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.,

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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.

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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.,

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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.,

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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

are other surveys, not quoted in their paper, of radiologically detected lesions of the proximal part of the alimentary tract which are mainly from the developing countries of East Africa⁷ and the West Indies⁸ and also from Scotland³ and South Australia.⁹ Although these surveys do not cover a population as well defined as that of the North-east of Scotland they were made on unselected patients who presented for barium swallow and meal examination in the main teaching hospital in the area concerned, and, in the case of the East African series, the only local hospital at that time which provided a comprehensive radiological service. Therefore, with some limitations, these series are, at least so far as disease of the oesophagus, stomach, and duodenum are concerned, comparable with the survey from the North-east of Scotland. The importance of the comparison of surveys of this type is related to the geographical aspects of pathology, the study of which may provide useful information on the aetiology of disease.—I am, etc.,

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Anticonvulsant Hypocalcaemia

SIR,—Dr. E. H. Reynolds (10 June, p. 656) and Dr. N. M. A. Viukari and others (24 June, p. 768) have argued that factors other than enzyme-induction must be involved in the aetiology of anticonvulsant hypocalcaemia and folate deficiency. They pointed out that phenytoin appears to have a more powerful effect than phenobarbitone on calcium metabolism¹ and folate metabolism,² whereas phenobarbitone is the more potent enzyme-inducer. This latter conclusion, however, is based upon experiments performed in animals (mainly rats) rather than man. The rat liver metabolizes drugs at a very different rate from human liver, and inferences about the enzyme-inducing properties of these drugs in man must be made with caution. Unfortunately, there is no good evidence available from human experiments.

Our suggestion that enzyme-induction may accelerate the metabolism of vitamin D has received firm support from studies in animals^{3,4} and in man⁴ of the rate of conversion of cholecalciferol to its hydroxylated metabolites. In our experience, anticonvulsant hypocalcaemia and osteomalacia responds promptly to administration of 25-hydroxycholecalciferol or whole-body ultraviolet light treatment. None of these observations can be explained by the alternative theories proposed by your correspondents, such as displacement of calcium from its protein-binding sites, calcium malabsorption, or some unspecified influence of folate-

deficiency on bone metabolism. (Incidentally, two of our osteomalacic patients, one of whom has previously been reported,⁵ had been receiving folic acid supplements for some months before their bone disease was discovered.)

None of our patients has shown any improvement in their epilepsy when their serum calcium levels were corrected. We consider that the disturbance of calcium metabolism is merely an occasional nuisance produced by long-term anticonvulsant treatment, and is not a fundamental mechanism by which these drugs may control seizure discharges in the brain. Folic acid deficiency appears to fall into the same category, for other than occasional macrocytosis and rare megaloblastic anaemia there is no satisfactory evidence that any more fundamental disturbance is produced by low folate levels.—We are, etc.,

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Balding Man

SIR,—As a follow-up to the article "The Hairy Story of Four Healthy Heads" (*Sunday Times*, 18 June), I would like to say that I was pleased to comply with the request to examine the persons concerned, because at least the two females involved were terrified by what they had been told at a hair clinic in London. Just as does the presence of too much hair in the conventionally wrong places in women, so too premature, temporary, or permanent hair loss from the accepted normal areas evokes in men, particularly in the younger age group, psychological reactions which are frequently out of all proportion to their clinical state. They will find it extremely difficult and often impossible to weigh for themselves the grave and even terrifying prognostications against the extensive and expensive course of physical treatment stated to be vital to prevent their rapid progress to the billiard-ball image. Could it not be, however, in some cases, a measure of the failure of our own profession to take time to communicate or to offer or obtain the informed medical diagnostic, advisory, and therapeutic services available within the National Health Service for such distressed patients, that they are driven to seek outside help?

As a practising consultant and chairman of the B.M.A. Dermatologists' Group Committee, which represents the opinions of colleagues throughout the country, who have nothing to gain but extra clinic work from this action, I feel that the widest possible publicity should be given to the following facts which are in no way controversial in medical circles but which seem generally unknown to the public at large.

(1) The progression of even premature or

normal male balding through frontotemporal recession to extending loss on the crown and to ultimate coalescence is, with rare exception, extremely slow and the presence or absence of dandruff is totally irrelevant to this. The maintenance of the status quo after three to six months of expensive treatment owes nothing to the activities of the "hair expert" concerned, and it is at this time that we are often first faced with a patient who owes a great deal of wasted money.

(2) Many disorders of hair growth in either sex are the result of or are associated with systemic diseases which require medical recognition, investigation, and treatment. Delay or neglect of such investigations, through non-medical ignorance, may be dangerous to life. Conditions such as thyroid disease or severe anaemia immediately spring to mind in this context.

(3) Research and medical experience have proved that, with extremely rare exceptions, the local application of creams, lotions, or shampoos, or the use of physical methods, manual or vibro-massage, ultraviolet or infrared light treatment, etc., have no influence whatever on hair growth. These exceptions are solely skin conditions affecting the scalp, which may respond to systemic or local treatment available only to the medical profession.

(4) Many disorders of hair growth—for example, telogen effluvium, mild alopecia areata, etc., do recover spontaneously within a few months and the "hair expert" will claim credit for cure when none is due. Failure of this early recovery in alopecia areata will call for medical treatment not permitted in the repertoire of the hair clinic.

(5) There is no treatment of proved value in any hair growth disorder which is not available under the National Health Service.

(6) In these days when V.D. is common once again in the United Kingdom it is vital to remember that syphilis, often undetectable in the female in the primary stage, may present itself, in the secondary stage, as a patchy alopecia, and failure to know and recognize and treat this may well result once again in the reproduction of children with the stigmata of congenital syphilis, and in serious cardiac or C.N.S. disease later in life for the infected person.

It seems to me that the profession can help here in informing their patients of these facts, where relevant, and in referring to us in our clinics those especially who seem to be over-reacting to their clinical state and who might so readily fall into the very expensive orbit of the charlatan. Local authorities are not empowered to refuse licences to private establishments provided their standards of hygiene seem acceptable and perhaps, as with the tattooing of minors, we may yet have to look to a Private Member's Bill in Parliament to deal with this insidious problem.—I am, etc.,

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Self-medication by Jockeys

SIR,—The description of the death of the jockey in the sauna bath (8 July, p. 71) prompts me to write to describe another feature of the pre-race preparation of the modern jockey which has an effect on health. Many jockeys now take diuretics—