in one or more skeletal muscles, I asserted that multiple abscesses were a classical feature of the disease. A classical presentation is not necessarily the most commonly encountered but is one in which the diagnosis is most likely to be correct and generally acceptable. —I am, etc.,

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Malignant Carcinoid Tumour with Gangrene of the Small Intestine

SIR,—Dr. I. M. Murray-Lyon and others (29 December, p. 770) report four cases of malignant carcinoid tumour with gangrene of the small intestine and discuss the cause of the ischaemic change. Vascular change with secondary mesenteric ischaemia was a feature of all the cases. In our case, as in theirs, no way was found of locating the tumour by angiography or any other method. The syndrome as "at risk" for mesenteric thrombosis. The situation has recently been corrected. In 1973 the National Radiological Protection Board circulated all members of the British Dental Association with details of its monitoring and survey scheme for dental x-ray units. This was supported by articles in the dental press on all aspects of radiation protection, radiography, and radiology in dentistry. I would submit that this has led to an increased awareness throughout the dental profession of the need for routine dental x-ray equipment checks and also for all operators to make sure that their standards of both safety and efficiency are constantly under critical review in the interests of patient, staff, and operator.—I am, etc.,

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False Interpretation of Fetal Heart Monitoring

SIR,—Recent observations (29 September, p. 694; 17 November, p. 420; 5 January, p. 39) on the false interpretation of fetal heart rate patterns prompt us to suggest that all facilities to permit display of the E.C.G. after initial amplification but prior to the application of any automatic gain control.

Many fetal heart monitors are equipped with such a signal output facility, but it is doubtful if it is widely used. Perhaps this failure of use could be attributed to a false sense of economy in the purchase of additional display equipment. The oscilloscopes which we use for this purpose cost less than £100 and have been invaluable in detecting poorly applied electrodes, failure of leads, and other artefacts which may lead to false interpretation of the fetal heart rate. We should like to encourage others to make use of these simple display devices.—We are, etc.,

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Correction of Plasma Calcium Measurements

SIR,—Readers may have been surprised to find consecutive papers by Dr. E. M. Berry and others (15 December, p. 640) and by ourselves (p. 643) which recommended that plasma (or serum) calcium be corrected or adjusted by reference to plasma albumin concentration, but which advocated different equations.

Applications of the adjustment of Dr. Berry and his colleagues to the calcium values of the 200 specimens received for liver function tests which we examined gave a calcium distribution, with 95% limits, of 9.5-10.9 mg/100 ml. After applying our adjustment the 95% limits were 9.0-10.4 mg/100 ml, identical with the limits of our normal range.

Is there a reason for the discrepancy? Dr. Berry and his colleagues did not quote their normal range for plasma albumin, but they stated that the mean was 5.0 g/100 ml, and inspection of their fig. 3 shows albumin values in 25 healthy persons before venous occlusion maintained between 5.6 and 6.0 g/100 ml. The normal range for this laboratory, though not taking account of small differences related to sex and age, is considerably lower, with 95% limits of 3.7-4.7 g/100 ml. Our performance over the past six months in the Wessex Health Authority Control Programme shows that the means of our assay values for albumin and calcium were not significantly different from the overall means of more than 300 participating laboratories. We therefore believe that our correction—adjusted calcium = albumin + 4.0 (where calcium is in mg/100 ml and albumin in g/100 ml) or adjusted calcium = calcium - 0.25 albumin + 1.0 (where calcium is in mmol/L and albumin in g/L)—can be applied to data from the majority of laboratories in this country.—We are, etc.,

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Chemotherapy of Disseminated Malignant Tumours

SIR,—We were interested in the letter from Dr. D. A. Cook (12 January, p. 77) in which references were made to our article on the multiple drug therapy of disseminated malignant tumours.1 Our paper was based on preliminary experience with a new multiple drug schedule for metastatic solid tumours, and the study was initiated in 1969.

We noted that the median survival for solid tumours was very much less used than at present, and there was widespread belief that such treatments could be carried out only with unacceptable levels of toxicity to normal tissues. The whole point of our paper was to show that such toxicity could be markedly reduced by the application of new concepts of the cellular basis of cancer chemotherapy. We are pleased to note that Dr. Cook has confirmed this aspect of our study.

With regard to the efficacy of the schedule against specific types of tumour, we were careful to avoid any dogmatic assertions as we did not have sufficient numbers of any type of tumour to constitute a statistically valid sample. We did infer that further studies of breast and bladder carcinomas might be warranted, but Dr. Cook's statement about optimistic results in lung cancer are his words and interpretation of the results, not ours. The response of any small number of lung cancer cases will be biased among other things by the proportion of the oat-cell type of disease. Therefore no conclusion regarding efficacy can be drawn from five cases and, in our paper, none was.

Our initial response rate in bronchogenic carcinoma (3/5) has not been sustained in