and after treatment are compared we believe that physical activity performed must be comparable at each time and that consideration should be given to variation in the time of waking.

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- ¹ Littler, W A, and Watson, R D S, *Lancet*, 1978, 1, 995.
² Floras, J S, et al, *Clinical Science and Molecular Medicine*, 1978, 55, 395s.
³ Jeffers, T A, et al, *British Journal of Clinical Pharmacology*, 1977, 4, 523.
⁴ Wilcox, R G, and Mitchell, J R A, *British Medical Journal*, 1977, 2, 547.
⁵ Wilcox, R G, *British Medical Journal*, 1978, 2, 383.

Retroperitoneal fibrosis after treatment with atenolol

SIR,—The report from Belfast City Hospital (23-30 December, p 1786) implying that atenolol may have been the cause of retroperitoneal fibrosis in a 68-year-old woman deserves comment. There are several reasons for supposing that the suspicion of a cause-and-effect relationship is not well founded.

The authors state that this case was reported "because of the established relationship between the earlier beta-blocker practolol and similar types of sclerosing fibroblastic reaction." However, in more than 200 cases of practolol sclerosing peritonitis, which principally affects the visceral peritoneum of the small bowel, no cases of retroperitoneal fibrosis have been identified. Moreover, the early onset of symptoms (six months of atenolol therapy in the Belfast case) is not in keeping with a median time of onset of 36 months (range 15-96) for sclerosing peritonitis caused by practolol.

Perhaps of greater importance is the fact that usage of atenolol to date is similar to that of practolol when it was withdrawn and no validated reports of the specific oculomucocutaneous syndrome have arisen with atenolol. Finally, it is known that a group of 16 patients who suffered from practolol toxicity have now been taking atenolol for up to five years without any suggestion of recurrence of adverse reactions of the oculomucocutaneous type.

On balance it seems unlikely that atenolol may have a propensity to cause "similar types of sclerosing fibroblastic reaction."

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Longest-stay patients

SIR,—The leading article "Who cares for the mentally handicapped?" (18 November, p 1386) pointed out that of the 50 000 citizens of Britain living in hospitals for the mentally handicapped, 20 000 have lived in hospitals for 20 years or more. Many of today's hospitals for the mentally handicapped were opened as institutions for mental deficiency after the end of the first world war. In them there are still some residents who were admitted as children in the earlier decades of this century. They have lived out their lives within these hospitals and have passed their golden jubilees, and some are about to reach their diamond jubilees of residence in hospital.

For example, at Meanwood Park Hospital, Leeds, first opened as a mental deficiency

colony in 1919, one man achieves 60 years of residence this year. Altogether there are 35 (15 men, 20 women) out of 530 residents (6.6%) who have been in that hospital for over 50 years. They have a total between them of 1924 years in hospital, an average stay of 55 years. Some mental handicap hospitals with histories dating back before the 1913 Mental Deficiency Act may have residents with longer periods of stay than 60 years. This prompts the thought of where is the longest-stay resident in this country.

As might be expected, these longest-stay patients represent mainly the more intelligent group of residents, who would never be accepted in hospital today. In a sense they are a lost generation of their time, people who have spent a lifetime in hospital, which should never happen again. They were the victims of a system which society now acknowledges to have been wrong.

For this reason these longest-stay patients are particularly in need of recognition. The nursing staff at Meanwood Park Hospital have suggested that it would be appropriate to acknowledge in some way these longest-stay hospital residents. It is likely that all hospitals, and perhaps their communities, will be interested in honouring such patients. They have been in hospital so long that now few of them want to leave. Their remaining years in hospital will have to be made as happy as possible. Hospitals might ensure that longest-stay patients' wards are as pleasant and comfortable as possible. There is plenty of scope for volunteers to work with these patients. All who show concern about mental handicap can find common ground in giving them special consideration.

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Staging of carcinoma of the pancreas

SIR,—The surgical treatment of cancer of the pancreas is now based on staging of the disease. This principle was set out in your leading article (10 December 1977, p 1497). We have followed the steps advocated, and so after a careful laparotomy with palpation of the liver and assessment of local operability we proceed to frozen section examination of the regional lymph nodes to differentiate stage III from stage I and II disease. Recently, however, we have modified this policy by extending the use of frozen section to include an examination of a wedge liver biopsy.

Six months ago a small nodule was noted on the anterior surface of the liver in a patient who was otherwise stage I. The nature of this lesion was not clear. It was therefore biopsied. Immediate section showed that it was a small cyst, but the pathologist reported the presence of a micrometastasis of adenocarcinoma within the same biopsy. This transferred the patient to stage IV. As a result of this experience routine biopsy has now been performed and in four patients examined since that time one other who had no macroscopic evidence of spread has been shown to have micrometastases in the liver.

It is interesting that Bender and Brennan¹ have recently noted the value of liver biopsy. They perform a percutaneous needle biopsy, but their report relates to a group of cases who had already undergone a bypass to relieve jaundice and were being considered for

palliative radiotherapy. Such an approach would not be appropriate in a jaundiced patient, but we have found no contraindication to operative biopsy. It is accepted that a small piece of tissue will offer only a small chance of picking up metastatic spread; but if the frozen section is positive, as in two of our patients, it clearly alters the staging and makes any resectional procedure inappropriate.

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- ¹ Bender, R A, and Brennan, M F, *American Journal of Surgery*, 1978, 135, 207.

Abortion and the NHS: the first decade

SIR,—The review of "Abortion and the NHS: the first decade" (27 January, p 217) is a superficial look at a vexed problem. It appears to be written on the assumption that an abortion is in itself a good thing and its performance is thus to be encouraged. The authors say that the effectiveness of an abortion service may be indicated by (a) the mortality rate; (b) the complication rate; (c) the proportion of abortions performed after 13 weeks' gestation; and (d) the concurrent sterilisation rate. They tell us the mortality rate but give us no figures for complication rate.

This, however, is only one side of the coin. We judge the effectiveness of a treatment or a service not only by the deaths or complications arising from that treatment, but by what good the treatment produced. The authors present no data on this subject at all. Before suggesting that "the number of abortions performed may be increased without any increase in running costs" the authors might care to ponder the suggestion that 102 675 abortions per year is already too many.

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Good general practice

SIR,—I read the Personal View by Dr J A R Willis (3 February, p 339) with considerable interest. Having qualified in the 1950s, I had similar feelings of bitterness about the low opinions held about general practice. This particularly applied because there were three general practitioners in my own family.

Undergraduate secondment to general practice is now a mandatory requirement by nearly all medical schools—except, unfortunately, my own. With the implementation of the Vocational Training Act, general practitioners should be properly trained, and we have our own royal college to help us do this. In general practice, there is a greater variation of standards between practitioners than in the consultant field. In this latter field, there is a fully integrated training programme with the appropriate royal college membership (or fellowship) examination as an essential part. With vocational training and the Royal College of General Practitioners it is to be hoped that the variation of standards in general practice will narrow.

Surely the MRCGP examination must be used as a tool to ensure that vocational training in general practice is working effectively?