

your article, were treated by radium only, and there seems little doubt that the high uterine dose necessary for a radium menopause is more likely to lead to later malignancy than the lower dose given by external irradiation.

The indications for inducing a radiation menopause are few; for a radium menopause there are none.—I am, etc.,

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- 1 Doll, R., and Smith, P. G., *British Journal of Radiology*, 1968, 41, 362.
- 2 Dickson, R. J., *British Journal of Radiology*, 1969, 42, 582.
- 3 Bamford, D. S., and Wagman, H., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1972, 79, 82.

Nutrition and Sleep

SIR.—Further to the interesting leading article "Nutrition and Sleep" (20 May, p. 418) one may ask whether sleep is not the "natural" state and wakefulness merely a respite for the satisfaction of instinctual (and socially inculcated) drives. The hibernating animal is unlikely to chance upon dangerous predators. On this model the satisfaction of drives would lead to sleep and their continued frustration to insomnia. This would fit the observation that rats became totally insomniac if kept without food¹ and the soorific value of the male orgasm.²

It has been observed that electrical stimulation in the regions of the tegmentum, posterior hypothalamus, and septal nuclei provide an extraordinarily powerful reward.^{3,4} Quoting these observations in a broadcast talk on drug addiction, Professor W. D. M. Paton has suggested that all drives may emanate from a single area in the brain and that the powerful appeal of narcotics arises from the simultaneous satiation of all drives by its effect on this area. It is noteworthy in this connexion that narcotic addicts go "on the nod" after intravenous administration.

It may be relevant to point out that sedative drugs used for alleviating agitation and anxiety reduce activity⁵ and cause drowsiness. Could the restless anxious state be a manifestation of frustrated social drives?—I am, etc.,

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- 1 Jacobs, B. L., and McGinty, D. J., *Experimental Neurology*, 1971, 30, 212.
- 2 Boland, B. D., and Dewsbury, D. A., *Physiology and Behaviour*, 1971, 6, 145.
- 3 Olds, J., in *Electrical Stimulation of the Unmyelinated Brain*, Eds. E. R. Ramey and D. S. O'Doherty, New York, Hoeber, 1960.
- 4 Olds, J. J., *Comparative and Physiological Psychology*, 1956, 49, 281.
- 5 Wintern, A., and Schild, H. O., *Applied Pharmacology*, 10th edn., p. 287. London. Churchill, 1968.

Fibrinolytic Therapy and Deep Venous Thrombosis

SIR.—Venous ulceration is an intractable and unpleasant aspect of the post-phlebotic limb and its prevention is clearly an admirable aim. It has been implied^{1,2} that the stigmata of the post-phlebotic limb naturally follow upon an attack of deep venous thrombosis, and that they may best be prevented by using fibrinolytic therapy which has been

shown to promote the most rapid dissolution of the thrombus with the greatest likelihood of preservation of valve function.

Without denying modern concepts of the pathogenesis of the post-phlebotic limb or the logic of this approach to treatment we were nonetheless interested to find that of the 30 patients currently attending our venous ulcer clinic, only six gave a past history of deep venous thrombosis and of these, four were puerperal, one postoperative, and one spontaneous. Nine had a past history of trauma and in 15 there was no past history suggestive of deep venous thrombosis—despite putting the direct question in several different ways to each patient. Halliday's experience³ of 103 venous ulcer patients was similar to ours. Thus, in the experience of these two clinics there seems to be very little that could have been prevented by the use of fibrinolytic therapy.

We, therefore, feel that whatever the other merits of fibrinolytic therapy, without epidemiological evidence to support it it seems incautious to recommend its use on the grounds of prophylaxis against the severe late sequelae of deep venous thrombosis.—We are, etc.,

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- 1 Kakkar, V. U., Howe, C. T., Laws, J. W., and Flanc, C., *British Medical Journal*, 1969, 1, 810.
- 2 Negus, D., *Annals of the Royal College of Surgeons of England*, 1970, 47, 92.
- 3 Halliday, P., *British Journal of Surgery*, 1971, 58, 104.

Differences in Thyroid Cancer

SIR.—May I comment upon your leading article on thyroid cancer (13 May, p. 365). You state: "Recently a rather different thyroid cancer, the medullary carcinoma, has been described" and quote three references to papers by E. D. Williams and others in the *Journal of Clinical Pathology*, dated 1965 and 1966. Only the informed reader would appreciate that this lesion was first described by Hazard, Hawk, and Crile in 1959.¹

I have the greatest respect for Professor Williams's work in this and other fields, and this comment is in no way a criticism of him. Indeed, in his 1965 paper, to which you refer, he states clearly that medullary carcinoma was first described by Hazard and his co-workers. It is a pity, when reviewers, including the writer, so frequently remark upon the American tendency to ignore European work, not to see a leading European journal give credit where credit is due.—I am, etc.,

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- 1 Hazard, J. B., Hawk, W. A., and Crile, G., *Journal of Clinical Endocrinology*, 1959, 19, 152.

School Meals

SIR.—Professor A. E. Bender and others (13 May, p. 383) have shown that the protein and energy content of the school meals fell short of the standards set by the Department of Health and Social Security. A recent survey that we have carried out on the lunch-time eating habits of over 560 senior school children has shown that nearly all the alternatives are even worse.

We obtained information on the source, nutrient content, and cost of the midday meal of these children from a questionnaire and from analysis of foods. Forty-one per cent. of the subjects took the school meal, 31% bought food outside the school, 20% brought food from home, 4% lunched at home, and 4% ate nothing at all. Children who ate at home had a meal which compared favourably with the school meal. We were concerned, however, about those who ate no lunch, and our attention was particularly attracted to the large proportion who either bought food outside the school environment or brought snacks from home.

Energy, Protein, and Sugar Consumption (median and range)

Source of Food	Energy kcal	Protein g	Sugar g
School Meal	680 (400-1,120)	20 (8-39)	19 (13-66)
Lunch at Home	555 (260-1,160)	19 (10-47)	19 (0-130)
Bought Food	680 (90-2,980)	15 (2-76)	29 (0-157)
Brought from Home	440 (150-1,250)	11 (3-40)	12 (0-150)

In the last two categories the protein consumption was considerably lower than that available from a school meal, and our survey indicates that the adolescent school children who bought food were selecting the less nutritious snack foods composed largely of "empty calories." Professor Bender's survey pointed out that high sugar intakes are to be condemned, and ours clearly shows that it is very easy for children to develop poor eating habits and to have an excessive sugar intake through high carbohydrate snacks and beverages. An improvement in the school meal itself would, of course be justified, but from the nutritional point of view, it still offers the best value for money.—We are, etc.,

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Trapped Nerves

SIR.—Your leading article on "Trapped Nerves" (6 May, p. 307) draws attention to the features of this clinically important group of conditions. The success generally attendant on decompression of the median nerve in the carpal tunnel and ulnar nerve at the elbow, even though the features are not wholly explicable or unassociated with other lesions in the neck and upper limb, should lead clinicians to seek other sites of nerve entrapment in the limb as a cause of symptoms and signs difficult to explain on any other basis.

The resistant tennis elbow is a problem where, despite conventional methods that normally lead to success, no lasting relief is obtained. It is our view that these patients frequently suffer from an entrapment lesion of the radial nerve or its branches (normally the posterior interosseous) as a result of pressure from reactionary oedema arising from the lateral side of the elbow joint.

We have described elsewhere¹ the results of operations on 45 elbows in 43 patients with a follow-up ranging from six months to 15 years. In well over 80% there have been good or excellent results without recurrence. The posterior interosseous nerve