Myocardial Infarction and the G.P.

SIR,—I am sure that there will be others beside myself who take exception to the tone of censure adopted by Dr. A. P. Niarchos towards his general-practitioner colleagues regarding the handling of coronary patients (14 November, p. 433). This attitude seems to be on the increase in medical correspondence nowadays, and I feel some comment is called for.

Having checked up on what he chooses to call "the visit delay" (the time between the onset of symptoms and the general practitioner's visit) in a number of patients with cardiac infarction, he suggests that the general practitioner should "visit the patient as soon as possible." Does he really suppose that general practitioners go out of their way to avoid visiting such cases promptly? Telephone calls from patients are not accompanied by diagnostic labels written by an infallible medical hand, but are requests for help varying in their intelligibility and emotional content which have to be interpreted by the practitioner or more usually by a receptionist in the first instance. General practitioners do also get delayed in seeing patients with heart disease because they are attending patients with abdominal, psychiatric, and other emergencies including road accidents.

Might I suggest that your correspondent channels his zeal into a co-operative project with his general-practitioner colleagues in an attempt to elucidate whether the incidence of bradyarrhythmias and ventricular fibrillation (the cause of most of the early deaths following infarction) is higher or lower in patients subjected to the traumatic upheaval of immediate transfer to hospital in a state of shock than in those managed initially at home.—I am, etc.,

E. J. RAFFLE.

Broughty Ferry,
Dundee.

What is the Best Coronary Care?

SIR,—Dr. H. G. Mather (24 October, p. 231) has given some statistical and large scale support to an impression shared by many general practitioners that it still remains to be shown that "intensive care" of a coronary patient is better for him or her than care in his own home. Yet there may be common ground between the advocates at either extreme.

If one remembers that the major advantage claimed for intensive care is in the detection and correction of arrhythmias particularly in the "smaller" infarct in the young male within the first few hours of onset, and that the advantages of intensive care over good medical ward care can be marginal,¹ one begins to wish to see some of the effort, the expenditure in time, personnel, and money given to special units transferred to caring for the patient in what may be a much safer environment at home.

Since for most of the patients in the British Isles the possibility of really good intensive care is likely to remain remote, we might be better advised to think of transferring nursing and doctoring attention from the confines of the hospital to those of the home for 12 or 24 hours, with real effort directed towards getting to the patient promptly. Within 24 hours those likely

really to benefit from sustained hospital care (for example those with recurrent arrhythmia or asystole or other complications) are most likely to declare themselves.

The hoped for establishment of effective prophylactic drugs—procainamide? (14 March, p. 646)—and the redirection of some (admittedly scarce) nursing and doctoring talent might be much more rewarding for coronary patients. One hopes that the dogmatism of enthusiasm will not obscure the issues.—I am, etc.,

S. J. COOPER.

Lowestoft.

REFERENCE

- ¹ Lawrie, D. M., *Lancet*, 1968, 2, 523.

Lactic Acidosis and the M.D. Thesis

SIR,—Your leading article on this syndrome (31 October, p. 258), though otherwise excellent, is incorrect in attributing the first description to Huckabee in 1961.¹ I have no wish to belittle Dr. Huckabee's admirable contribution, but would like to draw attention to the book on "agonal acidosis" written by I. F. Hansen,² a young Danish doctor working in Copenhagen in most difficult circumstances during the German occupation. Hansen's book, a copy of which is in the library of the Royal Postgraduate Medical School, was his M.D. thesis, and was published posthumously in 1948. He observed that an increased plasma lactate concentration was a constant phenomenon in the agonal state, and that the acidosis (with plasma pH values often below 7.0) frequently had an additional respiratory component; he also referred to several earlier European reports of acidosis in dying patients. Clearly these descriptions correspond to the first type of lactic acidosis reported by Huckabee.

My main reason in writing is to point to this story as one of the unfortunate results of the European tradition of the M.D. thesis. As far as I can discover no part of Hansen's thesis was published elsewhere; certainly nothing appeared in the journals quoted by the *Index Medicus*, and so his work died with him. That it was published at all was probably due to the fact that his university insisted, as do many others in Europe, on publication as part of the degree ceremony. In Britain the writing of an M.D. thesis is an even more sterile undertaking, for the only version of the final work available to the general medical public is the single copy deposited in the library of the candidate's university, where it gathers dust and remains unread because few know of its existence. If death, illness, or inertia prevent the author rewriting the work in a form acceptable to a medical journal, the world is deprived of the fruits of his labour. Our North American colleagues (including Dr. Huckabee) are fortunate that their professional advancement does not depend on the writing of a thesis; the M.D. is their qualifying degree, and so they can publish their work in the first place in journals of world-wide distribution and repute.—I am, etc.,

OLIVER WRONG.

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Dundee.

REFERENCES

- ¹ Huckabee, W. E., *American Journal of Medicine*, 1961, 30, 833; 840.
² Hansen, I. F., *Investigations on Agonal Acidosis*. Copenhagen, Branner, 1948.

Diabetes and the Driving Licence

SIR,—I write to support the wise advice given on this subject by the chairman of the medical advisory committee of the British Diabetic Association (24 October, p. 245).

The views expressed are in accord with those set out in the booklet *Medical Aspects of Fitness to Drive Vehicles* (pages 18-20),¹ except for one small point. A few long-distance lorry drivers and some continental coach drivers cannot avoid driving long hours without meal breaks in order to catch up with interrupted schedules. It is doubtful whether even diabetics controlled by diet alone should be employed under such circumstances, though they can of course undertake other public service vehicle and heavy goods vehicle driving jobs.—I am, etc.,

P. A. B. RAFFLE,

Chairman,

Transport Committee,

Medical Commission on Accident Prevention.
London S.W.7.

REFERENCE

- ¹ *Medical Aspects of Fitness to Drive Vehicles*, 1968, London.

Diabetic Follow-up

SIR,—I was very pleased to see the "Five-year Follow-up Report on the Birmingham Diabetes Survey of 1962" (8 August, p. 301), and congratulate the authors on a most important and time-consuming work. I should like to make just three comments.

The use of the term "florid"; diabetes mellitus is still the name of a clinical disease state rather than a biochemical estimation, and when prefixed by "florid" certainly suggests pretty severe symptoms or complications rather than a single blood sugar level. However, that is just a matter of semantics.

It would certainly be expected that a two-hour post-glucose figure of 135 mg./100 ml. would give better discrimination than 120 mg. I have long used 140 mg./100 ml. as our critical level.¹

I was taught and believe that the term "lag storage curve" should be used only when the half-hour post-glucose figure is elevated and not when the elevation applies to or includes any later readings. I have observed a few women whose hour figures only were raised becoming overtly diabetic within five years. May I make the plea that the authors separate off those subjects in whom only the half-hour level was high and see whether any of these have progressed or if the progression of glucose tolerance abnormality applies only to those who had high one-hour figures also?—I am, etc.,

W. P. U. JACKSON.

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University of Cape Town,
South Africa.

REFERENCE

- ¹ Jackson, W. P. U., *On Diabetes Mellitus*, p. 393, Springfield, Ill., Thomas, 1964.

G.M.C. Delay in Full Registration

SIR,—Drs. A. W. Prince and A. S. Green (17 October, p. 175) wrote of the delay in the granting of full registration by the General Medical Council, and suggested that