I would be very happy to discuss the trial with any clinician who is concerned with the treatment of patients with Wilms's tumour, and further information on the trial protocols may be obtained from the secretaries of the working party, Dr. P. Morris Jones, M.R.C.P. (Royal Manchester Children's Hospital, Pendlebury, Manchester M27 1HA), and Dr. Dorothy Pearson, M.B., F.F.R. (Christie Hospital and Holt Radium Institute, Withington, Manchester 20).—I am, etc.,

R. S. ILLINGWORTH

University Department of Child Health,
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¹ Illingworth, R. S., *British Medical Journal*, 1970, 4, 115.

Prescribing Mandrax

SIR,—Dr. Henry Matthew (21 July, p. 174) must have misunderstood my letter (23 June, p. 716). What I said was that in a nursing home there were 10 patients now all having quite large doses of methaqualone together with phenothiazines and electric convulsion therapy as part of a continuous narcosis regimen. Courses of treatment may last for six weeks or more. I suggested that "committee" doctors could go there and see for themselves the absence of "heroin-like" withdrawal symptoms. There are also hundreds of narcosis records at St. Thomas's and Belmont Hospitals and nurses treating such patients could also be consulted.

It was the nursing staff that first convinced me that methaqualone produced a better quality of narcosis and less withdrawal symptoms than the other drugs I have used for continuous narcosis in the past 30 years. The fifth edition of Sargent and Slater¹ was quoted only as a background reference and the actual chapter was written some time before the present Mandrax agitation went into full blast.

May I stress again that if Mandrax is to be used for ordinary patients it should generally be used only to get patients to sleep where Mogadon has failed. Only one or two tablets at the very most should be given. This will often be found preferable to the use of barbiturates. Tricyclic antidepressants, such as trimipramine and amitriptyline, should be added where poor sleep throughout the night or early morning waking remains the patient's main problem.—I am, etc.,

WILLIAM SARGANT

London W.1

¹ Sargent, W., and Slater, E., *An Introduction to Physical Methods of Treatment in Psychiatry*, 5th edn., Edinburgh and London, Churchill Livingstone, 1972.

G.P.s Direct Referrals for Barium-Meal Examinations

SIR,—The facility whereby general practitioners can refer patients directly for radiological examinations has been available fairly generally for some years. Previous authors^{1 2} have published the overall findings for all types of radiological examinations requested, and there is general agreement that the positive findings in radiological examinations are higher in G.P. referrals than in referrals from casualty or outpatient departments.³

In a study of referrals for barium meal examination from a rural population of 111,000 all the cases referred directly from G.P.s in the area in one year were analysed. The population is served by 49 G.P.s, of whom 36 referred cases during the year. In all, 652 cases were referred. The examinations were done almost entirely in one modern department equipped with image intensification and television monitoring. There were 631 new cases and 21 follow-up examinations. There were only three requests for a follow-through examination. Abnormalities were found in 402 (63.7%) of the 631 new cases.

The waiting-list time (number of days elapsing between the request card having been made out and the examination being performed) varied from time to time during the year. Non-attenders who subsequently attended accounted for some of the longer times. The variation in the positive-finding rates in relation to waiting-list time in the 631 new cases examined is shown in table I.

TABLE I—Relation of Waiting-list Time to Positive Findings

Waiting-list Time (days)	No. of Cases	No. Abnormal	% Abnormal
0-10	221	160	72
11-20	194	133	69
21-30	181	102	56
31-40	20	10	50
41-50	9	3	—
50+	6	4	—

Thirteen G.P.s in the area did not refer any cases during the year. The referral rates (expressed as referrals/1,000 list patients/year) in the group of 36 G.P.s who did refer cases varied considerably, as shown in table II. There was no obvious connexion between

TABLE II—Variation in G.P.s' Referral Rates

Referral Rate	No. of G.P.s
0-4	8
5-10	18
11-15	7
16-20	1
20-30	2

the size of a practitioner's practice and his rate of referral.

The trend towards giving G.P.s direct access to radiological examinations is useful and important. The main difficulties are ones of facilities and staffing and to a lesser extent communication. The overall positive-finding rate in these referrals is very satisfactory. In the present study there was no tendency towards doing unnecessary initial or follow-up examinations. Several bedfast patients were sent by ambulance for examination during the year. When the waiting-list time was brought down to less than two weeks the referral rate went up and the number of examinations performed rose from 12 per week to about 16 per week. Contrary to what one might have expected, the positive-finding rate increased. The referrals for barium-meal examinations from the surgical outpatient department did not change, while the referrals from the medical outpatient department dropped slightly. The G.P., it seems, has a considerable number of upper gastrointestinal tract problems in his practice and would probably apply diagnostic aids to these problems to a greater

extent if they were more freely available.—I am, etc.,

J. K. MILLAR

Edinburgh

- ¹ Cook, P. L., *British Medical Journal*, 1966, 2, 351.
- ² Davis, R. H., and Williams, J. E., *British Medical Journal*, 1968, 1, 502.
- ³ Anderson, J. A. D., *Lancet*, 1968, 2, 97.

Vocational Training and the R.C.G.P.

SIR,—I read Dr. S. L. H. Smith's letter (14 July, p. 108) with sympathy and interest.

Several years ago I attended a local committee meeting of the Royal College of General Practitioners. I resigned my membership of the college on the following day. I had joined the college as an associate and then became a member years ago because I supported the original concepts of the college. I became increasingly disillusioned as I attended meetings, and realized that a dreadful hunger for power and a desire to form an elitist organization had become dominant in the college. The membership became an examination, the college became royal, and it then invented a fellowship.

This was followed by a powerful invasion and domination of postgraduate teaching, which has absolutely no justification whatsoever.

Of course, the formation of a G.P. hierarchy will suit the increasingly bureaucratic N.H.S. There will be no difficulty in allocating merit awards or differentials in salary. Many times I have heard members and fellows of the R.C.G.P. refer to themselves as the "cream of general practice." The college is an infant. It should suckle at the breast of humility.—I am, etc.,

WALLACE WHITE

Great Baddow,
Essex

Diazepam Suppositories in Prolonged Convulsions

SIR,—Diazepam has proved a useful drug when administered parenterally, either intravenously or intramuscularly, in the treatment of status epilepticus. When given orally in this condition it is ineffective. We have recently employed the drug in a suppository form to control epileptic seizures in two children and would recommend its trial in similar circumstances. In both cases the children experienced recurrent prolonged convulsions, the frequency of which could not be controlled by varying their oral anti-convulsant therapy, except with unacceptable side-effects.

In both instances we tried the effect of diazepam in a dosage of 0.2 mg/kg body weight in suppository form. Major seizures were controlled within 20 minutes. The mothers of the children have experienced no difficulty in giving the drug by this route and both are delighted that they are in a position to control their children's attacks. Before the diazepam suppositories were used each prolonged convulsion required either urgent referral to hospital or an emergency call from the family doctor. This has not happened since.

It may be argued 20 minutes is an unacceptable length of time before a con-

vulsion is controlled, but the attacks invariably lasted longer than this when the suppositories were not employed, while waiting for an ambulance or the family doctor. In our second case the child had to remain in hospital for some weeks because though her mother wanted to take her home she was terrified because she felt helpless when her daughter convulsed.

The suppositories were prepared according to the general method described in the *British Pharmaceutical Codex* (1968), incorporating the prescribed dose of diazepam in melted theobroma oil. They are not available commercially in this country, though they are on the Continent. We are sure that if it was found that the diazepam suppositories had a place in the management of such situations as we have outlined, then the manufacturers of the drug would be prepared to market them.—We are, etc.,

A. F. CONCHIE
G. R. LOWIS

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Victoria Hospital,
Worksop, Notts

Heat and the I.U.C.D.

SIR,—In 1969,¹ I drew attention to the possible hazards to the efficiency of intrauterine contraceptive devices when patients received pelvic short-wave diathermy.

The introduction of the new contraceptive device containing copper wire (Gravigard) again raises the possibility of distortion of the plastic and possible burns to the endometrium from the presence of metal in the uterus if short-wave diathermy is applied to the pelvis. As short-wave diathermy is often used in my infertility clinic, I obtained the consent of a patient for the following experiment.

A Gravigard was placed in the posterior fornix and, using a large anterior and posterior electrode 20 minutes' short-wave diathermy was given. The patient felt no sensation of burning or any other discomfort, indicating that the copper on the device is not a hazard. However, on removing the Gravigard I found that the springiness of the device had been diminished and the horizontal arm was now capable of distortion with quite light pressure and to some extent had lost its "memory." There is thus a possibility that after such treatment the device might easily be expelled.—I am, etc.,

BERNARD SANDLER

Manchester Victoria Memorial Jewish Hospital,
Manchester

¹ Sandler, B., *British Medical Journal*, 1969, 4, 807.

Traveller's Ankle

SIR,—I was interested to note the letter from Mr. H. Daintree Johnson regarding "traveller's ankle," (14 July, p. 109) and his recommendations for prevention of this syndrome.

Mr. Daintree Johnson may be interested to know that for some years in their booklet *Before You Take Off*¹ B.O.A.C. have advised prospective passengers as follows: "Though B.O.A.C. seats are specially designed to ensure maximum comfort, a few passengers on long flights tend to develop swelling of the feet and ankles after sitting for long periods. A simple way to avoid this and to relieve

any discomfort is to bend and stretch the ankles at regular intervals on each sector of the flight. Use the opportunity at transit stops of exercising the muscles of the legs by walking. . . ." Similar advice is given in the *Air Attendants' Hand Book*, which I wrote for the St. John Ambulance Association and which was first published in 1965.²

Analysis of the true incidence of this condition will therefore be difficult, as certainly the airlines have already been recommending preventive measures for several years.—I am, etc.,

A. S. R. PEFFERS

Air Corporations Joint Medical Services,
Heathrow (London) Airport,
Hounslow, Middlesex

¹ British Overseas Airways Corporation, *Before You Take Off*, London, B.O.A.C., 1973.

² Peffers, A. S. R., *Air Attendants' Handbook*, London, St. John Ambulance Association, 1965.

Legal Aid and Tribunals

SIR,—Under the Legal Aid and Assistance Act of 1972 individuals appearing before a tribunal may now obtain legal help to the extent of £30 worth of work, but not actual representation. Consultant psychiatrists who have any detained patients in their care therefore not only have a duty to inform their patients of their legal rights and how to appeal against detention, but should additionally now, in my opinion, ensure that their patients know of this situation and apply for legal aid if they so wish. Whether it is necessary or wise or helpful to the patient is not strictly relevant. There are many arguments in favour and even more against; the last thing one would want to see would be for mental health review tribunals to become mini-courts of law.

An unfortunate sequel may be that patients who are kept fully informed of their rights, or have relatives and friends willing to help and advise them, would now be able to strengthen their appeals for discharge from compulsory detention, while those who are bereft of friends and are situated in hospitals where they are not so freely encouraged to appeal may, because of the "domino" effect, be equally deprived of knowledge of their legal rights or not positively encouraged to exercise them—let alone to seek legal aid. But this would be no excuse for not publicizing the situation until such time as the Lord Chancellor's Advisory Committee on Tribunals has considered the matter further. Presumably also, in due course, the Department of Health and Social Security will be issuing notes of guidance.

A further factor which should be taken into account is that if patients are going to seek legal aid, they should do this as soon as they make their application to appear before a tribunal, because late arrangements may result in tribunals being adjourned to permit the legal representative time to prepare the case. The delay means a prolongation, therefore, of compulsory care and perhaps further anxiety as well as complications for tribunal staff in making mutually convenient arrangements.—I am, etc.,

E. W. SHEPHERD

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Watford, Herts

Return to Work

SIR,—With reference to your leading article (28 July, p. 186), no new service to provide a better link between doctor and industry is necessary. The occupational therapist with her medical background is already qualified to provide that link. Her assessment of the patient in relation to his work environment should provide doctor, social worker, and employer with the information necessary for vocational resettlement or retraining.—I am, etc.,

FRANCES E. MACE

London, S.E. 23

Earnings of G.P.s and Hospital Doctors

SIR,—It seems from Mr. C. R. Sandison's reply (11 August, p. 355) to Professor A. R. Prest's letter (28 July, p. 238) that his figures of earnings and expenses for general practitioners are based on a sample taken from his own accountancy practice, whereas the figures of £7,710 gross remuneration, less £2,200 expenses, given in the third report of the Halsbury Review Body¹ are average figures, derived on a statistical basis, from Inland Revenue sources. Though he may well be able to demonstrate, from his own practice, that amounts are being earned by general practitioners in excess of the net figure of £5,510 there will be cases of general practitioners earning less than this in other parts of the country. Inevitably, therefore, a restricted and not necessarily representative sample drawn from information available from one limited source is no more likely to provide an indication of average earnings of general practitioners over the whole country than it is of those of consultants, a significant number of whom receive additions of 20% or more to their basic remuneration in the form of distinction awards.

Mr. Sandison has complained that there is little detailed information about the nature of general practitioners' expenses but I am afraid that it is a subject which cannot be satisfactorily reviewed without research over a period of time. The Review Body is a standing body, and as a result numerous references can be found in each of the Review Body reports and the evidence submitted by the professions; references to the background, bases and amounts of expenses, and levels of incomes can be found, for example, in the following Review Body reports—Cmnd. 2992 (1966); Cmnd. 4352 (1970), para. 134; Cmnd. 4825 (1971), paras. 32-42; Cmnd. 5010 (1972), tables 2 and 3 of appendix 2; Cmnd. 5353 (1973), para. 134—and also in the professions' evidence, paras. 2. 15-18, in connexion with the last review. I am sure that the B.M.A. would be pleased to supply him with copies of the professions' evidence if they are not obtainable from his medical clients.

While there are a number of other comments which should be made about the method of comparison adopted by Mr. Sandison, these can only be taken up in correspondence when he has had the opportunity of examining in more detail the way in which general practitioners' expenses are calculated.—I am, etc.,

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