physiological increase in red blood cell production. The resulting increased viscosity of the blood is liable to be enhanced by dehydration from enforced diuresis. Vascular thrombosis, a well-recorded complication of altitude, is also more likely to occur. In this context it is questionable whether women mountaineers should be taking the contraceptive pill while at altitude.

Although rapid ascent to altitude seems to precipitate acute mountain sickness, it is by no means the definitive cause. Of the four women patients quoted two were thoroughly fit and acclimatized, having walked for three weeks and crossed several passes between 4 and 15,000 ft (1-4,500 m).

The only specific treatment for acute mountain sickness is descent to a lower altitude—and staying there. People feel dramatically better within hours of going down to the valleys. Because of ignorance of the serious implications of this illness several tragedies have occurred by patients returning to the mountain that has cost them dear to reach, after a short period of convalescence when their symptoms disappeared.

I endorse your suggestion that written warnings should be available to people at risk.

Parties of mountaineers going above 15,000 ft (4,500 m) would be wise to carry oxygen with them for the emergency treatment of acute mountain sickness with pulmonary oedema. Intermittent positive pressure respiration is not practical on a mountain; it might, however, be useful in a comatose patient suffering from cerebral oedema after evacuation to a lower level hospital.—I am, etc.,

PETER R. STEELE

Medical Officer to 1971 International Mount Everest Expedition

Frenchay Hospital,
Bristol

- 1 Steele, P., *Lancet*, 1971, 2, 32.
- 2 Steele, P., *Doctor on Everest*. Hodder and Stoughton, London, 1972.
- 3 Singh, I., et al., *New England Journal of Medicine*, 1969, 280, 175.
- 4 Forward, S. A., Landowne, M., Follansbee, J. N., and Hansen, J. E., *New England Journal of Medicine*, 1968, 279, 839.
- 5 Gray, G. W., et al., *Aerospace Medicine*, 1971, 42, 81.

SIR,—I was interested to read in your leading article (8 July, p. 65) on acute pulmonary oedema of mountains that no fatality had yet been reported in a woman. I should like to report such a case in Nepal in 1969.

The patient was taking part in a trek and was aged 50. She had been passed fit for this in the United Kingdom, and during the march-in of 100 miles (160 km) she had appeared to be one of the fittest members of the party. When she reached a height of 17,000 ft (5,000 m) she became very tired and found climbing the last 1,000 ft (303 m) to the highest point of the trip more of an effort than other members of the group. She managed to get down to 16,000 ft (4,700 m), where we camped, but the next day she was unable to walk and had to be carried down 13,000 ft (3,994 m).

That night she had little in the way of respiratory symptoms or signs, but at 3 a.m. her breathing was noted to be abnormal, and when I saw her she was dying and appeared to have acute pulmonary oedema, being unconscious with blood-stained froth issuing from her mouth. She died within

two or three minutes, and although there was no postmortem there seems little doubt that she was a victim of acute pulmonary oedema of mountains.—I am, etc.,

J. C. FOSTER

Henley on Thames

SIR,—In your interesting leading article (8 July, p. 65) you state that women have not so far been recorded as victims of the disease. Unfortunately this is now not so. When climbing recently in the Kulu area of the Central Himalayas, I was concerned in the attempted rescue of a Japanese woman climber. She had attempted to climb a 19,600-ft. (5,800 m) mountain but collapsed, became stuporose, then comatose. Unfortunately she died before we were able to reach her. She had attempted to climb the mountain within a week of arrival in the Himalayas and it seems certain that she died from pulmonary oedema. Her companion, who was obviously in pulmonary oedema, was rescued by helicopter and survived.—I am, etc.,

A. PINES

Ware Park Hospital,
Ware, Herts

Free Mass Screening in Austria

SIR,—Examination of the healthy population, which is to be without any charge to those requesting it, is to be started on 1 November 1972 in Austria. A pilot scheme will begin in Vienna and the province of Carinthia for one year. After that it is proposed to extend the scheme to the rest of the country.

At first only women over 35 years of age and men over 45 years will be eligible, and taking the population as a whole it is estimated that when the scheme is fully operative 10% of those living in the town and 5% of country dwellers will take advantage of the scheme and request screening.

The cost to the Government of Austria will be just under £6 per person; this will be paid to the doctor carrying out the examination, who will have to fill in a form in order to claim his fee, similar to the practice existing in Britain where claims for payment are sent to the executive council for maternity fees, vaccinations, etc. The Austrian Ministry of Health is well prepared for the screenings to start, and 45-60 million Austrian schillings have already been set aside for this purpose.

The examinations are to take place on a purely voluntary basis for both doctor and patient. Tests will include blood and urine analysis as a routine, gynaecological examinations for women, and examinations aimed at detecting early symptoms of common ailments of men, such as prostatic conditions.

It is interesting to note that the first reactions to these announcements are not entirely favourable. There is criticism of the one-year test period and the arbitrary choice of Vienna and Carinthia for pilot schemes while the remainder of the country will have to wait a further year for screening, although technically there are no reasons why the health examinations should not get underway this autumn throughout the whole country. There is also some dissent about the scheme extending only to those in early

middle age, and the Minister is being urged to consider offering it to a younger age group as well. The point is also put forward that it might make more sense to have more thorough examinations during school days and in the army. (Austria has a period of compulsory military service for men.) It seems probable that while it is testing consumer reaction to the scheme, as well as seeing how the extra work will be accepted by doctors, that the Austrian Government is playing safe before making the scheme nationally available.

Whatever the reasons being put forward by the sceptics of the scheme, and clearly there are going to be difficulties before the scheme can be made fully operative and acceptable, the overall value of it to the population can hardly be disputed. Many people who already have periodic check-ups privately as well as the majority of the population are very much in favour of a scheme offering the prospect of free health examinations.—I am, etc.,

FRANCIS P. DURAS

London Colney,
Herts

People with Epilepsy (1972)

SIR,—The Reid Committee has reason to congratulate itself on the success of its report, *People with Epilepsy*,¹ the public interest it has aroused, and the promise of ministerial action on its recommendations. There is unfortunately a danger in the very success of the document. Its recommendations which pertain to the situation as it stood in 1969 are liable to be regarded as gospel and its on-going recommendations dismissed as superfluous. Much of the purpose of the Reid report will be lost if desire "that arrangements should be made to assess results over a period of years, to watch developments and reexamine the evolution of services for people with epilepsy from time to time" is not fulfilled. In deciding the future shape of the committee or its successor, thought should be given to the case for a different balance within the committee, which reflects both the weaknesses of the report and the social changes which have already taken place since the report was drafted.

The social changes since 1969 relate particularly to the epileptic person with a severe handicap. The operation of the Disabled Persons Act has brought new insight into every aspect of community care. The assumption made by the Reid Committee that the risk of institutionalization outweighs loneliness, isolation, hostility, and difficulties in supervision in homes and flats in the community cannot go unchallenged. And in practical terms the size of the task confronting local authorities in resettling mentally retarded, psychiatric, and geriatric patients into the community will mean that only a modest reduction in the number of residents in the epileptic colonies can be anticipated in the near future. Social change has not left the colonies untouched. Many of the recommendations made on epileptic centres or colonies relate to a much earlier study by Jones and Tillotson,² before the colonies had established a joint consultative committee or developed a liaison with neighbouring neurological and neurosurgical units. Since 1969 improvements have occurred in social attitudes within the colonies; and, par-

ticularly in the north-west, where three of the four largest colonies are situated, strong links have been forged with neurological units, amounting to the formation of the special units envisaged in the report—but, as yet, without recognition as such.

The composition of the Reid Committee, though august, lacked balance, not in its theoretical but in its practical orientation. No positive recommendations were forthcoming on—the methods of obtaining a combined medical and work assessment of epileptic adults; the problems of superannuation, insurance, and accident liability; and the needs of school children with fits. Too much was made of the potential contribution, over and above that of the informed general practitioner, which can be made by general physicians or paediatricians without special knowledge of the techniques of assessment. The general practitioner should have more direct access to a neurological or epilepsy clinic, supported by a properly equipped assessment unit.

I feel that the committee has misread the situation in their lack of concern for the future of those caring for the severe epileptic person. They are nowadays in an inferior position compared with S.E.N. staff or trainees working in general hospitals or with “mental” or “subnormal” trained personnel working in psychiatric units, and they can no longer seek similar qualifications within their specialty. There is a lack of training facilities, with a resultant loss of trained staff from the colonies and local authority homes. And there is a danger of replacing those with some acquired knowledge of epilepsy who work in colonies by those, at present left in total ignorance of the care of epileptic persons, who are concerned with the residential care of disabled or geriatric persons in homes to which epileptic individuals are liable to be sent.—I am, etc.,

EDMUND CRITCHLEY

Departments of Neurosurgery and Neurology,
Royal Infirmary,
Preston

- 1 Department of Health and Social Security, Welsh Office and Central Health Services Council, *People with Epilepsy*. London, H.M.S.O., 1969.
- 2 Jones, K., and Tillotson, A., *The Adult Population of Epileptic Colonies*. London, British Epilepsy Association, 1965.

Overseas Secondment

SIR,—I understand Sir Douglas Hubble's anxiety (17 June, p. 703) about sending young trainees to developing countries without the promise of future professional support. The nationalism of the 70s may see idealistic young men and women ejected from, say, Africa because they are white, so that a man of the right calibre with a young family has to think carefully before leaving the training ladder in the United Kingdom. I suppose the young African looking north may also wonder about his reception in the U.K. and his future when he returns home.

The “pairing” of medical schools offers some help in that at both ends of the line the consultants working in these centres get to know each other well. For example, the Birmingham Medical School has been privileged to be “married” to Salisbury, Rhodesia. Since the inception of the medical school senior examiners, postgraduates, and students have moved in both directions (some with their families) since 1961. At the

moment three of my young colleagues in this department are serving in Rhodesia. Two colleagues will soon arrive in Birmingham from Rhodesia. These arrangements are not of course unique. Belfast has a 20-year link with Jamaica, Glasgow with Kenya, and so on. University links, however, add up to a tiny fraction of the numbers who travel to train either in the U.K. or overseas. I mention our Birmingham “marriage” to state from experience the value of personal selection of four young men and women deemed suitable for overseas service. My preference is for personal arrangements between seniors, but inevitably many candidates must be selected by committees or overseas colleagues for service in the British N.H.S., that is, the ideal of personal contact between sponsors cannot always be achieved.

A group who deserve support in the U.K. are missionary doctors who return on sabbatical leave, perhaps to train for the M.R.C.O.G. or other qualification. I personally feel that they have a special claim to our best training posts in the U.K., although they know they may have to wait for a place. They bring, of course, great knowledge and experience from overseas, opening the eyes of students and nurses to the challenge of clinical work far from comfortable British hospitals.

It is a wonderful fact of life that in a few hours the jet plane now puts the world at the feet of our young men and women. I have no doubt that in future the best of our young doctors will go on responding to a challenge to help overseas. They give but they also receive, that is, they themselves grow in stature with experience and responsibility. It is equally a challenge to the young African or Indian to leave his family and hospital for overseas experience. The welcome he or she gets is, I fear, not always as good as expected.

To sum up: a sensible man or woman (especially one with family responsibilities) is wise to make sure that the job he is going to is worthwhile, that he will be welcome, and that his salary will be paid as agreed in his contract. In support of our travelling younger colleagues, as Sir Douglas says, it is up to those of us who are their sponsors to back them up not only when they are on service overseas but equally when they return home.—I am, etc.

H. C. McLAREN

Department of Obstetrics and Gynaecology,
University of Birmingham

SIR,—It was refreshing to read the article by Sir Douglas Hubble (17 June, p. 703) concerning British aid to medical schools in developing countries.

As a psychiatrist, trained at the London Hospital and recently appointed on a two-year contract as lecturer in the professorial department of psychiatry at Makerere University, I would endorse from personal experience what was said concerning psychiatric services in developing countries. There is no doubt as to the need for psychiatric services on economic or humanitarian grounds. There is also no doubt as to the benefit to the trainee both in terms of professional training and the “widening and deepening of human experience.”

It is to be hoped that university departments and the National Health Service will continue to make arrangements whereby

postgraduates can work for a period in medical schools in developing countries. In particular it is hoped that the new Royal College of Psychiatrists will include this topic in its deliberations on postgraduate psychiatric training.—I am, etc.,

J. L. Cox

Department of Psychiatry
Makerere University,
Kampala, Uganda

Open Door Policy

SIR,—In the furore which will, no doubt, follow the Graham Young case, may I draw attention to the nuisance caused by those afflicted with lesser forms of mental illness. Numerous minor social pests who steal, drive away cars, commit minor sexual offences, do wilful damage, and get drunk are supposed to be in mental hospitals either as a condition of probation or under Section 60 of the Mental Health Act 1959. Because of the open door policy followed by many hospitals they are more often out in the community up to their old tricks, much to the annoyance of the public.

The bigotry with which some psychiatrists hold to this permissive policy, reminds one of the man, who, the poet tells us:

“And thought the nation ne'er would thrive
Till all the whores were burnt alive.”
(Matthew Prior).—I am, etc.,

J. ELWES DUFFIELD

Littlemore Hospital,
Oxford

Survey of Alimentary Radiological Findings

SIR,—I read with interest the paper by Dr. J. C. Petrie and others (8 April, p. 78) and wish to congratulate the authors on the thoroughness of their survey of alimentary findings in the North-east of Scotland region. However, there are two points about which further comment seems warranted.

Although the survey shows over 600 examinations which demonstrated gastric ulcers and 4,500 examinations which demonstrated duodenal (and pyloric) ulcers, there is no mention of examinations which demonstrated concomitant gastric and duodenal ulcers. Many series of barium meal examinations or of studies of peptic ulcers show a varying incidence of concomitant gastric and duodenal ulcers and this can be very high.¹ Therefore, it is difficult to see how in a series with such large numbers as that of North-east Scotland there were no examinations which demonstrated concomitant ulcers, for other series from England² and Scotland³ have included these. One can only assume from the North-east of Scotland survey that those examinations showing concomitant ulcers were classified as either gastric or duodenal. I do not wish to criticize this excellent survey, but merely to point out that comparison with future surveys which include the incidence of concomitant ulcers may be difficult, particularly in relation to the geographical variation of the incidence of concomitant ulcers and their significance in relation to the aetiology of gastric ulcer.⁴⁻⁶

Secondly, the authors state that “Other radiological surveys have been carried out but these have not been related to a defined population” and this is quite true, but there