

more detailed aspects of this matter, such as the financial benefit of a screening system to an employing authority. However, my main purpose is to draw attention to what I consider is a serious error in the thinking of the working party on collaboration and the Department of Health and Social Security which should be rectified.—I am, etc.,

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SIR,—The work environment and the assessment and control of general and specific hazards; the identification of people at risk because of their work disability and their ongoing supervision as they live and work; the critical scrutiny of sickness absence, identifying causative factors and advising both patients and others concerned with their work; helping the patient recovering from illness as he resumes work; the rehabilitation and retraining and work adaptation of the patient partially disabled by his illness—these are some of the down-to-earth problems which doctors and their patients face. Are we tackling such problems in the way we could?

General practitioners are often too busy to take this part of their patients' lives seriously, and are often ill-trained and too remote from working conditions to play an effective role. Industrial medical officers, where they exist, often lack sufficient knowledge of the employees committed to their care, being isolated from their general social and medical background, and have difficulty in liaising with N.H.S. colleagues. The Department of Employment's recent offspring, the Employment Medical Advisory Service, offers an opportunity to improve the industrial environment and develop its rehabilitation service further. But can it create a role for itself whereby doctors working within it are seen to be an integral part of industry, making a contribution to the vast problem of absence attributable to sickness, encouraging, educating, and advising on a continuing basis and thereby maintaining and improving the standards of safety with regard to occupational hazards? Furthermore, can any of these services play a part in not only preventing occupational disease and helping people to live with their diseases but in creating good working conditions?

When are we going to learn to shape up to the task of caring for our patients wherever they happen to be, with no prohibited or inhibited areas? This is what the real doctor wants to do as his part in a concerted integrated effort. I fear that recent reports and services being implemented are still nibbling at the problems. The nibbles are getting bigger, perhaps, but the orientation to each remains the same.—I am, etc.,

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Aetiology of Varicosity

SIR,—Mr. R. S. Lawson (9 September, p. 645) asked some specific questions which I will attempt to answer.

(1) "Has it been established that haemorrhoids and varicose veins occur together more often than the chance co-incidence of these two common conditions would provide for?"

I have been unable to find any evidence that the possibility of such a relationship has ever been investigated. I hope this will be done. Latta and Wilkinson (personal communication, 1971), recognizing a similar epidemiological association between varicose veins and diverticular disease, have recently investigated the association of these two diseases in individual patients and have shown a strongly positive relationship. Patients with diverticular disease appear to have approximately twice the frequency of varicose veins as do age- and sex-matched controls.

(2) "Can this theory explain why varicose veins are so much commoner in women?"

In the western world constipation, diverticular disease, and cancer of the colon are all commoner in women. If varicose veins were related to intestinal stasis this sex difference would be expected. In some developing countries where men adopt a western-type diet before women there is evidence that varicose veins, though rare, are commoner in men. With regard to aggravation in pregnancy, this can be only a supplementary factor since there is certainly no geographical relationship between the prevalence of pregnancy and that of varicose veins.

(3) "Can this account for the often quite irregular (and sometimes bizarre) distribution of varicose veins? It is not at all uncommon for them to be quite marked on one lower limb and not (or scarcely) in evidence at all on the other."

When two or more organs or structures are subjected to a common injurious environment they are seldom equally affected. Examples that can be cited are atherosclerotic gangrene of one limb, cancer of one lung, or tuberculosis of one kidney.

Mr. Lawson's suggestion that "hereditary influence is the most important of perhaps several factors responsible for varicose veins" is inconsistent with the situation in Africa and India, where the prevalence appears to be related not to ethnic background but to the extent to which western customs have been adopted. Only last month I was in Johannesburg, the largest city in sub-Saharan Africa, where the prevalence of varicose veins is steadily rising, and was later with a nomadic tribe in northern Kenya where the sole doctor for a population of over 200,000 cannot recall seeing more than three patients with varicose veins in 14 years.

If, as suggested by Mr. Lawson, angiomas are "second cousins" to varicose veins they might be expected to have a similar geographical distribution, whereas I am not aware of their being any less common in Africans than in Europeans. "To accept varicose veins as due to constipation" may seem "almost too credulous to Mr. Lawson," but I have still to find any alternative hypothesis which is consistent with indisputable epidemiological evidence.—I am, etc.,

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Acrylic Cement and Fat Embolism

SIR,—We believe that Professor J. Hume Adams and others (23 September, p. 740) have been hasty to implicate acrylic cement in the "genesis of permanent brain damage."

In a series of more than 70 arthroplasties of the hip using acrylic cement hypotension has always been transient.¹ This has been associated with a rise in the level of monomethylmethacrylate in the blood. Monomer rapidly disappears from the blood and its half life in vivo is only two minutes.

We presume that the total knee replacement in Mr. T. G. Sprunt's patient was performed under a tourniquet. In our experience of this operation hypotension never occurs at the time of insertion of the prosthesis. However, as in any such procedure the blood pressure falls when the tourniquet is released. Our patients have suffered no ill-effects from the transient hypotension. We believe that it is unjustifiable on present evidence to implicate acrylic cement per se as the cause of prolonged hypotension in Mr. Sprunt's patient.—We are, etc.,

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¹ Phillips, H., Cole, P. V., and Lettin, A. W. F., *British Medical Journal*, 1971, 3, 460.

Confinement of Subnormal Offenders

SIR,—Over the past two years or so the word "normalization" has become more often heard in the discipline of mental sub-normality. As I understand it, it is meant to convey to the uninitiated that the patient's life should be made as comfortable as possible and as pleasant as possible, comparable to that in a good home. I am in favour of this trend, which I am sure is all for the better, and have recently on two occasions tried to advocate it. I am asked to see people (with a view to admitting them to my hospital) who have committed serious offences such as indecent assault, attempted rape, and grievous bodily harm—to mention but a few. Several that I have seen have been able to converse rationally with me as well as being able to understand that they have committed a serious offence.

Others, who are in the minority, have been in fairly regular employment, but because they have succumbed to various temptations, resulting in some of the offences as described above and are subnormal within the meaning of the Mental Health Act of 1959 are the subject of requests to be admitted to hospitals such as mine. As the current trend is rapidly towards open hospitals with an abhorrence of closed wards I cannot see what justification there is for admitting patients such as these into open hospitals. If we are encouraged to normalize the lives of these people my view is that if they commit offences as described they should pay the penalty through the operation of the law. I must emphasize that I make this statement with full regard to the view that they are high grade subnormals, in some instances with I.Q.'s of between 75% and 85%, and that in this context it seems to me that the question of their being subnormal is irrelevant.

I have discussed this matter with the psychologist and other senior medical staff at this hospital and we feel that with few exceptions, we are unable to effect a "cure" for such cases. Further, they will usually be admitted under Section 60 or 65 of the