ourselves whether we are not taking yet another step in the direction of the partial dissolution of the family? And might not some of our contemporary social problems be a result of this tendency?—I am, etc.,

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Training of Surgeons

SIR,—Mr. Neville Stidolph's article on the training of surgeons (9 November, p. 379) and his timely recommendations will I hope be implemented with a sense of urgency which has so far been lacking in previous attempts to reform surgical training.

May I comment on two points? Firstly, although one cannot dispute Mr. Stidolph's figure that only 12% of aspirants pass the English Fellowship, my impression is that a much higher proportion of my friends and acquaintances who seriously set out to become surgeons have eventually gained the F.R.C.S. This, of course, only serves to compound the disappointment and frustrations which are rife in the large group of fourth- and fifth-year registrars. Probably, in order to calculate an accurate figure for the Fellowship pass rate, it would be necessary to analyse by name the numbers of candidates sitting for the primary and final examinations over a five-year period.

Secondly, the training scheme proposals appear to make no allowance for the post-registration doctor who wishes to step out of line for one or two years for such commendable reasons as foreign travel or to gain a wider experience of life and living. There is much to be said in favour of a prolonged break in intensive study, and this is often the only time that a young man can be free of family or professional ties. National Service provided this opportunity for many, but independent initiative now is viewed with suspicion by appointments committees.—I am, etc.,

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SIR,—I was most interested in Mr. Neville Stidolph's article on the training of surgeons (9 November, p. 379). I hope his suggestions and conclusions will be noted by those involved in the training schedules being developed in this country.

While I was in the Sudan the late Julian Taylor helped to establish the primary F.R.C.S. examination in Khartoum, and quite a number of my junior medical staff successfully passed it. When they tried to follow this up by going to England in preparation for the final examination, they often found great difficulty in getting suitable jobs. It occurred to me that, as the Royal College of Surgeons was responsible for setting them on the path towards full surgical status, it might have been useful for it to accept a further responsibility in placing these doctors, generally the cream of the local medical graduates, in suitable training positions. It could have been possible, perhaps, for the College to have a panel of consultants around the country prepared to accept successful primary candidates from overseas simply on the College's recommendation. I think this

panel is still necessary and would be quite easy to arrange.

An important point mentioned by Mr. Stidolph is the demand made by some countries for the return of their graduates immediately on achieving the higher diploma. I have had some experience of this, and can recall the case of one of my junior staff, who was unfortunate enough to come to England and pass the final Fellowship examination at his first attempt two months later. He was back in his own country within a few weeks and was promptly posted to a remote area as junior surgical specialist, without adequate experience or supervision. I certainly feel that a compulsory period of post-diploma work in this country should be introduced for overseas graduates, possibly by some device similar to the post-qualification, pre-registration period now in force for newly qualified doctors. This would, of course, be in addition to any pre-fellowship training, and might in a sense be more valuable as there would be no examination looming ahead. It would give some protection to the graduates against premature uprooting, and would certainly improve the quality of some of the British-trained surgeons now returning to their home countries with the F.R.C.S. Many are, of course, of first-class calibre, and are very good ambassadors, but it is inevitable that, where there is a gross shortage of medical personnel, and even more so of people with higher qualifications, these latter, on returning to their home countries can be thrust into positions of great responsibility for which in some cases they are not fitted. I think the image of British surgery would be enhanced if these diplomats were returned to their countries with something more than letters after their names.

Mr. Stidolph has rightly pointed out that the overseas graduates coming here for training need to have facilities for study, particularly free time, and proximity to centres of learning. However, as they tend to be employed mostly in the peripheral hospitals, where the work-load can be very heavy, their opportunities for study are considerably reduced. I think rotating designated training posts, and the grouping of district and peripheral hospitals into a training scheme under the aegis of a university hospital, perhaps parallel to that designed for the production of consultants for home-consumption, would produce several results. Many more jobs would be made available, more hospitals would be upgraded with consequent improvement in recruiting, and consultants not now directly involved in the training programmes would be given a fresh stimulus in their work.—I am, etc.,

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Brescia-Cimino Shunts for Dialysis

SIR,—Dr. R. McMillan and Dr. D. B. Evans (28 September, p. 781) describe their experience with three patients in which Brescia-Cimino shunts (arteriovenous fistulae) were established and used for access to the circulation in intermittent dialysis therapy.

We have previously recorded our experience in 15 patients in whom Brescia-Cimino arteriovenous fistulae were established for regular dialysis treatment.¹ Our experience now extends to 48 cases, which we have been able to follow on our own regular dialysis-

transplantation programme. We have observed these patients for a total of over 330 dialyses months; 23 of these received cadaveric transplants. Two of the transplanted patients are rehabilitated on regular dialysis treatment following rejection of second grafts, and two others following rejection of the first graft. Though we have had many problems, including death, no patient has suffered any complication, cardiovascular or otherwise, which could be attributed to the Brescia-Cimino fistula. Thirteen of our patients have had experience of the Scribner-type external shunt prior to the arteriovenous fistula. They are unanimous in their preference for the latter. None of the group demonstrated increase in cardiac size, deterioration in E.C.G. pattern, or the development of progressive exertional dyspnoea. In addition, 11 arteriovenous fistulae have been established for patients on other regular dialysis treatment programmes, including home dialysis.

The retrospective impressions of Drs. McMillan and Evans on three patients, who between them developed multiple serious and well-known complications of renal transplantation, can only be regarded as a totally inadequate and unfair commentary on the merits or otherwise of the Brescia-Cimino arteriovenous fistula. Control of hypertension is the greatest single indication of successful regular dialysis treatment no matter what method of access to the circulation is employed. Frequency of dialysis and adequate flow rates are critical factors in this context. To achieve the latter with the Brescia-Cimino fistula reasonable expertise in the techniques of repeated venepuncture is essential. Drs. McMillan and Evans present no positive evidence on these critical points in relation to their three cases. As reported at the symposium on the subject at the Dublin Meeting of the European Dialysis and Transplant Association,² cardiac complications with arteriovenous fistula are confined to patients in whom hypertension has not been controlled.—We are, etc.,

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Exchange Transfusion and Perforation

SIR,—We were interested to read the reports of Mr. J. J. Corkery and others (9 November, p. 345) and Drs. R. L'E. Orme and Sheila M. Eades (p. 349) on perforation of the bowel in the newborn period as a complication of exchange transfusion. Perforation, however, is only the most dramatic result of mesenteric vascular occlusion, and is not inevitable.

At a meeting of the South West Paediatric Club on 26 May this year, and again at a meeting of the Neonatal Society in London on 17 October, we presented six personally studied cases of neonatal gut infarction. Two of our cases had been preceded by at least one prolonged and technically

difficult exchange transfusion. In the first of these two cases there was a positive blood culture for *E. coli* associated with bowel necrosis extending from the caecum to the descending colon. Our second case had diarrhoea for seven days, which preceded the onset of abdominal distension and peripheral circulatory collapse owing to necrosis and perforation of the terminal ileum only. Unfortunately both these infants died without laparotomy being undertaken, and at necropsy we were able to demonstrate antemortem thrombi in the ductus venosus and portal vein in the first and in the portal and splenic veins in the second. We note that in the series quoted there is no comment on the state of the portal vein in those infants who died. A fuller report is being prepared for publication.—We are, etc.,

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Screening for Cervical Cancer

SIR,—As practitioners we have been asked to read a circular letter from the Ministry of Health on the population screening for cancer of the cervix¹ which was sent to all senior administrative medical officers and secretaries of regional boards in August of this year.

We are amazed that the Ministry either refuses to acknowledge or accept that its policy is erroneous, and that it loses the support of those of us who are working in the field of cytology. We have just summarized the histological findings in the last 214 consecutive patients who were shown to have either dysplasia or carcinoma-in-situ of the cervix when a cone biopsy was performed for a positive smear. These show that out of this total no fewer than 64 were below the age of 35 years. These patients were taken from antenatal, gynaecological, family planning, venereal disease, and well-women clinics. No account was taken of their age, but every woman in whom a routine pelvic examination was being made also had a routine cervical scrape. These figures are broken down in age groups (Table). This does not take account of those patients who during such a routine investigation were also found to have carcinoma of the cervix (there was one aged 18 years) or other gynaecological findings warranting treatment. Our figures, as in those of the British Columbia experiment,² show that there is a peak in the age prevalence of this disease at around 35 years, but we also see that the disease is just as likely to occur under, as it is over, the age of 35.

TABLE

Age	Patients with Pre-invasive Lesions of Cervix
Below 20	2
20-25	20
26-30	38
31-35	34
36-40	51
41-45	39
46-50	16
51-55	9
Over 55	5

The difficulty in persuading a woman to have a vaginal examination in the absence of symptoms is well known, and most practitioners agree that a cervical cytology smear should be taken at the time of any routine examination in any clinic, and that this should include all age groups of women at risk—that is, from the age of puberty onwards. It is much more relevant to offer a woman a cervical smear if she commenced coitus at the age of 14 years with a variety of boy friends than if she is a married woman over the age of 35 with one, possibly two, children and only one husband. This simple fact the Ministry have persistently refused to accept, and what is more they have the audacity to offer a miserable fee to the general practitioner and set an age limit which positively discourages him from taking a smear below the age of 35. What is more, should he think it necessary, or indicated on clinical grounds, to take a further cervical smear before five years have elapsed he will not receive a further fee. This ignores completely the fact that a woman may present new vaginal symptoms within less than one year. Small wonder that the Ministry finds it necessary to send a circular to practitioners admonishing them for their lack of enthusiasm in cervical cytology.

Many women, and indeed many general practitioners, are firmly of the opinion that the Ministry policy implies that it is not necessary to have a smear below the age of 35. As our figures show, 30% of proved but previously unsuspected pre-invasive lesions of cervix occur below this age in what are readily screened groups. We sincerely hope that members of the profession are not taken in by this second-rate cytology service.—We are, etc.,

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Inhibition of Lactation by Oestrogens

SIR,—Professor D. Llewellyn-Jones claims in his letter (9 November, p. 387) that inhibition of lactation is best effected by oestrogens. In his series, however, 53% of the patients only had lactation temporarily suppressed or postponed. Further oestrogens were required in 30%, and there are no figures on the 42-day follow-up of the patients treated with the placebo. Other series¹⁻³ have been published in which oestrogens are shown to have little or no advantage over treatment with mild analgesics and adequate breast support. Furthermore they indicate that it is patients treated with oestrogens who are most liable to develop painful lactating breasts after discharge from hospital.

We have recently conducted a double-blind trial using stilboestrol and placebo tablets. Eighty-six mothers who did not wish to breast feed were given one tablet thrice daily for two days, followed by one tablet twice daily for two days, and one tablet daily for two days. Forty-seven patients received a total of 60 mg. stilboestrol and 44 received the placebo. We had previously found that a larger dose gave no

advantage. One patient, who had taken the placebo, subsequently required Nephenthe, but the remainder had either no analgesic or paracetamol. More of the group given placebo received paracetamol (19 against 7) but more of those given oestrogens required further oestrogens from their general practitioners (9 against 2). It is of interest that several patients having started oestrogens decided to breast feed and did so without difficulty.

The exhibition of oestrogens for the inhibition or suppression of lactation seems to be based largely on custom and theory. The published series suggest that they may only delay the onset of lactation and fail to suppress it once it is established. Many doctors, nurses, and patients have an almost religious faith in oestrogens, and the quantity prescribed annually for this purpose must be considerable. In addition there may be an increased risk of thrombo-embolism.^{4,5} Some units have already discontinued the use of oestrogens for this purpose without adverse results, and I hope that others may be stimulated to follow suit, and possibly also to undertake more extensive trials.

I am grateful to Mr. Bryn, Miss A. Commings, Sister V. Rudwick, and the staff of the department for their cooperation.

—I am, etc.,

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Cause of Unexplained Anaemia

SIR,—Drs. C. M. Stanbridge and P. C. Srivastava (26 October, p. 252) stressed the importance of quantitating haemoglobin A₂ for investigating the cause of unexplained anaemia among the immigrants in this country. They had picked up four cases of thalassaemia and thought that this trait would be highest in India and West Pakistan. Without sufficient statistical data, no one would accept this view. The writers did not emphasize the frequent occurrence of thalassaemia among people originating in the Mediterranean basin who might as well be the immigrant in this country and suffering from "unexplained anaemia."

The history, physical examination, and blood film appearance are usually sufficient to suggest the diagnosis of anaemia. We do not jump on to serum iron estimation and bone marrow study. Marked hypochromia is present in iron-deficiency anaemia as well as in thalassaemia major.¹ In thalassaemia the serum iron is normal or raised but not lowered.¹ The low serum iron and stainable iron in the marrow suggest iron-deficiency anaemia, but this diagnosis is not complete without demonstrating the source of blood loss from the body. I wonder whether those immigrant patients had full investigation before iron therapy was started.

The writers commented that the incidence of β -thalassaemia would seem to be highest