amounts given more often if desired to even out absorption through the day.—I am, etc.,

D. F. HAWKINS

Hammersmith Hospital,
London W.12

¹ *Documents Geigy Scientific Tables* (1970), ed. K. Diem and C. Lentner, 7th edn., p. 499. Basle, Geigy.

Genital Medicine

SIR,—Dr. R. N. T. Thin (5 July, p. 43) calls our specialty by yet another name, Genital Medicine, a title which some might consider too bald. However, it is better than "Genitourinary Medicine," which I criticized (24 May, p. 446), because that implies poaching on other people's fields with the possible danger of neglect of the venereal or sexually transmitted diseases (S.T.D.) in favour of more academically interesting ones. However, both these titles are, to my mind, unsatisfactory as they refer to a circumscribed area of the body, whereas S.T.D. often involves the whole person—for example, syphilis or Reiter's syndrome. Lines of demarcation as to who does what may sometimes be necessary but not in this case. The problem of finding a suitable title for the departments where S.T.D. are treated was solved long ago by giving them local or personal names such as the Whitechapel Clinic, Lydia Department, or James Pringle House.

Dr. Thin says that only a minority of his patients have legally defined venereal disease but I suspect that most of them would not have come to him if their troubles had not followed extramarital sexual exposure. I am sorry that he hopes to "spend less time coping with emotional problems," as these are just as important to the patient as physical ones. Perhaps it is my seniority, to which Dr. Thin kindly refers, which makes me think, in an old-fashioned way, that being a good doctor is more than being just an interpreter of scientific findings but involves the total care of the patient, mental and physical, most especially, in the management of S.T.D. I think there has been too great a tendency to concentrate on science and research leaving the rest to social workers and nurses. This narrows the specialty and so discourages recruits who are interested in patient care. Dr. Thin and Dr. Harrington Sims (5 July, p. 45) must not think that I wish to lower our standards by adding the ability to do good doctoring to academic qualifications.

The sexually transmitted diseases will remain emotionally charged with an element of guilt attached, which will not be altered by any change in the title of our specialty. That will come when the public itself considers marital sexual intercourse completely acceptable to all parties, which I expect will not be for some time yet.—I am, etc.,

JAMES JEFFERISS

Præd Street Clinic
St. Mary's Hospital,
London W.2

Appendicular Carcinoids

SIR,—Your leading article on the diagnosis of malignant carcinoid syndrome (19 July, p. 122) states: "The commonest site of the tumour is at the tip of the appendix, where

it was formerly regarded as benign—hence the term carcinoid. Pearson and Fitzgerald, however, in reviewing a large series found metastases in 38% and emphasized that all carcinoids should be considered malignant."

There is a dangerously misleading implication here that appendicular carcinoids frequently metastasize. In fact, Pearson and Fitzgerald wrote, "Metastases were present in 38% of the present series of *non-appendicular* carcinoid tumours" (my italics).¹ A more recent publication² states that metastases from appendicular carcinoids are extremely rare (less than 1%) and found only in tumours over 2 cm in diameter.

As carcinoids are the commonest of appendicular tumours (and appendicectomy is the commonest of operations performed by aspiring surgeons) it is important that their benign prognosis should be appreciated.—I am, etc.,

A. D. MORGAN

Westminster Hospital,
London S.W.1

¹ Pearson, C. M., and Fitzgerald, P. J., *Cancer*, 1949, 2, 1005.

² Morson, B. C., and Dawson, I. M. P. D., *Gastrointestinal Pathology*, p. 410. Oxford, Blackwell Scientific, 1972.

Digoxin Bioavailability: Paradoxical Increased Toxicity on Dosage Reduction

SIR,—Since 1972, when it was first reported¹ that digoxin tablets B.P. were subject to differences in bioavailability, much work has been published concerning serum levels and clinical response, the formulation factors involved, and the establishment of an in-vitro dissolution test to control this variable. One aspect of the digoxin saga which has not been previously reported is the increased toxicity which can follow dosage reduction. This situation arises because, though there are many brands of the 0.25-mg tablet of varying bioavailability marketed in Great Britain, there is only one source, the highly available Lanoxin brand, of 0.125-mg and 0.0625-mg tablets. The extent of the problem is shown in the table below, which compares the dissolution results after one hour of the three Lanoxin strengths and the 0.25-mg tablets purchased on contract by this hospital. The weight of digoxin in solution at one hour has previously been shown to correlate ($r = 0.995$) with bioavailability as estimated by the area under the serum concentration/time curve from 0–6 hours.²

Dissolution Results of Hospital-contract and Lanoxin Digoxin Tablets (Mean of Three Experiments with Five Tablets)

Tablet	Mean Tablet Content (%)	Labelled Strength in Solution at 1 h (%)	Weight Digoxin in Solution at 1 h (mg)
Hospital contract 0.25 mg	95	33	0.082
Lanoxin 0.25 mg	97	83	0.208
Lanoxin 0.125 mg	98	87	0.109
Lanoxin PG 0.0625 mg	98	98	0.061

It is apparent that a patient receiving the contract 0.25-mg tablets and experiencing digoxin toxicity would on reduction of his dosage to the only available 0.125-mg tablets find his symptoms exacerbated. Indeed, even by quartering the labelled dosage to the only available 0.0625 mg an effective dosage reduction of only 25% occurs. As there are

several brands of digoxin tablets with dissolution profiles similar to the contract brand studied above, the paradoxical increased potency on dosage reduction is capable of widespread occurrence and provides a further reason for the introduction of a dissolution test into the *British Pharmacopoeia* in October this year.—I am, etc.,

R. H. LEACH

Queen Elizabeth Hospital,
Birmingham

¹ Shaw, T. R. D., and Hamer, J., *Lancet*, 1972, 2, 303.

² Fraser, E. J., et al., *Journal of Pharmacy and Pharmacology*, 1973, 25, 968.

Fees for Family Planning Services

SIR,—Hospital staff are constantly being urged to economize and face up to questions of priority. Actual cuts in the service have already taken place and more are contemplated. It is therefore pertinent to question whether the agreement between the profession and the D.H.S.S. on fees for sterilization (26 July, p. 260) has been costed, and how this together with the actual cost of providing the facilities will be funded. It is remarkable how the profession has to adopt such unifying postures when seeking improvements in basic salary, whereas quite generous agreements of this nature can be completed so silently—if it happens to further one of the Government's pet schemes. This no doubt also explains the ability of the same service to issue free contraceptives.

It is also questionable whether, as in the case of the award of shorter working hours and increased statutory holidays to various hospital staff, the D.H.S.S. has realized all the implications, some of which are not directly financial. What priority is to be afforded the clients for "social" sterilization when patients await surgical and gynaecological operations? What will be the attitude of non-medical workers where doctors are being paid for work which is not so much "private" as non-clinical?

All this is quite apart from the more fundamental questions of the state of a nation that pays its doctors to sterilize its people without even the pretence of medical indications. Are doctors still expected to exercise discretion or is it now to be sterilization on demand?—I am, ec.,

D. E. B. POWELL

Bridgend General Hospital,
Bridgend, Glamorgan

SIR,—That fees are to be paid for the provision of family planning services through the hospital service (19 July, p. 185 and 26 July, p. 260), particularly sterilization, surely strikes at the root of the idea of patient care. As one who has performed the operation often four times a week in the last 25 years in the interest of the patient, it was a normal part of patient care. Now I realize that it is gilt-edged patient care and all the benefits from management of other aspects of patient care, such as prolapse and even malignant disease, are relegated to a reserve list of little importance so that the desperately short finances of the National Health Service can gild the sterilized gingerbread. How can our negotiation with the D.H.S.S. really justify this item of service payment by which a general practitioner gets more for giving contraceptive advice than for looking after a