occurred deep into the dermis, a block dissection is often performed—though it has been found that the prognosis is not greatly improved.4 Some believe that all metastases should be tackled vigorously, but both primary and secondary tumours may disappear spontaneously,12 a feature that may explain the occasional remarkable results of radical surgery in apparently hopeless cases. Moreover, survival for five years is no guarantee of cure, for in this disease possibly more than in any other the metastases may appear after a long delay.

A better guide to prognosis in those receiving early and adequate treatment is probably the clinical appearance when first seen. Melanomas on the trunk, foot, and hand; those that have ulcerated; and those with palpable and histologically affected lymph nodes, all carry a poor prognosis.2 13 Women in general have a better prognosis than men because most of the lesions in the former are on the face and leg; those patients with a history of over a year2 3 and lesions less than 2 cm in diameter14 have a good prognosis. Pregnancy is now discounted as having an adverse effect on the prognosis.14 15

Most published reports about the prognosis of malignant melanoma have included malignant lentigo, which has a very good prognosis, so that the overall survival rate is improved according to the proportion of this type of melanoma in the individual series. Malignant lentigo appears in people over 50. In 70% of cases it is on the face, starting as a brown macule which spreads peripherally and irregularly and becomes mottled.14 The appearance of an indurated area, nodule, horn, or crust—which may take from 2 to 40 years16 17—suggests the development of a malignant melanoma. Hence the patient should be kept under observation, though extensive excision is probably unnecessary. The macule including the malignant melanoma should be excised, but the size and site of the lesion and the age of the patient often preclude the recommended wide excision.

The incidence of malignant melanoma is about three per 100,000 people per year,18 making it a relatively rare tumour. Nevertheless, a high degree of suspicion by all doctors should improve the prognosis even more, and possibly permit it to approach the figure of 100% survival at 5 years recently quoted4 for stage-I tumours.

Phenobarbitone and the Shoulder-Hand Syndrome

The total amount of phenobarbitone that has been consumed by anxious, sleepless, or epileptic patients must be formidable, and it would have seemed improbable that any undesirable side-effects of the drug remained to come to light. Yet an association between barbiturate treatment and the shoulder-hand syndrome has recently been suggested.1

The authors were struck by the spontaneous development of severe bilateral shoulder pain and diffuse swelling and atrophy of the soft tissues of the hands in three epileptic patients on phenobarbitone. This unusual finding prompted an analysis of 75 patients with the shoulder-hand syndrome attending the University Hospital in Leiden. It unexpectedly showed that 33 patients had received phenobarbitone before or during the development of this curious syndrome. In most of them the syndrome was bilateral. Duration of treatment had varied from a few weeks to more than 20 years and was longer in cases of bilateral than unilateral disease. The acute symptoms—burning pain and stiffness, oedema, and hyperhidrosis—lasted from three to nine months and were followed by atrophic changes in the hands with finger contractures. The authors state that continuation of phenobarbitone after the onset of the syndrome did not appear to alter the prognosis.

Arthralgia during barbiturate treatment was first described over forty years ago2 but is not commonly seen. Perhaps this recent clinical observation associating barbiturate medication with the shoulder-hand syndrome will provoke wider recognition of it.

Public Health Dispute

On 1 March the Minister of Health was asked to intervene in the dispute between the two sides of Whitley Committee C over the failure to review the pay of public health medical officers.1 He has refused to do so, and at an emergency meeting on 7 April the Public Health Committee asked the B.M.A. Council to take action to support it in this dispute. (See Supplement, p. 17.)

Public health medical officers form the third branch of the N.H.S. Their pay and terms of service are decided in the Medical Whitley Council Committee C, which was set up for this purpose. Ever since their exclusion from the terms of reference of the Royal Commission on Doctors' and Dentists' Remuneration ten years ago doctors in the public health service have asserted that they should be treated like other doctors in the N.H.S., and that their pay should be reviewed whenever the Review Body reports. Mr. Dennis Vosper, Minister of Health at the time of the Royal Commission, promised them as much—as we pointed out last month1—but Mr. Robinson denies this in a letter we print at p. 18 of the Supplement. Public health doctors are now the only sizable group of doctors in Britain who have had no review of pay since the Seventh Report of the Review Body in May 1966.

Doctors in all branches of medicine will wish to support their public health colleagues at this time, for two very good reasons. Firstly, if the profession as a whole fails to look after its minorities, these will always be in danger of being sacrificed to Government expediency. Secondly, unless all practising doctors are treated as such—and not just as employees of local authorities or industry—then good doctors will not be attracted into these fields.

Recruitment in public health is already difficult because of uncertainty about the future. The Royal Commission on Local Government is sitting; the reports of the Kilbrandon2 and Mallaby3 Committees and the published evidence to the Seebohm4 Committee all suggest that widespread changes are going to be made in local government services in the '70s. In the last two years doctors in the two major branches of the N.H.S. have demanded a fresh look at their conditions, and have got some reforms. Doctors in public health feel that they too need a new deal, with a realistic career structure and scope for the practice of modern preventive medicine.

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4. Ibid., Supplement, 1966, 1, 60.
5. Ibid., Supplement, 1967, 2, 10.