underground workers. The helmet will only protect the head from injury if it is worn correctly and is designed to prevent those injuries which are foreseen. It must always be regarded as a second line of defence; accident prevention must be the primary aim.

Mr. Jennett is in error when he states that V. S. Caviness's conclusions² were based solely on a study of first world war gunshot wounds. In the statement I quoted from reference was made to the work of W. F. Caveness,³ who investigated 356 young adult males who sustained head injuries in the Korean war campaign. Of these, 159 had non-missile head injuries. The report deals with the occurrence of epileptic attacks in the first 8 to 11 years following head injuries. W. F. Caveness stated, "While mode of injury is an important factor in the onset of fits, there is no significant difference between missile- and non-missile-injured men as regards the cessation of fits. A common clinical impression has been that the earlier the fits take place the less likely are they to persist. This has been held especially for those fits that occur within a few hours or days after injury. Conversely, it has been thought that those attacks that begin after one year seldom cease. In the current series neither is borne out."

Because Mr. Jennett's investigations⁴ were of civilian head injury cases, his views are of great importance to those assessing prognosis, and especially his statement, "Early epilepsy (within a week of injury) has a 75% chance of permanent remission, but epilepsy developing later (whether or not there has been early epilepsy) persisted in more than 80% of 200 patients followed up for more than two years after their first fit."

Knowledge that seizures may cease can be an important factor when resettling patients. Unfortunately, to many managers the word "fit" is synonymous with unemployability. The possibility that seizures can cease may prevail on them to find suitable work, especially if the injury was the result of a works accident. Reduction of status and earnings are a deterrent to a proud craftsman from accepting the usual only available employment—for example, labouring. Acceptance of this work is made more likely when management undertake to upgrade a patient to his old skills if seizures cease permanently.—I am, etc.,

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Regional Medical Officer,

Bristol. Central Electricity Generating Board.

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Recognizing Early Myxoedema

SIR,—The facial appearances of patients with well-marked myxoedema have long been familiar to clinicians, but the earliest manifestations of this are not easy to recognize.

Considering this problem recently, I realized that a personal method of assessment that I have long used might be of value to young general practitioners. (It is of no value to those seeing such patients for the first time.) It is, quite simply, the fact that on seeing such a patient my first thought has been: "Mrs. So-and-so is losing her looks."

This is most obvious in the 45–55 age group.

The woman whose face is getting plumper does not provide this thought, nor do the tragic sufferers from depression.—I am, etc.,

Leeds.

A. U. MACKINNON.

Investigating Hypertension

SIR,—My letter (29 July, p. 306) was intended primarily to offer critical comment on your leading article (1 July, p. 4) which I had found not particularly helpful or informative. In that article you chose to quote Chamberlain and Gleeson's paper,¹ and I offered certain criticisms of their paper to which they have now replied (19 August, p. 495). Although they state that they "would not wish to advocate diagnostic nihilism but merely recognition of the limitations and potential dangers of a particular diagnostic technique," their comments are apt to be taken up and used as evidence against the value of aortography—as in your leading article and in recent correspondence elsewhere.² In my view their paper had certain limitations which should be recognized.

I share their view that the outcome of surgical treatment of hypertension may be unpredictable or disappointing—but I repeat the comment that the value of aortography should not be judged on this alone. If the procedure adds to the diagnostic data and enables one to exclude certain disorders (for example, fibromuscular dysplasia) and assists in obtaining a likely explanation for the hypertension (for example, "essential hypertension" with renal arterial anomalies) then there has been a useful gain. Further, I believe that medical management may be influenced in a number of ways by the aortographic findings—if only in providing a once-in-a-lifetime survey of the renal and intra-abdominal vascular tree and relieving the physician of the misgiving that he may be overlooking some important disorder. I have seen the sad consequences of inadequate investigation too often to feel confident in advising my patients after incomplete assessment.

Drs. Chamberlain and Gleeson chose to quote only our first and smaller series³ in an implication that our series was somewhat unrepresentative (with a 9-to-1 male to female ratio, and two-thirds of the patients being Service personnel). The second paper which they mentioned⁴ but did not quote in this context studies almost three times as many patients (341 as against 121), and 1 in 4 of the patients was female. As a matter of fact over the eight years which our unit has been working the proportion of Service to civilian patients is almost exactly 50%.

Their own work presented an interesting analysis of a retrospective study on a relatively small number of aortograms. We were not told of the period of time from which these results were collected, nor from how many hypertensive patients their 107 cases were selected—nor indeed how they were selected. Presumably since their text states "records of all aortograms were available and through these a retrospective study . . . was possible," the figure of 107 represents all patients subjected to angiography for hypertension at the Westminster Hospital since angiography was first introduced. It would be unusual if there had not been many hundreds, if not thousands, of hypertensive patients attending for advice, investigation, and

treatment over this period—so my comment that their series was highly selected must stand.

Whether our own papers described a selected series of patients is not relevant to the discussion on angiography, though it might be to any discussion on hypertension. Any series is in fact initially selected by geographical, environmental, and other features—but we did describe the findings from a large number of unselected angiograms (since all patients under investigation for hypertension were angiographed) in a prospective study. This seems to me a much more acceptable method of assessing the value of the procedure.

If Dr. Chamberlain and Dr. Gleeson would care to visit our unit at any time they will be most welcome, and we would hope to show them that our work is not founded on "uncritical . . . aortography in the hope that this will provide a diagnostic answer that it is incapable of doing." Further, they would see that a large amount of evidence has accumulated over the past seven or eight years in support of our contention that renal dysplasia, often familial, is associated with much clinical disorder, including hypertension. Papers on these and other aspects of the work are in an advanced state of preparation.—I am, etc.,

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Progestin Therapy of Breast Cancer

SIR,—Dr. B. A. Stoll (5 August, p. 338) has to be congratulated for his very worthwhile attempt at screening the efficacy of various progestational preparations in the treatment of advanced breast cancer. The paucity of satisfactory responses in his series of seven compounds tested should not discourage the search for more effective agents. The smallest change in the chemical structure of these steroids can markedly alter their clinical efficacy. For instance, the negative impression gained in the earliest trial in this country with norethisterone oenanthate was dispelled by a very similar compound having a shorter side chain and giving improved clinical results. Similarly the addition of 5 mg. oestradiol benzoate to progesterone 50 mg. by daily injection proved successful in 7 of the 15 cases with breast cancer treated by Landau *et al.*¹

In this department further experience was gained from the combination of progesterone (19-nor-17 α -hydroxyprogesterone caproate) 100 mg., with oestradiol valerate, 30 mg. Twenty-five patients (four premenopausal) with advanced cancer of the breast in whom previous surgery, radiotherapy, oestrogens, and androgens have either failed to arrest the progress of the disease or ceased to be effective were treated with this compound for periods of one to 14 months, receiving intramuscular injections weekly, later increased to twice weekly. In 8 cases (32%) a moderate to good response was noted with regression of visible skin and glandular neoplastic infiltration, disappearance of oedema, and amelioration of general conditions. In

no case, however, did the arrest of the disease last for a period longer than ten months. No untoward side-effects were noted except in one patient who did not tolerate the agent on account of nausea. A detailed report on this trial will be published shortly.

Of the possible modes of action of progestins in breast cancer listed by Dr. Stoll probably the most important—that is, the action of progestational compounds on target organs via changes in mesenchymal structures so prominent among the known effects in endometrial carcinoma—has not been mentioned.

Theorizing in the context of the rationale of treatment is very important, as none of the synthetic progestational compounds possesses all of the known properties of natural progesterone, and, since the various properties are present in varying degrees in the compounds on trial, different criteria must be employed for testing their efficacy.

In this regard, according to Swyer *et al.*,² in premenopausal women only the cessation of menstruation is of value to give data for a probit analysis. Other tests such as vaginal smear changes, depression of karyopyknotic index, inhibition of ovulation, etc., do not help in establishing potency ratios with fiducial limits of error. Effects on vaginal smears are not likely to be more reliable in this regard in post-menopausal women, and caution should be exercised in drawing conclusions for the selection of patients suitable for this type of hormone therapy.

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B. JOLLES.

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G.P.s and Health Centres

SIR,—In view of the interest in health centres, we circularized all general medical practitioners in the London Borough of Redbridge (population 248,000), asking whether they would be prepared to consider transfer-

interesting to note, however, that 32 out of the 56 practices which replied (57%) were willing to consider some form of health-centre practice. It is possible that many of those who did not reply were unwilling to

Type of Practice	No. of Replies	No. of Practices	Practices Willing to Consider Transferring Sole Surgery Whole Time	Practices Willing to Consider Transferring Main Surgery Whole Time	Practices Willing to Consider Transferring Branch Surgery Whole Time	Practices Willing to Consider Transferring Branch Surgery Initially and Main Surgery Later	Practices Unwilling to Consider Transfer	Other
Single-handed, sole premises ..	28	28	15	—	—	—	10	3
Partnership, sole premises ..	22	12	6	—	—	—	5	2
Single-handed, more than one surgery ..	3	3	—	—	—	2	—	1
Partnership, more than one surgery	20	13	—	5	4	—	4	—
Totals ..	73	56	21	5	4	2	19	6

ring their practice premises to a health centre, assuming that the proposed site of the health centre was satisfactory.

One hundred and forty-seven questionnaires were despatched and 73 replies (50%) were received. The information received is shown in the Table.

We do not claim statistical validity for the information, because we do not know the views of the 50% who did not reply. It is

commit themselves at an early stage, but, if experience in other areas is any guide, once a health centre is built there are often requests from general practitioners to be allowed to participate.—We are, etc.,

I. GORDON.
A. SHAW.

Health and Welfare Department,
London Borough of Redbridge,
Essex.

Importance of Medical Administrators

SIR,—It would be true to say that since 1948 medical administrators at hospital level have had a very thin time, in many cases being unwanted by management committees and their posts being dispensed with by hospital boards. Those who remained, and with more than a minimal number of sessions allocated to administration, found these sessions priced at an appreciably lower level than their clinical sessions.

It is therefore encouraging to note the increasing, if tardy, recognition of the importance of medical administration and the need for appropriate remuneration and training, as expressed in the Memorandum on the

Current Problems of Hospital Medical Staff (*Supplement*, 13 May, p. 93, para. 32).

Likewise, it is welcome news that the Health Departments and the professions are agreed on the importance of this work, and are united in a desire to see an increase in the number of doctors qualified by training and experience to be medical administrators, as expressed in the Joint Second Report on the Negotiations with N.H.S. Hospital Doctors and Dentists (*Supplement*, 19 August, p. 119, para. 8).—I am, etc.,

NORMAN V. WILLIAMS.

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St. Mellons, nr. Cardiff.

Opportunities in British Medicine

SIR,—I read in the Australian-printed edition of the *B.M.J.* that the Ministry are to woo doctors back from overseas (15 July, p. 128). The very fact that the Australian edition exists is a pitiful commentary on the Ministry's previous efforts related to practice in Britain. After considerable experience of English general practice and lately sufficient sight of Australian practice in a town of some 40,000 people, may I offer some advice to two sections of your readers. Firstly, to any young doctors who are contemplating English general practice: Don't! Give up the idea and leave as soon as possible.

Secondly, to the Ministry officials who are going overseas: You may possibly have some success with the older migrants who have deep roots in Britain, provided that you offer them access to hospital in some reasonable form. They will, however, look at you in amazement when you explain that the immense experience they have gained overseas will be rewarded by loss of seniority.

There are some quite good administrative posts overseas, so it is to be hoped a second Ministry team is not necessary to get the first one back.—I am, etc.,

Albury, N.S.W.,
Australia.

F. W. B. BREakey.

Points from Letters

Temporary Residents and the Casualty Department

Dr. G. W. GRIFFITHS (Bangor, N. Wales) writes: Often in areas whose temporary population is increased owing to its popular holiday appeal patients (young and old) use the overburdened casualty/accident units as "casual surgeries." By this I mean patients (and I refer particularly to children) who are brought in with non-urgent, non-traumatic illnesses.

For this service the general practitioner claims a fee—quite rightly and properly. The poor casualty officer, however, cannot claim even a shilling—and has a further burden of responsibility to carry on his often relatively inexperienced shoulders.

Infectivity of Scabies

Dr. J. O'D. ALEXANDER (Glasgow) writes: I observe with regret that my colleague Dr. R. W. Carslaw (12 August, p. 437) has misinterpreted my remarks on the diagnosis of scabies (17 June, p. 766). I said, "Above all it depends on the constant suspicion that an itchy patient may have scabies, even though the evidence is scanty." This is not advocating the *treatment* of a case of itching as scabies without confirmation. Suspicion will make the physician even more careful in his examination. It will prompt him to look for further evidence and critically to assess what evidence he has. The risk of not diagnosing a case of scabies will be reduced. I am in entire agreement that treating all cases of itching as scabies as a blanket cover for possible errors is unwise. I would go further and say it is foolish, because it creates far more difficulties than it solves.

On the other hand, Dr. Carslaw's remarks about the infectivity of scabies should not pass without comment. I think he is perhaps stretching a point when he says that infectivity from clothing and bedclothes is a myth. Mellanby¹ showed quite clearly that there was a risk if volunteers slept in the beds previously occupied by scabies. The risk was small (he put it at 1 in 200) but nevertheless could occur. It should not therefore be stated to be a myth.

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