Such side effects rule out the use of 5-FC for vulval candidiasis except where this is disabling. Such cases do, however, occur, and the patient described above has been transformed from an anxious, depressed woman to a happy housewife, all her family sharing the benefits.

The 5-PC was provided by Dr. J. Garrod of Roche Products Ltd. Microbiological investigations were performed by Dr. A. T. Willis and blood 5-FC levels estimated at the Mycology Reference Laboratory.

—I am, etc.,

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Cot Deaths

SIR,—In your leading article (2 March, p. 341) on cot deaths, also referred to as the sudden infant death syndrome (S.I.D.S.), it was stated that "post-mortem examination of infants with S.I.D.S. has shown an adequate cause of death, such as pneumonia, acute bronchiolitis, or gastroenteritis in 25% to 50% of cases." I feel that it would have been more appropriate to define S.I.D.S. precisely in your article and adhere to the definition throughout the course of your discussion. Thus both semantic confusion and the inflation of the incidence of S.I.D.S. by 25-50% would have been avoided.

At present a widely recognized definition of S.I.D.S. is "the sudden death of an infant or young child, unexpected by history, in which a thorough postmortem examination fails to demonstrate an adequate cause of death."¹ Prior to 1970 to most investigators S.I.D.S. was the death of an infant or child who was thought to be in good health or whose terminal illness proved to be so mild that the possibility of a fatal outcome was unexpected. However, unless we adhere to a generally acceptable definition, studies on S.I.D.S. either to evaluate its true incidence or to elucidate the cause and/or mechanism of death are bound to have a limited significance.—I am, etc.,

S. SIVANESAN

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¹ *Sudden Infant Death Syndrome: Proceedings of the Second International Conference on Causes of Sudden Death in Infants*, ed. A. B. Bergman, J. B. Beckwith, and C. G. Ray. Seattle, University of Washington Press, 1970.

Meningioma Mimicking Features of a Pheochromocytoma

SIR,—Drs. R. Gabriel and B. D. Harrison (11 May, p. 312) report a case of supratentorial meningioma mimicking the clinical and biochemical features of pheochromocytoma in which the raised vanilmandelic acid (VMA) excretion returned to normal after removal of the tumour. The explanation offered, that raised intracranial pressure had produced these features through stimulation of the sympatheticoadrenal pathway, is not the only possible one and not perhaps the most likely.

Since the time of Cushing¹ vasomotor changes have been accepted as part of the clinical picture of raised intracranial pressure; such changes occur usually only with a rapid pressure rise² and then in-constantly and mainly in children with

lesions that directly compromise the posterior fossa.³⁻⁵ In the case described no mention is made of papilloedema and the lumbar cerebrospinal fluid pressure was only 270 mm.

The association of pheochromocytomas and meningiomas with von Recklinghausen's disease is well accepted, the link probably lying in the common neural-crest ancestors of these tumours. Other neural tumours have been reported as secreting VMA.⁶ Is it not probable that the meningioma may on occasion have this capacity? After all, other intracranial tumours, the haemangioblastomas, secrete hormones and the latter is found in association with pheochromocytomas. It would have been of interest to know the cytochemical characteristics of this patient's tumour.—I am, etc.,

J. SCOTT

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Birmingham

- 1 Cushing, H., *American Journal of Medical Sciences*, 1902, 124, 376.
- 2 Pickering, G. W., *High Blood Pressure*, p. 520, 2nd edn. New York, Grune and Stratton, 1968.
- 3 Browder, J., and Meyers, R., *Archives of Surgery*, 1938, 36, 1.
- 4 Johnston, I. H., Johnston, J. A., and Jennett, B., *Lancet*, 1970, 2, 433.
- 5 Plum, F., and Posner, J. B., *Diagnosis of Stupor and Coma*, 2nd edn., p. 32. Philadelphia, David, 1972.
- 6 Kogut, M. D., and Kaplan, S. A., *Journal of Pediatrics*, 1962, 60, 694.

The Heart during Sleep

SIR,—With reference to your leading article (13 April, p. 70) in the beginning of open-heart surgery in the 1950s it was recognized from first principles and practical experience that pain, fear, and exhaustion predisposed to death from arrhythmia, and the protective value of providing adequate sleep was quickly appreciated.

In the early 1960s coronary care units appeared and some of us introduced, and continued to find useful in threatened and acute myocardial infarction,¹⁻⁴ the sleep regimens that we had developed in the surgical wards.—I am, etc.,

P. G. NIXON

Charing Cross Hospital (Fulham),
London W.6

- 1 Nixon, P. G. F., *et al.*, *Lancet*, 1968, 1, 726.
- 2 Nixon, P. G. F., in *Recent Advances in Medicine*, ed. D. N. Baron, N. Compston, and A. M. Dawson. London, Churchill, 1968.
- 3 Nixon, P. G. F., in *Seventh Symposium on Advanced Medicine*, ed. I. A. D. Bouchier. London, Pitman Medical, 1971.
- 4 Nixon, P. G. F., *Practitioner*, 1973, 211, 5.

Blind Babies

SIR,—I was pleased to read your leading article (8 June, p. 518) on xerophthalmia, the blinding disease due basically to a lack of vitamin A in the food. It is a scourge in many countries yet little is taught about it in medical schools in the West. This is particularly unfortunate at present as preventive schemes are starting in many parts of the world and accurate diagnosis is essential. The Governments of India, Indonesia, and Bangladesh are distributing, each six months, a large dose of vitamin A (300,000 IU) in oil by mouth to children under 5 years old in the hope that this will maintain a satisfactory level of vitamin A in the liver and blood. The results of these measures are not yet available, but one hopes that the impact will be great and that the stream of malnourished children with xerophthalmia

coming daily to paediatric and ophthalmic outpatient clinics will be reduced.

However, such children, who are the most at risk of going blind, can be effectively treated at a relatively small cost. At Madurai in Southern India, Dr. Venkataswamy directs a nutrition centre for children suffering from malnutrition and xerophthalmia where the child and parent (usually mother) are given food which provides vitamin A and which is both local and cheap. In practice this means provision of about an ounce (28 g) a day of well-boiled and mashed carrots or dark green leafy vegetables such as spinach, amaranth, drumstick leaves, or turnip tops. The rest of the food is designed to supply a good level of protein and calories. The parents do the marketing and cooking and are encouraged to continue the food when they go home. The results have been sufficiently encouraging for the work to be extended into surrounding villages.

The Xerophthalmia Club exists to help preventive measures. A current activity is an attempt to encourage governments and charitable bodies which send dried skim milk to disaster areas to ensure that all such milk is fortified with vitamin A. If protein food is given to a malnourished child already deficient in vitamin A the last remnants of vitamin A in the body are used up and xerophthalmia may be precipitated. Such disasters still occur.¹ Unicef and the Governments of the United States and the Netherlands have already agreed that all dried skim milk exported shall contain vitamin A. We hope this will become universal.

The Xerophthalmia Club is financed entirely by the Royal Commonwealth Society for the Blind. There is no membership subscription for those seriously interested in the prevention of xerophthalmia.—I am, etc.,

ANTOINETTE PIRIE

Hon. Secretary, Xerophthalmia Club

Girton College, Cambridge

¹ Oomen, H. A. P. C., *Xerophthalmia Club Bulletin*, No. 5, 1974.

Forensic Neuropsychiatry

SIR,—I disagree with some of Dr. M. F. Cleary's comments in his Personal View (1 June, p. 498) about the psychiatrist in court. Of course psychiatry is a woolly subject, but it need not be quite as woolly as some psychiatric witnesses make it seem.

As Cuthbert¹ has pointed out, serious crime may be a manifestation of brain disease, especially when the offence is not readily "understandable." In this situation it is not enough to order a neurological examination and E.E.G., both of which may give entirely normal results in the presence of significant disease.^{2,3} I believe it is essential, if justice is to be done, to offer a thorough neuropsychiatric investigation. In practice this will usually require a brain scan, air encephalography, psychometry, and in some cases a sphenoidal E.E.G. as well. In this way, significant brain disease is unlikely to be overlooked. Indeed, there is no other way of assessing the cerebral atrophy which frequently accompanies alcoholism,² and the relationship between crime and alcoholism is well known. Some tentative diagnoses of temporal lobe epilepsy are clinched when the air encephalogram shows marked temporal atrophy.³ Retrospective diagnosis,

despite Dr. Cleary's doubts, becomes easier with this sort of help.

I have previously reported on two trials^{4,5}—one for murder, the other for drunken driving—in which air encephalographic evidence of cerebral atrophy was instrumental in preventing a miscarriage of justice in the first case and a manifestly inappropriate sentence in the other. In a more recent trial⁶ the defence, learning that the accused had a documented history of alcoholism, rightly raised the possibility of brain damage. The air encephalography revealed no atrophy and it was possible to discount this suggestion beyond all reasonable, or even unreasonable, doubt. He was found guilty of murder.

The most questionable of Dr. Cleary's thoughts is that psychiatric evidence should be given after the verdict rather than before. I have pointed out⁷ that in the case of Carl Sodeman, hanged in Australia in 1936 despite unopposed psychiatric testimony that he was "McNaughton insane," cerebral atrophy and probably meningitis were found at necropsy. Air studies could have detected this before death and would probably have influenced any appeal in his favour. Execution is now unfashionable, but the possibility of further useful investigation still diminishes sharply after conviction since there is an understandable reluctance to permit action which might lead to a retrial. —I am, etc.,

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Queen Elizabeth Hospital,
Birmingham

- 1 Cuthbert, T. M., *British Journal of Psychiatry*, 1970, 116, 1.
- 2 Brewer, C., and Perrett, L., *British Journal of Addiction*, 1971, 66, 170.
- 3 Slater, E., and Beard, A. W., *British Journal of Psychiatry*, 1963, 109, 95.
- 4 Brewer, C., *Medical Journal of Australia*, 1971, 1, 857.
- 5 Brewer, C., *Medicine, Science, and the Law*, 1974, 14, 40.
- 6 *Attorney General of Jersey v. English*, Spring Assizes, Jersey 1974.
- 7 Brewer, C., *Australian and New Zealand Journal of Criminology*, 1971, 4, 94.

Industrial Action by Radiographers

SIR,—The proposed industrial action by radiographers causes anxiety in that some patients may subsequently allege that they have suffered avoidable harm attributable to a failure to order a particular x-ray examination. To protect themselves against such allegations and to ensure that responsibility properly devolves upon the hospital authority members of the Medical Protection Society are recommended to take the following course of action.

(1) Written requests for x-ray examination should continue to be made on the appropriate form where the clinical indications are present as in normal circumstances.

(2) The forms should be sent to the x-ray department. This action should be taken irrespective of the fact that the x-rays may not be performed.

(3) The fact that an x-ray has been ordered should be recorded in the clinical notes.

(4) Particular care should be taken in writing clinical notes for the practicalities of the situation will require that a greater reliance than ever is placed upon clinical findings. Full contemporaneous notes will provide valuable evidence in that regard.

Radiologists may have the unenviable task

of allotting priorities. The hospital authority should be informed that this is very much a contingent duty forced upon them in circumstances for which they are not responsible but for which the hospital authority is ultimately responsible.—I am, etc.,

P. G. T. FORD

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Medical Protection Society, Ltd.

London W.1

Tests for Immigrant Doctors

SIR,—Of the General Medical Council's 45 members, only two or possibly three work in provincial non-teaching hospitals. This would appear to explain, though hardly excuse, the G.M.C.'s extraordinarily complacent attitude to the examination of foreign doctors well shown in the letter from the Registrar (6 July, p. 46). It does not explain the G.M.C.'s apparent ignorance of the content of the E.C.F.M.G. examination. Of course it tests factual recall, but it is also a searching test of clinical reasoning and choice of priorities in diagnosis and treatment.

I have worked with many foreign doctors who are perfectly competent and have an excellent command of English—quite a few have also passed the E.C.F.M.G. A much smaller number cannot understand or be understood in English and as a result their clinical effectiveness has been inadequate, they are protected and "carried" by their colleagues and by senior medical and nursing staff. As far as I know none have passed the E.C.F.M.G.

The E.C.F.M.G. is a well-tried examination that can be taken near to a candidate's home country (failures thereby escaping the additional fee of a return passage to the United Kingdom). If the existing E.C.F.M.G. machinery was used to screen foreign doctors this would please the provincial consultant, it would raise the standard of patient care in those hospitals, and it would please the great majority of competent foreign doctors whose collective character is being sullied by a few failures. Only, of course, the non-university examining bodies would lose the opportunity of testing 7,000 candidates per annum (some several times) by a completely untried examination.

My letter to the President of the G.M.C. on this subject produced neither an acknowledgement nor a reply.—I am, etc.,

ROGER HOLE

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United Action

SIR,—With the medical, dental, and nursing professions now facing the most serious crisis in their history, why on earth can we not all unite to form potentially the most powerful body in the country? Only then do we stand any chance of being able to resist political pressure groups.

These honourable professions may then be able again to carry out their onerous duties in accordance with their ethical tradition.—I am, etc.,

N. J. KNOTT

Press Secretary,
West Wilts Section,
British Dental Association

Westbury, Wilts

Private Beds and the N.H.S.

SIR,—Two cheers for the National Union of Public Employees! They may have shown that the days of private practice in National Health Service hospitals are numbered (hence no third cheer, for I am convinced that this will be to the serious detriment of patient care in the service), but they have also conclusively demonstrated the strength of the consultants' position in negotiations with the Government regarding conditions for the phasing out of private practice, which we must now surely accept is inevitable. The almost indecent haste with which Mrs. Castle (having 24 hours earlier refused a gentlemanly request to do so) came scuttling from the Elephant and Castle to conduct negotiations at the first suggestion of determined action by the B.M.A. must surely have been most heartening to all consultants.

In the light of this demonstration of strength our negotiators should insist on the following compensation as a minimum for the loss of private practice in the N.H.S. (1) A "no detriment" clause ensuring that no part-time consultants would suffer loss of present or potential future earnings. Such conditions are usual in situations of this sort and were accepted by the Government without question in the case of local government and N.H.S. administrative reorganization. (2) The salary of all future consultant appointees should include increments equal to the global average earnings currently pertaining to private practice in the N.H.S. A similar increment should be awarded to all consultants now employed on a full-time basis. (3) All income should be tied to the cost of living index and adjusted accordingly each year. (4) A satisfactory and clearly defined contract of service should be agreed.

We can determinedly pursue these modest demands with a clear conscience secure in the knowledge that far from depleting the precarious finances of the N.H.S. we shall in fact be augmenting them, since the vast sums of money which Labour politicians have repeatedly told us go from the public sector to finance private practice will be saved and will surely more than cover any increase in the salary bill for consultants. —I am, etc.,

R. F. HEYS

Halifax

SIR,—Recurrent attacks on the private sector by Government leaders prompts me to bring to the attention of our profession the abuses of the National Health Service by such people to which I have referred already elsewhere.¹ We all have knowledge of the way people in political power use their positions to obtain personal and preferential treatment within the N.H.S. and then boast of their adherence to their egalitarian principles after their treatment.

May I plead with anyone consulted by these people as N.H.S. patients that they be given no priority treatment other than is medically indicated? Doctors are obviously flattered to be consulted by important people and may allow acceleration up waiting lists or personal performance of the operation in such cases. It is only by making these people, be they Minister of the Crown or editor of a newspaper, feel the rough end of the Health Service stick personally that we can hope (or expect) to increase the funds available to the N.H.S. and improve the quality of the service.