of "drug dependence" that is supposed to avoid the confusion of the term "drug addiction" causes confusion of its own.

The W.H.O. Expert Committee defined drug dependence as "a state, psychic and sometimes also physical . . . characterized by behavioural and other response that always include a compulsion to take the drug. . . ." The authors' subjects and patients had no compulsion ("irresistible drive to commit irrational acts") to take fenfluramine or imipramine. Consequently they were not dependent on or addicted to these drugs. The semantic booby trap into which the authors fell is the equating of withdrawal symptoms with (physical) dependence. But physical dependence is an accidental feature of drug dependence; it may or may not accompany it. Conversely withdrawal symptoms (or physical dependence) may or may not indicate drug dependence or drug addiction. Many times it does not. It is a common clinical experience that only a small fraction of the patients that have been given morphine over long periods to relieve pain are or become morphine addicts, though all may have withdrawal symptoms. Nalorphine and cyclazocine produce marked withdrawal symptoms after prolonged administration but no desire, much less compulsion, to continue taking the drugs.² And the infant that is born to a heroin-addicted mother shows obvious narcotic withdrawal symptoms, but he could hardly be called a heroin addict or a heroin-dependent individual.—I am, etc.,

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¹ Expert Committee on Drug Dependence, 16th Report, World Health Organization Technical Report Series, 1969, No. 407, p. 6.

² Martin, W. R., Gorodetzky, C. W., *Journal of Pharmacology and Experimental Therapeutics*, 1965, 150, 437.

The New F.F.R.

SIR,—Dr. C. G. Whiteside (11 September, p. 639), while expressing his unease about the new F.F.R., ignores the fact that the D.M.R.D. has become outmoded in that it includes too much physics and not enough radiographic photography and normal radiographic anatomy. The latter subjects form an important part of the syllabus for Part I of the D.M.R.D. Nevertheless, as pointed out by Dr. F. Pygott (28 August, p. 533), it may be advisable to have a qualification such as the D.M.R.D. which shows a modest competence in radiology as a fall-back for those unable or unwilling to obtain the F.F.R.

Furthermore, like Dr. Whiteside I am sceptical about the intention to maintain the same standard in the F.F.R. This seems difficult when on the one hand the syllabus is to be enlarged, and on the other candidates will be allowed to sit only three years after starting radiodiagnosis, compared with four years at present. The radiology of disease in all systems of the body is far too big a subject to be mastered in two and a half years after the candidate has passed Part I of the F.F.R.

There is a further difficulty. In some parts of the country the D.M.R.D. is part of a university curriculum, and the universities may well abandon support of radiology if there are no candidates to sit for their qualification.

May I suggest a solution? The syllabus for Part I of the D.M.R.D. should be altered to comply with the syllabus of the new Part I of the F.F.R. Both the D.M.R.D. and the F.F.R. could continue, while enjoying the advantages of the new syllabus.—I am, etc.,

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Evidence to the Coroner

SIR,—As Coroner of the Diss District of Norfolk I have recently come across a sudden modification of time-honoured procedure which should concern doctors as much as coroners. Without any warning or previous consultation, a health visitor refused to co-operate with my inquiry into circumstances attending a cot death on the basis of a circular sent out by her Association.¹ The County M.O.H. immediately overruled her action but was subsequently himself overruled by the County legal department; eventually the health visitor had to be subpoenaed to secure her attendance at the inquest. A second cot death ensued within the month and it was necessary to have recourse to the same compulsion.

On inquiry I have discovered that it is almost unknown for a coroner to have to subpoena any witness in relation to giving professional medical evidence. It is clear that the Norfolk County Council had given no consideration to the matter previously, and that when it did so there was a failure to appreciate the difference between a Coroner's court of inquiry and all other courts.

I gather that the suggestion is being made by the Health Visitors' Association that readiness to give evidence amounts to a general breach of professional confidence, and that this is a broad principle of ethics to be demonstrated on all occasions, and not just in the rare event when a specific question about the family's social background might put a health visitor in breach of confidence.

All this poses important questions for doctors. Are we going to tolerate what could be a public demonstration that our standard of professional ethics appears to be less exacting than that of the health visitors who work for us? Is it really desirable for medical auxiliaries and their professional associations to come to independent decisions on important matters of this sort without even warning us, and, finally, should the health visitor who has been working on