Probably the most important single contribution of monitoring to the care of the fetus in labour is the earlier detection of asphyxia. Abnormal patterns of the fetal heart rate may precede acidosis by some hours, which in turn occasionally precedes abnormalities of the auscultated fetal heart rate. Thus monitoring, apart from allowing more babies to be saved, should result in the delivery of fewer asphyxiated babies in poor condition. Information on this point is so far lacking.

Whether fetal monitoring is worthwhile must depend on whether the systems become generally applicable to most busy obstetric units. Additional expense can be justified by the importance to the community of ensuring that babies achieve their maximal intellectual potential in later years. But the practical problems of introducing monitoring are considerable, and among other things the need for medical staff to play a fuller part in the labour ward must be recognized. If the diagnosis of fetal asphyxia is to become dependent on the use of monitoring techniques now available, a doctor with no other responsibilities than for the patients in labour must be always available on the labour ward. Unquestionably the skill needed to interpret continuous records of fetal heart rate and fetal pH is greater than was previously required to diagnose fetal asphyxia, and for this reason the introduction of monitoring techniques into clinical practice must be gradual. It seems certain that new methods for monitoring the fetus in labour will eventually supersede the fetal stethoscope, but the form they take will depend on the experience gained with the techniques over the next few years by obstetric departments throughout the country.

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The members of the Cancer Co-ordinating Committee are distinguished clinicians and research workers, as are the team which went out to the Ringberg-Klinik. They deserve to be congratulated on so faithfully completing a somewhat thankless task. But its cost to the nation is considerably more than the price of some air tickets, hotel rooms, and restaurant meals. To carry out their study these exceedingly busy people have had to interrupt their work in the laboratory and at the bedside for some weeks, and, though it may be an exaggeration to say, as has been said in passing, that cancer research in Britain came to a halt for three months, the effects of a diversion of this kind go much further than is generally realized. Popular clamour for a will-o'-the-wisp has occupied the time of people who are much more likely to bring benefit to sufferers from cancer if left to get on with their work.

In a microcosm this whole unhappy episode exemplifies how not to influence research. The relationship between research workers and the community they serve is at present being questioned among the research workers themselves as closely as it has been for some time in Government circles. The results of any important investigation are often unpredictable, so that a high degree of trust is needed between the people doing the work and the people who in the end foot the bill. There will always be pressure from the general public to investigate this or that project, and the mass media have an obligation to treat what must be uninforming enthusiasm with responsibility. Research workers, with their expert knowledge of the possibilities, already find it hard enough to discover the right course between responding to the obvious needs of the community and keeping strictly to an investigation whose results may prove abstruse and of little immediate practical use. Pressure of the kind to which the Cancer Co-ordinating Committee felt obliged to respond can severely harm the interests of the people applying it.

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**Rheumatoid Neuropathy**

Peripheral neuropathy in patients with rheumatoid arthritis has been recognized with increasing frequency since it was described by F. D. Hart and his colleagues in 1957. The neuropathy may take one of several forms. Firstly, compression, particularly of the median nerve at the wrist or of the ulnar nerve at the elbow, is common with gross joint disease. The second main form of this disorder is a mild distal neuropathy, entirely or predominantly sensory; and the third is a severe, fulminating sensory-motor disorder. Minor degrees of neuropathy may be difficult to diagnose in patients with joint disease, since pain, stiffness, and disuse atrophy may easily be confused with symptoms of the neuropathy and the muscle wasting produced by it. Nevertheless, when neuropathy develops patients are often aware that their symptoms have changed in character, while the doctor may find objective evidence of sensory loss. Another feature is that, though rheumatoid arthritis is much commoner in women, rheumatoid neuropathy is at least as common in men.

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**Cost of a Report**

The report to the Cancer Co-ordinating Committee on the results obtained at Dr. Joseph Issels’s Ringberg-Klinik in Bavaria is as critical as informed observers had all along supposed it must be. In fact the Committee has clearly chosen its words with great care, and some of the delay in publication despite Government pressure and public impatience must be attributed to the committee’s effort to prepare a report at once thorough and judicious. It is in several respects a contrast to the paper published by Issels himself last December. The report to the Cancer Co-ordinating Committee on the results obtained at Dr. Joseph Issels’s Ringberg-Klinik in Bavaria is as critical as informed observers had all along supposed it must be. In fact the Committee has clearly chosen its words with great care, and some of the delay in publication despite Government pressure and public impatience must be attributed to the committee’s effort to prepare a report at once thorough and judicious. It is in several respects a contrast to the paper published by Issels himself last December.
that patients with mild neuropathy sometimes had evidence of more widespread nerve disease than would have been expected from clinical assessment alone. Motor conduction velocity was grossly reduced in some instances and fell within the range usually associated with histological changes of segmental demyelination. In fact examination of sural nerve biopsies from five of the same 32 patients showed such changes; axonal degeneration was, however, more prominent than segmental demyelination in most nerves, particularly in the severe group. In general, the clinical severity correlated well with the degree of histological abnormality.

The mild, distal form of neuropathy is relatively benign and tends to improve, though complete recovery is rare. The severe sensory-motor disorder behaves quite differently. It is usually abrupt in onset and progressive, and its distribution is that of mononeuritis multiplex. Many patients have died within a year of the onset of this kind of neuropathy.1 4 They have clinical and pathological evidence of widespread vasculitis, the most dangerous being of mesenteric and coronary arteries. Similar lesions have been found in the vasa nervorum, and the ischaemia secondary to these is the most likely cause of the neuropathy.5 7 Vascular changes in the vasa nervorum have also been described in patients with mild distal neuropathy, and Weller and his colleagues3 think that they probably play an important part in the aetiology. However, in this situation the role of ischaemia is less certain.

Finally, it has been suggested that steroid therapy may be one cause of rheumatoid neuropathy. Though the disorder seems to have become commoner since steroids have become available, this increase may be only apparent owing to greater awareness of the condition. Neuraphy has developed in some patients after beginning treatment with steroids or following a change in dosage, but there is no clear evidence that this is other than coincidence, and most reported series have included patients who have never received steroids. These drugs can certainly cause myopathy, but have not been implicated as a cause of neuropathy outside rheumatoid arthritis.

The treatment of rheumatoid neuropathy is unsatisfactory. Fortunately it is unnecessary for mild neuropathy, which usually tends to improve spontaneously; there is no known effective treatment for the severe form, and no evidence that steroids are helpful for either type.

Bladder Cancer and Occupation

Certain occupations are associated with an increased risk of cancer of the urinary bladder, and others are suspected of having a similar association.1 4 But only a minority of persons who develop the disease have an obviously relevant occupational history. Smoking may increase the risk of bladder cancer, though by how much is not known.1 In an attempt to fill gaps in our knowledge of the aetiology of bladder cancer Honor Anthony and Greta Thomas8 studied the whole-life occupational histories of 812 men and 218 women who attended the urological departments of the Leeds General Infirmary and St. James’s Hospital, Leeds, between 1959 and 1967 with a diagnosis of carcinoma or papilloma of the bladder.

The occupational pattern in the Leeds area has been relatively stable since 1931, and virtually all patients with bladder tumours attended one or other of the two hospitals. One interviewer obtained all except 50 of the occupational histories analysed, and the diagnosis was confirmed histologically in 99% of cases of “carcinoma” but in only 80% of cases of “papilloma.” Unfortunately, information about smoking habits was obtained from only 383 of the male and 57 of the female patients. Moreover the matched controls were patients who were interviewed an average of five years before the bladder cancer patients, and the interviewer was aware of each patient’s diagnosis at the time of interview. The survey showed no clear association between cigarette smoking and the occurrence of bladder tumours, though the disease was found to progress more rapidly to a fatal outcome in smokers than in non-smokers.8

The survey confirmed the risk of bladder cancer to dye workers,3  and disclosed risks to medical workers, particularly nurses, to tailors, tailors’ pressers, and to some groups of engineers and textile workers. In addition a possible risk to hairdressers and tailors’ cutters was indicated. In the cases of dye workers, tailors’ cutters, and hairdressers, but not of other suspect occupations, tumours of the bladder occurred at younger ages than in controls.

An interesting observation was that more patients with bladder tumour than controls had had only one occupation (apart from war service) during their lives. This is consistent with the disease being due to prolonged exposure to factors in their working environment. Partly on the basis of this observation Anthony and Thomas calculate that over 20% of the bladder cancers in men in their survey could have been occupational in origin.

The discovery that a particular occupation carries an increased risk of a particular form of cancer is only the first stage in the identification of the hazardous chemical or chemicals responsible. It is interesting that this latest survey, while confirming the presence of a potent hazard in the chemical dye industry, failed to indicate a hazard to dye users. Textile dyers and leather dyers showed no excess of the disease, and the mean age at diagnosis of bladder cancer in patients engaged in these trades was not low. The increased risk among medical workers, including medical laboratory technicians and nurses, may have resulted from the use in former times of benzidine in tests for occult blood in urine and faeces.1 3 8

An increased risk of bladder cancer has been shown by previous surveys in the case of textile workers,4  engineering workers,4 5 and hairdressers,4 5 but the identities of the chemicals responsible are obscure, and it is not known whether workers are still exposed to them. A possible clue from the latest study is that hand-tailoring appears to be—or to have been—more hazardous than machine-sewing. Certainly many challenging problems remain for those whose aim it is to banish this unpleasant disease by preventive measures.