patients was the thrombus confined to the calf. This is at variance with a large study,¹ in which thrombus was confined to the calf in 49% of 493 legs containing thrombus. To say that "there was a general reluctance on the part of individual doctors to perform phlebography on patients with negative ^{99m}Tc-red-cell scans" merely emphasises the bias of investigation in favour of their own technique.

Secondly, this technique apparently lacks the facility of radionuclide venography, its nearest rival in providing a simultaneous lung scan. Finally, the acid test of all new diagnostic procedures is whether they may be applied in the district general hospital as readily as the teaching hospital. Conventional phlebography fulfils this criterion. We remain unconvinced that this new technique can alter the situation in any way, being more demanding in time, expertise, skilled manpower, and expensive equipment.

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¹ Stamatakis, J D, *et al*, *British Journal of Surgery*, 1978, **65**, 449.

No more textbooks on primary care?

SIR,—How sad that Dr Ian Tait should plead for "no more textbooks on primary care or general practice" (27 January, p 256). He argues that the range of primary care is too comprehensive and the clinical activities too variable between different practitioners to allow adequate coverage in standard texts. Primary care, he believes, is "inherently resistant to ossification in any form of standard text."

These arguments could be used against any standard text for most major specialities and to that extent they are valid. Indeed, it might be argued that all knowledge becomes ossified the moment it is set down in texts; but there are many good reasons why the attempt should be made, which do not necessarily relate in an obvious way to the needs of an intended reader. The first is that the creative activity involved in writing and the critical activity involved in reading medical texts, even standard texts, advance our specialty. This alone is sufficient reason for producing them. Medicine, however, does not consist of some theoretical body of knowledge which exists independently from patients. It can be understood and described only in relation to a given population. It is for this reason that Ian Tait's statement that the textbooks the general practitioners uses "are no different from those that serve the rest of his profession" should be analysed most carefully.

Primary medical care, wherever and however it is practised, is first-contact care and the population served by the general practitioner is fundamentally different from that served by the hospital doctor. Most medical textbooks are written by hospital doctors who have gained experience and carried out research on hospital patients. Their findings are fine for hospital patients but they cannot be applied uncritically to general practice. They may be right but there are many good reasons why they may not be. I have referred before in

your columns (1 July 1978, p 53) to the mistakes we can make when we base diagnostic and management norms and even our ideas about aetiology and prognosis on a hospital population. Our textbooks must be different from those that serve the rest of the profession because our patients and their problems are different; as with all texts, there will be good and bad but with impending mandatory vocational training we have never needed the good ones more urgently. They must continue to embody sound research into clinical medicine in general practice and involve everyday problems such as urinary infection, ischaemic heart disease, hypertension, and a score of other conditions, so that aetiology and prognosis can be more soundly based and diagnostic and management norms can be set—thereby building up knowledge that is relevant to the needs of our patients.

Of course, we need the help of our colleagues in other specialties but our problems have many unique features and attempting to produce a "standard text" is one way of helping us solve some of them.

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Hazards of fiberoptic bronchoscopy

SIR,—I would like to make a few observations regarding the leading article on "The hazards of fiberoptic bronchoscopy" (27 January, p 212).

One of the problems of performing this investigation under local anaesthetic (apart from the fact that a large number of patients find it very distressing) is the choice of drugs used for "sedation." This usually varies between an opiate and a benzodiazepine, usually diazepam. While it is well known that opiates in general produce respiratory depression, it appears to be less well appreciated that in the elderly and infirm diazepam is equally effective in producing it, even in small doses (2.5–5.0 mg intravenously). This equally applies to patients with chronic respiratory failure. It is one of the anaesthetist's less enviable tasks to be summoned to an apnoeic patient under these circumstances, and asked to undertake intermittent positive-pressure ventilation, for what may eventually be several weeks, owing to upsets in the physiological norm for that patient—the more so since rarely is the anaesthetist consulted, prior to the bronchoscopy on these problem patients, about the most appropriate form of anaesthesia.

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SIR,—Your leading article on the hazards of fiberoptic bronchoscopy (27 January, p 212) appears to us to overstate the case. This is a pity because it might well discourage the setting up of a district fiberoptic bronchoscopy service, such as we have in this group, offering inpatient or outpatient bronchoscopy on almost any day of the week.

After twenty years' experience of rigid bronchoscopy and now five years' experience of fiberoptic bronchoscopy, we have no doubt that this is a simple procedure, largely trouble free, and a great scientific advance. We have carried out over 1000 fiberoptic bronchoscopies under local anaesthesia, with no complications whatsoever. We use no premedication and

have had no trouble with bleeding. In our previous series of 4000 bronchoscopies under general anaesthesia using the rigid bronchoscope, we had five deaths, one due to haemorrhage and one to rupture of a large upper lobe abscess, and three in patients with lung cancer complicated by severe cardiorespiratory disease.

Advantages of fiberoptic bronchoscopy include the retention of the cough reflex and the absence of any respiratory-centre-depressant drugs, making bleeding unimportant. Also there are several simple methods of administering oxygen during the procedure. Again, after operation or in an intensive care unit a patient with atelectasis can be sucked out easily since the bronchoscope can be taken to the patient's bedside and, similarly, a diagnostic test can be easily carried out on a sick patient without moving him from his bed.

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Antinuclear factor in patients on prazosin

SIR,—Dr A J Marshall and his colleagues (20 January, p 165) described an increase in frequency of antinuclear factor (ANF) in patients under treatment with the hypotensive drug prazosin. Overall, 19 of 57 patients (33%) were found to have ANF, with some developing autoantibodies only after commencement of the drug. In contrast, our own data on a larger group of patients indicate that therapy with prazosin is not associated with increased ANF incidence. We found ANF in 9.8% of 132 hypertensive patients treated with prazosin compared with 11.6% of 1087 patients treated with other hypotensive drugs.

In a previous communication (7 January 1978, p 14) we have shown that methyldopa is clearly associated with a raised ANF incidence, so further analysis of our data was necessary. This showed that the incidence of ANF in patients treated with hypotensive regimens excluding methyldopa (736 patients), in patients taking prazosin but not methyldopa (92 patients), and in untreated hypertensives (352 patients) was not significantly different (7.3%, 6.5%, and 6.0% respectively). The combination of methyldopa with prazosin did not increase the ANF frequency beyond that of the group on methyldopa alone (20.5% with methyldopa, 17.5% with methyldopa plus prazosin).

A criticism of Dr Marshall's paper is that their data have not been evaluated against large numbers of age-matched controls. This is important as the frequency of ANF increases with age and is higher in women than men. The first group of 47 patients on prazosin described by Marshall *et al* were aged 55–73. No information is given on the ages of their control populations. A comparison from our series of treated hypertensives aged 60–69 compared with those aged 20–29 shows the ANF incidence to be 16.7% in the former and only 2.6% in the latter, a greater than sixfold difference. Similarly, the incidence of ANF in women patients aged over 50 on treatment with methyldopa is 52%, while for all patients on treatment with this drug ANF was found in fewer than 20% (391 patients). Despite this frequency of ANF it was not, in these

patients, associated with any evidence of drug-induced lupus.

It is possible therefore that extension of Dr Marshall's investigation to larger numbers of patients, with appropriate age-matched controls, could result in conclusions different from those reported. However, their finding that all prazosin-related ANF patterns were of the speckled variety is very unusual. When ANF did occur in patients on prazosin in our study it was not restricted to this morphological pattern. This suggests that there may be some unusual factors influencing results in Dr Marshall's patients.

The full data from which this summary is drawn will be presented elsewhere.

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¹ Wilson, J D, *et al*, *British Medical Journal*, 1978, 1, 14.

Treatment and survival in advanced breast cancer

SIR,—Dr T Priestman and his colleagues have reported the results of a comparative trial of endocrine versus cytotoxic treatment in advanced breast cancer (16 December, p 1673; 14 May 1977, p 1248). In their trial they administered oestrogen to postmenopausal patients with lung metastases and prednisone to postmenopausal patients with spread to liver or lymphangitis carcinomatosa and compared the therapeutic results with those of cytotoxic agents. In cases of extensive visceral involvement (the authors do not report details about the extension of metastases) the patients are at immediate risk. In these cases we believe it is not justifiable to treat them with oestrogens or only steroids (no matter what kind of trial they did) when it is well known that it takes at least three to four weeks for a hormonal response, whereas an immediate therapeutic response is needed. The treatment of choice is an intensive chemotherapeutic combination (including steroids).

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Synovial biopsy in arthritis

SIR,—I was interested to read your leading article (10 February, p 363) on "Synovial biopsy in arthritis." I was more than a little surprised to find that it contained no reference to the use of arthroscopy in this procedure. Among its uses arthroscopy allows the clinician to comment on the macroscopic appearance of the synovium, examine the joint surfaces, and to find a suitably representative area of synovium for biopsy. The latter can reduce the "sampling errors" of a blind technique.

I am grateful that the leading article threw light on the types of synovitis and their histological differences, but I am sure that many of us involved in synovial biopsy, whether by needle or under vision with arthroscopy, are concerned by the number of times the report simply states a non-specific inflammation.

Surely it is only by building up experience

of macroscopic and microscopic features that a better differential diagnosis of synovitis can be obtained.

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Epidemiology and public health in American universities

SIR,—May I draw attention to a slip somewhere between pen and print which changed "without" to "with" in my recent article in your columns? (23-30 December, p 1737)? Neither W T Sedgwick, professor of biology and public health at Massachusetts Institute of Technology, or C-E A Winslow, first professor of public health at Yale, had medical degrees. Indeed a purpose of this passage was to draw attention to the fact that some of the leading early teachers of epidemiology in the United States, though bacteriologists, were *not* medically qualified.

Sedgwick embarked on a medical course (at Yale in 1877) but was so disillusioned with the unscientific approach to the subject there at that time that he left New Haven for Johns Hopkins, where he studied biology.¹ Winslow, who was a pupil of Sedgwick's, never studied medicine at all, and as a bacteriologist directed courses in his new department at Yale towards scientists who did not have medical degrees.²

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¹ Curran, J A, *Founders of the Harvard School of Public Health*. New York, Josiah Macy Jr Foundation, 1970.

² Acheson, R M, *American Journal of Epidemiology*, 1970, 91, 1.

Abortion and the NHS

SIR,—An analysis of the first decade of legal abortion in England and Wales is timely because the Wessex Regional Health Authority is now considering whether or not to introduce a regional day case abortion unit. Dr F G R Fowkes and others (27 January, p 217) present a case for more NHS abortions, but do not say whether such provision should be at a district or regional level.

The chief argument against the status quo is the "unfairness" of abortion provision, district by district and region by region. However, there is evidence that these disparities are lessening, not only from the paper by Fowkes *et al* but also from the Wessex abortion study.¹ A second argument is the different provision between the private sector and the NHS. In particular, single women aged 17-34 are less likely to get NHS abortions and more likely to be aborted in a private clinic. In practice, the private sector offers abortion almost "on demand," whereas the doctor in NHS practice is more likely to be selective. There are two reasons for this: NHS doctors on average tend to interpret the 1967 abortion act less liberally and, secondly, they are constrained by a shortage of resources for all forms of gynaecological care. The Wessex study has identified this fact and shown that districts where resources are less than average tend to do less abortions.

Like mixed sex wards, day care units are now the administrator's dream. Superficially it

seems that here is a way to save money and reduce waiting lists; but in practice day care units are very demanding and complex to run, and many of the savings are spurious.

There are no medical arguments in favour of increasing the number of NHS abortions vis-à-vis private abortions: the arguments are emotional and political. At a time when other types of private medical care are substantially increasing and when NHS waiting lists of all kinds are getting longer, it is difficult to understand why abortion should be singled out for priority care. If more money is spent on abortion units there must be less money for other patients.

Already NHS abortion practice is becoming more even-handed throughout the land. To develop regional units would polarise attitudes and distort the equitable and proper district developments for gynaecological services. It would be better to increase the allocation of money at each district gynaecological unit and encourage current trends.

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¹ Ashton, J R, *et al*, *Second Report of the Working Group set up by the Wessex Regional Health Authority with the University of Southampton to Study the Provision of Induced Abortion and Abortion Related Services in Wessex*. University of Southampton, July 1978.

SIR,—The recent review of the first decade of experience of the Abortion Act (1967) (27 January, p 217) confirms what we have said in various places since 1971.^{1 2} The decline in mortality and morbidity rates, the use of concurrent sterilisation, and the shorter duration of pregnancy at abortion, particularly within the NHS, are also welcomed by us. However, it is not enough that we should merely accept this situation.

Comparison of the results of abortion obtained by the NHS and by the charitable and private sector shows so clearly how the results and the services could be improved immediately and considerably with almost no additional cost to the NHS. We can only conclude that the major factor responsible for the provision of poor abortion services within the NHS is reluctance on the part of the gynaecologists and health administrators who should be concerned. General practitioners are much more aware of the needs than the specialists, and the public has been unflagging in exerting pressure for the provision of humanly sensitive, safe, early, and efficient abortion.

An ill-informed spokesman for the DHSS made a hasty reply³ to our letter (19 August 1978, p 562) drawing attention to the differential mortality rates for abortion between the NHS and the private sector. We were promised early publication of the facts to rebut our suggestions that the NHS is still carrying out abortions too late, using inappropriate techniques, too often combined with sterilisation, and too often by relatively inexperienced operators. Later the DHSS suggested to us that our observations were a matter for the profession rather than the Department. We fail to understand how the profession can draw conclusions without the facts, which remain unpublished and which the DHSS surely have. As the delay in obtaining this information increases, we feel bound to ask the DHSS once again to provide the public and the profession with information that would enable the quality of our abortion services to be improved. We have personally asked the