the same is true too of spontaneous abortion rates, and the supposition is borne out by the only authoritative study known to me on this topic.³ So the disparity (suggested above) in the data of Dr. Roberts and Mrs. Lloyd exists *in spite of*, not *because of* social class differences between the areas. (2) Dr. Roberts and Mrs. Lloyd show that if there is a deficit in reporting of abortions in area A it seems not to be dependent on social class. However, (a) their technique of controlling for social class is very coarse (they use only two social class categories, manual and non-manual) and as such could not be expected to eliminate class differences within the categories, and (b) this suspected reporting deficit may be dependent on factors other than social class.

Dr. Roberts and Mrs. Lloyd are committed to rejecting the alternative of this reporting deficit; they seem, therefore, to be saddled with the difficulty of explaining why non-A.S.B. spontaneous abortions (like A.S.B. spontaneous abortions) are less common in area A than area B. However, it is perhaps not appropriate to devote too much a priori argument to their hypothesis. After all, it is testable. I suggest that samples of spontaneously aborted fetuses in the two areas be examined. If the hypothesis is correct, there should be a higher proportion of A.S.B. fetuses in the low-risk area.—I am, etc.,

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- 1 Chase, H. C., *International Comparison of Perinatal and Infant Mortality: the U.S. and Six West European Countries*. Public Health Service, National Center for Health Statistics, Publication No. 1000, Series 3, No. 6. Government Printing Office, Washington, D.C., 1967.
- 2 Spicer, C. C., and Lipworth, L., *Regional and Social Factors in Infant Mortality*. General Register Office Studies on Medical and Population Subjects No. 19. London, H.M.S.O., 1966.
- 3 Taylor, W. F., in *Proceedings of the Third International Conference on Congenital Malformations*, ed. F. C. Fraser, V. A. McKusick, and R. Robinson. New York, Excerpta Medica Foundation.

Oxygen Therapy

SIR,—In their article entitled "Oxygen Therapy in Chronic Respiratory Failure" (20 October, p. 154) Dr. R. Hume and others state that the M.C. mask "normally delivers about 60% oxygen." This bald statement, while ostensibly being covered by the words "normally" and "about," may give a false impression of accuracy to an uncritical reader who may subsequently have occasion to use the mask. The figure of 60% will then spring to mind unaccompanied by any conditions or reservations.

Devices of this kind have such a highly variable performance that it is important when referring to them to leave no doubt about the accuracy and variability of the resulting inspired oxygen concentration and the conditions affecting it. The only conditions which are easy to define are the flow rate of oxygen and the respiratory frequency. Unfortunately, these are usually less important than the tidal volume, the inspiratory flow rate, and the shape of the patient's face in relation to the mask. Moreover, because of the small volume of the mask there is, during the course of one breath, a highly variable inspired oxygen concentration. The mean PaO_2 thus produced is not

necessarily the same as would be produced by the inhalation of a constant mixture of the same concentration as the so-called "mean" from the M.C. mask.

These masks are not suitable for the administration of accurate concentrations of oxygen and it is submitted that in the context of this article it would have been better to talk only in terms of the PaO_2 that the device produced in a particular patient at a particular time than to quote unreliable figures for inspired oxygen concentrations.—I am, etc.,

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Treatment of Depression in General Practice

SIR,—The results and comments of Dr. D. A. W. Johnson in his paper on the treatment of depression in general practice (7 April, p. 18) seemed so different from our own experience that we were prompted to extract some figures of our own depressed patients.

Part of our practice is urban and based on Woodside Health Centre, Glasgow. We extracted information retrospectively from all patients diagnosed as depressed in our Woodside practice (3,400 patients) attending over a four-month period. This was easy to do as we use a system of morbidity and workload recording based on feature cards. The relevant results are as follows:

	Our results	Dr. Johnson's results
Total numbers	66	73
Years on list		
0-5	20%	50%
6-10	17%	25%
10+	62%	25%
Known to health visitor or social agency	20%	0%
Average times each patient seen in 18 weeks after presentation	4.7	2.3
Average times each patient consulted doctor in two years before diagnosis	16	not known

Our figures thus differ significantly from Dr. Johnson's. With the average depressed patient having been on our list for 17 years and having consulted us 16 times in the past two years we can fairly be said to be likely to have a knowledge of the patient and his background. We do not claim that our practice is a typical one, but neither had Dr. Johnson any reason to claim that the practices he selected were typical. Further, the depressed patients he selected were only those who had had no symptoms or psychotropic medication for the year before the present attack.

From a small group of selected patients studied under abnormal circumstances from selected practices, all apparently in one city in Britain, Dr. Johnson draws conclusions about all depressed patients managed in any city in Britain. This is an unjustified extension of his findings. Our own findings show that they are certainly not universally applicable.—We are, etc.,

KENNETH HARDEN
W. THORBURN
R. T. W. PRENTICE
DIANA KIERNAN

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Scotland's Drink Problem

SIR,—Licensing laws are said by both the Erroll Committee in England¹ and the Clayton Committee in Scotland,² referred to in your leading article (13 October, p. 64) to play a minor part only in the control of alcohol misuse. Both rightly stress the great importance of education and research—though one wonders why such research into the gaps of knowledge should not be undertaken before any of the proposed changes in legislation. At any rate, it has certainly *not* been proved that restrictive legislation—for example, the limitation of opening hours—is of no avail. In fact, the change in England from a situation of widespread drunkenness to relative sobriety took place fairly suddenly during the 1914-18 war³—in the views of many observers mainly as a consequence of the recommendations of the Liquor Control Board.^{4,5} In the view of G. B. Wilson³ the remarkable improvement was brought about by direct restrictions on the supply of liquor, by the administrative restriction on hours of sale, by dilution of beers and spirits, etc.; and he felt that "particularly since 1913 . . . later hours of opening, the midday break, and earlier closing hours have been very important factors . . . in checking a rise in the aggregate consumption . . . and possibly in checking individual consumption."⁵ Similarly, Shadwell felt that among state control measures "shorter hours and higher taxation . . . have proved really efficacious."⁶ Most of the recent work in this field has been carried out by the Addiction Research Foundation in Ontario; they regard the price of alcohol in relation to disposable income as the most important factor in influencing alcohol consumption, and they feel that the area of control of days and hours of sale deserves further research.⁷

Clearly, as Erroll points out, other factors (for example, counterattractions, increasing affluence, etc.) contributed to the decrease of the drink problem in the first half of the twentieth century.³ Such factors, however, also affected other nations, none of which (as far as I am aware) showed the remarkable sudden drop in drunkenness. Rather than for this country to follow the "civilized" drinking of Continental countries one wonders whether it might not be a better idea for such countries—most of them with far larger alcohol problems (as yet?) than Britain—to study the conditions and methods used in this country. It is well known, for example, how far the alcoholism problem in France with all its "civilized" drinking habits outstrips the British problem.

To what extent the changes recommended by Erroll and Clayton will increase alcohol consumption or otherwise is of course not known. They certainly will increase availability, and health-related alcohol and drug problems may stem not only from individual ("host") susceptibility but also from availability of the "agent" (alcohol or other drugs).⁸ Recent research in Ontario has confirmed earlier findings⁹ of a relationship between a nation's per capita alcohol consumption and the prevalence of alcohol-related damage and complications.^{8,10} In his recent talk to the 1973 conference of the Medical Council on Alcoholism, De Lint¹⁰ pointed to the evidence that the current world-wide trends in excessive alcohol use and alcohol-related mortality followed a growing acceptance of alcohol use in every-

day social life, the declining cost of alcohol relative to disposable income levels, a lack of public awareness of health consequences, and the liberalization of alcohol control policy on the part of many governments. The Erroll and Clayson Committees seem likewise to have ignored the possible public health consequences of their recommendations. By trying to keep in step with, and follow, current social trends of increasing alcohol use in England and Scotland alike, the Erroll and Clayson recommendations, if accepted by Government, may easily strengthen even further and accelerate the social acceptance of heavier alcohol use, and with it, in line with the Ontario research workers' conclusions, the risks of increased alcohol-related physical and social damage.—I am, etc.,

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- 2 *Report of the Departmental Committee on Scottish Licensing Law*. Edinburgh, H.M.S.O., 1973.
- 3 Glatt, M. M., *British Journal of Addiction*, 1958, 55, 51.
- 4 D'Abernon, Viscount, Preface to Vernon, H. M., *The Alcohol Problem*. London, Baillière Tindall and Cox, 1928.
- 5 Wilson, G. B., *Alcohol and the Nation*. London, Nicholson and Watson, 1940.
- 6 Shadwell, A., *Drink in 1914-1922: A Lesson in Control*. London, Longmans Green, 1923.
- 7 *International Symposium on Alcohol and Alcoholism*, ed. R. Popham. Toronto, Addiction Research Foundation, 1973.
- 8 Archibald, H. D., in *29th International Congress on Alcoholism and Drug Dependence*, ed. L. G. Kiloh and D. S. Bell. Chatsworth, N.S.W., Butterworths, 1971.
- 9 Ledermann, S., in *27th International Congress on Alcohol and Alcoholism*. Lausanne, International Council on Alcohol and Alcoholism, 1965.
- 10 De Lint, *The Epidemiology of Alcoholism*. First International Medical Conference on Alcoholism. London, 1973.

Tylosis, Leukoplakia, and Oesophageal Carcinoma

SIR,—The association between tylosis (palmo-plantar keratoderma) and oesophageal carcinoma in two Liverpool families has been well documented.¹ The opportunity has recently arisen to examine the mouths of 16 affected members of these two families ranging in age from 4 to 50 years, eight being male, eight female. Of these 16 patients, 15 exhibited abnormalities of the oral mucosa recorded as either preleukoplakia or leukoplakia. Of the group of seven patients between the ages of 4 and 15 years, all were found to have diffuse preleukoplakia of the buccal mucosa, the condition being most marked in the older patients of the age group. In the older group of eight patients (age range 26-50 years) this condition of diffuse preleukoplakia was seen to be present in all cases though less markedly than in the young patients. Seven of this group of patients also exhibited lesions classified as leukoplakia, 16 lesions being present in the seven patients. One of these patients (male aged 50) has developed an oesophageal carcinoma during the course of the investigations. A group of four non-tylotic siblings of members of the affected group (age range 7-17 years) showed no similar abnormalities of the oral mucosa, nor did a group of four unrelated patients.

Biopsy material has been obtained from the buccal mucosa of seven affected patients, including four areas of preleukoplakia and

four of leukoplakia. The histology of the leukoplakias was found to be of benign keratosis in each case, with no distinctive cytological changes. The areas of preleukoplakia were found to show changes similar to those seen in developmental epithelial disorders of the oral mucosa.²

The incidence of preleukoplakia and leukoplakia in the general adult population is low, being of the order of 8% in heavy tobacco users and less than 1% in non-tobacco users.³ The presence of lesions of this kind in children is virtually unreported, being described only in the case of the hereditary epithelial disorders, and no general association has been shown to exist between tylosis and abnormalities of the oral mucosa.¹ It is therefore concluded that the chance occurrence of the present lesions in 15 out of 16 patients is highly unlikely and that a real association probably exists between the oral lesions, the skin lesions, and, by implication, the tendency to oesophageal carcinoma.—We are, etc.,

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- 1 Howel-Evans, W., McConnell, R. B., Clarke, C. A., and Sheppard, P. M., *Quarterly Journal of Medicine*, 1958, 27, 413.
- 2 Pindborg, J. J., in *Textbook of Dermatology*, ed. A. Rook, D. S. Wilkinson, and F. J. G. Ebling, 2nd edn., p. 1674. Oxford and Edinburgh, Blackwell, 1972.
- 3 Tyldesley, W. R., *British Journal of Oral Surgery*, 1971, 9, 21.
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Statue Syndrome

SIR,—I am collecting some clinical material about the relatively rare "statue syndrome" and I am writing to ask if any of your readers would care to share the essential details of any cases with which they have come into contact. All letters will be acknowledged and the anonymity of the patients will be preserved.—I am, etc.,

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M.P. Pressure

SIR,—Prompted by various comments in the national press recently regarding "queue jumping" in the National Health Service, I am writing to ask if any of your readers may have had experience of a ploy of the following kind.

The complainant writes to the consultant surgeon on whose waiting list he has just been placed, threatening that if he is not promptly admitted he will write to his M.P. When it is pointed out to him that there are other more deserving cases waiting for a long time, he carries out his threat. The politician, ever anxious to please, writes to the hospital secretary expressing his great concern about the matter. This letter usually arrives on impressive House of Commons

note-paper. The arrival of this letter, needless to say, causes quite a flurry in the administrative dovecotes and the upshot is that the letter ends up on the consultant's table (if he has a table!) with a request for action. His only answer is the answer he has already given in the first place.

I do not know what happens after that, but I presume the consultant's answer is forwarded to the politician who then writes to the complainant expressing his deep regret that such a state of affairs exists. I would be very surprised if he wrote to the complainant admitting that the responsibility for the state of affairs was his rather than that of the surgeon to whom the complaint was made in the first instance.—I am, etc.,

D. F. THOMAS

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Senior Hospital Staff

SIR,—So it seems that at last Mr. Heath is to investigate and legislate upon the "unacceptable face of capitalism." It would be equally appropriate if his Minister for Social Security were to investigate the unacceptable face of the Government's role in the welfare of its employees. For too long have the consultants in the Health Service been completely fettered with regard to their salaries and conditions of service, lip service only being paid by the Review Body in its recommendations, working within the confines of a dictated policy. It should have been seen that firm recommendations were made as to what should be awarded regardless of the financial climate. It is my personal fear that unless some drastic action is taken to restore faith, then whatever is left of morale and goodwill is going to evaporate completely.

Our general practitioner colleagues were farsighted enough to sense the dangers inherent in the merit award, and equally the junior hospital staff have been sufficiently adroit in using the media to advance their cause, unflinchingly supported by the Department of Health and Social Security with their endless and earnest exhortations to regional boards and boards of governors to make available more free time. To these various medical colleagues I raise my somewhat battered and well-worn hat (unable to find anything more suitable with which to recognize these achievements). A letter in the October issue of the *British Journal of Hospital Medicine* reflects an unusual and heartening interest in the affairs of senior hospital staff by members of a junior staff group.

At the present time I suspect that the great majority of consultants do not receive merit awards. Many are likely to receive only "C" awards, the value of which today is derisory. I will not bore you with the well-worn phrases of severe overwork and ludicrous pay for endless hours of service duty, on call, teaching, and other too numerous non-medical commitments which the consultant is expected to fulfil, but I am very sure that, if the present system continues, then the Government must realize that sooner or later it will break the camel's back—or its patience.—I am, etc.,

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