

Tumoral Calcinosis

SIR,—I read with interest the article by Drs. S. McClatchie and A. D. Brenner (18 January, p. 153) in which they report their experience of this condition among African patients. I wish to report that it occurs fairly commonly also among the inhabitants of Papua-New Guinea, the large island lying off the northern tip of Australia.

During the two years 1966-7 16 such specimens were submitted to the central laboratory for histological examination. The clinical, radiological, and pathological features are demonstrated in the accompany-

ing illustrations, and they resemble closely those illustrated by Drs. McClatchie and Brenner. A representative case was submitted to Dr. F. M. Ensinger, of the Armed Forces Institute of Pathology, Washington, and he also confirmed this diagnosis.

Ten of these cases were females and six were males. The mean age was 32 years, the youngest being 13 years. The anatomical distribution of the lesions was as follows: Thigh, 5; buttock, 5; hip, 4; elbow, 1; knee, 1.

The lesions were single, but the man with the lesion over the elbow had had similar lesions removed from both buttocks five years previously. The largest tumour measured 8 by 5 by 4 cm., and the smallest was 1 cm. in diameter. All had been treated by local excision. Eleven cases came from the central highlands area (above 5,000 ft. (1,520 m.) altitude) and the remaining six were from coastal areas.

Histories were difficult to obtain, because the people have little concept of time. It appeared, however, that the lesions had been



FIG. 1

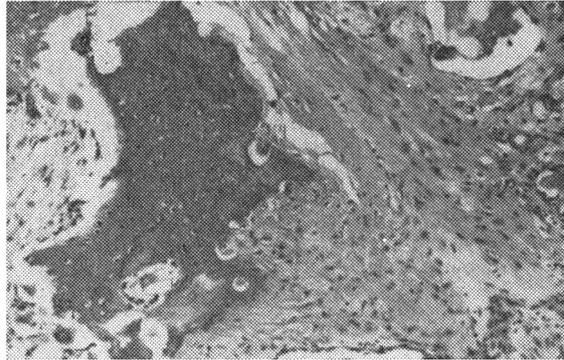


FIG. 2

FIG. 1.—X-ray of right hip showing heavy calcification in a large subcutaneous tumour. FIG. 2.—An occasional area of dysplastic bone was present. ($\times 87$)

present for many months. No history of previous injections or of any particular trauma to the areas involved was obtained in any case.—I am, etc.,

R. A. COOKE.

Royal Brisbane Hospital,
Brisbane,
Australia.

Consultant Surgeon at Southend

SIR,—A post of consultant surgeon to the Southend Hospital Group has recently been advertised (23 August, p. xxvii). This is a new post created to replace that of a senior registrar, now disestablished. The duties will be mainly in connexion with emergency surgery, and in much the same way as was done by the senior registrar the new surgeon will provide cover for two of the present surgeons who live at a distance. He will not in effect be doing consultant work. This situation will continue until the two surgeons whose emergency work he will be covering have retired by early 1971.

The North-east Metropolitan Regional Committee for Hospital Medical Services is strongly opposed to this appointment. The principle that a consultant should be

appointed, even for an interim period, to do anything but consultant work is wrong. The present accepted concept of the consultant's role is that of the Platt Working Party,¹ who designated the consultant as the only doctor who should be finally responsible for the care of patients in hospital beds, other than those assigned to general practitioners. This concept has now been undermined.—I am, etc.,

T. M. HENNEBRY,
Honorary Secretary,
North-east Metropolitan Regional
Committee for Hospital Medical Services,
North Middlesex Hospital,
London N.18.

REFERENCE

¹ Ministry of Health, Department of Health for Scotland, *Report of the Joint Working Party on the Medical Staffing Structure in the Hospital Service*, 1961. London, H.M.S.O.

Filming during Anaesthesia

SIR,—Excessive exposure to radiant heat during cinematography in the operating-theatre can be avoided through the use of a light source specially developed for this purpose.

Heiss¹ reported on his experience with the *Operationsscheinwerfer* (Firma Auer, Graststr., Munich, West Germany) at the University Hospital in Munich. The same

lamp has been in use by the photographic department at Guy's Hospital for some years. The apex of the tungsten bulb carries an integral mirror, so that virtually all the light and heat from the filament is reflected to a large parabolic interference-coated mirror at the back of the lamp housing. While virtually transparent to infra-red radiation, this mirror will reflect almost 90%

of the visible light to project an intense but cool beam of light.—I am, etc.,

CHARLES ENGEL.

Director, Department of Audio Visual
Communication, B.M.A.

London W.C.1.

REFERENCE

¹ Heiss, W., *Medical and Biological Illustration*, 1961, 11, 257.

Hazards of Sugar

SIR,—Your leading article (4 October, p. 2) suggests that we should beware the use of substitutes for sugar. This is wise counsel, but it should surely be set against the known hazards of feeding children on sugar itself.

Four tons (2,000 kg.) of teeth are extracted from the mouths of British children every year. Any doctor who has given a general anaesthetic for such an operation must be appalled by the act of mutilating a little mouth. He must ask himself if nothing can be done about it. We must find a safe substitute for sugar just as we found a safe substitute for cocaine. The fact that a substance is produced from a living plant does not mean that it must always be better than a synthetic one.

By all means advise caution. But please let it be remembered that we are talking about one of the causative agents of a disease that affects 80% of the people in Britain.—I am, etc.,

D. N. BARBER,

Chairman,
Public Relations Subcommittee,
East Lancashire Branch, B.D.A.

Manchester 21.

Genetic Counselling

SIR,—With reference to your report on my paper to the Annual Scientific Meeting of the British Medical Association (26 July, p. 230), I wish to point out that I did not quote any precise figure for the risk of recurrence for a sibling of either a sporadic or inherited example of a translocation involving chromosome 21. When discussing the recurrence risk in families where one parent carries a translocation, I stated that the approximate risk was of the order of one in three.

The observed incidence varies considerably, however, and is affected by a number of factors such as the type of translocation, the chromosomes involved, and which parent is the carrier. The discrepancy between the expected and the observed numbers of normal, carrier, and affected children born to a parent with a translocation have recently been discussed in detail by Ford and Clegg and by Hamerton,^{1,2} to whom the interested reader is referred.—I am, etc.,

A. W. JOHNSTON.

Aberdeen Royal Infirmary,
Aberdeen.

REFERENCES

¹ Hamerton, J. L., *Cytogenetics*, 1968, 7, 260.
² Ford, C. E., and Clegg, H. M., *British Medical Bulletin*, 1969, 25, 110.

Load of . . .

SIR,—Sad it is, no doubt, about these heavy, if unweighted, teaching loads (11 October, p. 64), but how many doctors now "carry a heavy patient load" who formerly "enjoyed a large practice"?—I am, etc.,

Edenbridge, Kent. LINDSEY W. BATTEN.