Sir,—I am dismayed by the last paragraph of the letter in the B.M.J. of 29 June from 28 of the junior staff of the Middlesex and University College Hospitals (p. 830). It is pertinent to ask those who are Association members the following questions: (1) Have they tried to influence opinion at their regional meetings or at meetings of their own Regional Hospital Junior Staffs Group? (2) Did they try to obtain a seat for one or more of their number at the Annual Representative Meeting at Eastbourne? (3) Did they try to place a resolution on the agenda at the Annual Representative Meeting? If the answers are "No," then I submit their resignations are merely destructive. Some form of constructive involvement in the affairs of the Association would be far more useful.

To those who are not members I would suggest that they renounce any improvements in pay and remuneration which have been secured for them by the Association.—I am, etc.,

B. D. MORGAN WILLIAMS.

Annual Representative Meeting, Eastbourne.

Verapamil in Angina

Sir,—I was interested in Dr. D. N. Phear's evaluation of the use of verapamil in angina pectoris (22 June, p. 740), but feel that the results of his trial are of limited value since the assessment was made solely on a subjective basis. Although the problem of the well-known suggestibility of anginal patients with any new preparation can to some extent be overcome by a double-blind trial, a greater problem remains since it has been clearly shown that there is little correlation between frequency and severity of angina and the degree of actual coronary insufficiency. Not only is alteration in the anginal attack a poor criterion of the value of an anti-anginal preparation, but it may also lead to potentially harmful results by allowing excessive exertion in a patient in whom the anginal pain is improved without a corresponding favourable effect on the myocardial ischaemia.

I have recently completed a controlled double-blind objective evaluation of the use of verapamil in 16 anginal patients which shows quite clearly that verapamil is of considerable value in improving myocardial ischaemia (in press). A brief mention of the results is of interest in view of the prior publication of Dr. Phear's negative findings. I studied two dose levels of verapamil, 40 mg. t.d.s. and 120 mg. t.d.s., used for a month at a time, also included propranolol 100 mg. t.d.s. for the placebo, for the drugs being given on a double-blind basis. The assessment was based primarily on the changes in myocardial ischaemia shown by a combination of radiocardiography during exercise and conventional electrocardiography after exercise. Averin 120 mg. t.d.s. produced a statistically significant improvement in both the exercise tolerance and in the amount and duration of ischaemic ST depression in the exercise tests. Furthermore there was no significant difference in the beneficial effects on myocardial ischaemia produced by both verapamil and propranolol. As a matter of interest I found also that verapamil 120 mg. t.d.s., as well as in the lower dose 40 mg. t.d.s., resulted in statistically significant improvements in exertional angina, recorded daily by the patients, and in glyceryl trinitrate consumption, although there was no corresponding objective improvement in the electrocardiogram with the lower dose of verapamil.

Disregarding the higher dose of verapamil as it is unfair to compare 360 mg. daily with 240 mg. daily, the differing subjective results obtained by Dr. Phear, using 80 mg. t.d.s., and myself, using 40 mg. t.d.s., merely serve to emphasize the unreliability of basing the assessment of an anti-anginal drug solely on a subjective symptom such as angina, and show quite clearly the necessity for an objective evaluation of any new drug in this difficult field.—I am, etc.,

G. SANDLER.

St. Helen Hospital, Barnsley, Yorks.

References

2. Russek, H. I., Zohman, B. L., and Dorost, V. J., Amer. J. med. 1950, 9, 143.

Postoperative Chest

Sir,—In your leading article on the postoperative chest (22 June, p. 713) you follow the convention of restricting this term to cover only the infective chest complications of surgery. You also deplore the failure to achieve progress in this field, but progress is not likely until it is generally realized that the term postoperative chest covers two quite separate entities. In addition to the infective group, which you discuss fully, there is pulmonary embolism, which you fail to mention, although there is ample evidence that pulmonary embolism is an important cause of death in the postoperative period. Indeed, from the point of view of mortality, embolism is probably much more important than infection.

You mention the well-known association between bronchitis, smoking, and upper abdominal operation with the infected chest, but entirely different factors are relevant in the causation of embolism—namely, immobility, malignancy, heart failure, pelvic operations, venous thrombosis, the "pill," and, above all, obesity. It follows that the prevention and treatment of these two types of postoperative chest complication are also completely different.

Because the postoperative chest patient may be suffering from infection or embolism or from both these conditions, he presents a problem in diagnosis which may at times be a difficult one. The difficulties are greatly increased if pulmonary embolism is not even considered in the differential diagnosis.—I am, etc.,

J. H. ROLLAND RAMSAY.

Chest Clinic, Royal Infirmary, Sunderland.

Withdrawal of Drugs

Sir,—Your correspondent (8 June, p. 621) rightly draws attention to the difficulty which may result when a manufacturing company announces its intention to cease production of a given drug. He illustrates his case by reference to Avertin (bromethalin in amylene hydrate). But the withdrawal of Avertin now does not matter. Chloromethiazole, safer for the mother and the baby than Avertin, appears to be the drug of choice for the treatment of pre-eclampsia and eclampsia.—I am, etc.,

M. E. TUNSTALL.

Maternity Hospital, Foresthill, Aberdeen.

Verapamil and Angina

Sir,—I regret the letter of Dr. E. R. Beck and others (29 June, p. 830) was given publicity in your columns at a time when junior staff within the B.M.A. were seeking to precipitate further discussion to establish "the rational career structure which we all desire," and when the medical assistant grade had already been completely rejected at the Annual Representative Meeting at Eastbourne.

To those who have resigned on the issue, and to those who have yet to join the B.M.A., I would paraphrase the comments of the Chairman of Council: do not leave a room dirty, but rather come in and help us clean it up.—I am, etc.,

BRIAN LIVESLEY,
Manchester Hospital Junior Staffs Group. Annual Representative Meeting, Eastbourne.

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G. R. DANIEL,
Chairman, Association of Medical Advisors in the Pharmaceutical Industry and Medical Director, E. R. Squibb and Co. Ltd., Twickenham, Middx.