after the onset of the stroke: in our study the mean interval between the ictus and arriving in hospital was 5½ hours.

Dr J W Norris (6 January, p 56) questions the validity of clinical evaluation at one year but our article makes clear that we also assessed the patients at 10 days and at three months. We found no significant difference in morbidity and mortality at these intervals.

To Dr F Clifford Rose and his colleagues (6 January, p 55) we would reiterate that the purpose of our study was to determine whether unselected patients with stroke would benefit from dexamethasone since the previous literature is inconclusive on this point. We agree that further studies are needed to see if a subgroup of such patients will benefit from steroids, but this requires the use of CAT-scanning, which is not available to physicians in district general hospitals, where the majority of stroke victims present.

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* *Dr Mulley and his colleagues have made an important point about "Condensed Reports," which are a compromise between authors and editor enabling articles to be published for which we would not otherwise have the space. In future, we shall routinely ask these authors to comment before publication on letters to the Editor about their articles.—ED, *BMJ*.

Premenstrual tension syndrome

SIR,—Although many claims have been made for progesterone deficiency in the pathogenesis of the premenstrual syndrome, evidence is in fact lacking. In your recent leading article (27 January, p 212) two studies were cited. In one only 30% of patients were shown to have lower than average progesterone levels.¹ Of this small number 70% were effectively treated in an uncontrolled study of dydrogesterone. In this study and that of Backstrom² the onset of symptoms was found to precede the changes in progesterone secretion, suggesting some other agent to be causative in this syndrome. Moreover, if progesterone deficiency, or a decrease in the progesterone-oestrogen ratio, were responsible for the syndrome symptoms would be expected to occur during the preovulatory rather than the premenstrual phase.

The administration of progesterone, however, may be expected to relieve symptoms by virtue of its natriuretic action and its central nervous depressant action. Even so, there is not yet a double-blind controlled study to support the effectiveness of the drug despite enthusiastic claims.³ Other studies, in fact, have suggested that progesterone excess is responsible for the syndrome. This is a more logical hypothesis. Gillman showed that the administration of progesterone actually gave rise to premenstrual symptoms.⁴ In a recent study in Nottingham⁵ higher levels of progesterone were shown in symptomatic subjects during the postovulatory phase of the cycle: the difference preceded the onset of symptoms. The levels of prolactin and aldosterone were similar in symptomatic and controlled subjects. Even so, spironolactone reduced psychological symptoms and

reduced weight in more than 80% of subjects in a double-blind crossover trial.

It is unlikely that the syndrome is due to a single hormonal change. The combined effects of the many hormones (perhaps through shifts in neuronal electrolyte state) should be considered. It is probable that the high levels of progesterone following ovulation give rise to a diuresis and natriuresis. This is followed by a phase of a salt and water retention as the aldosterone becomes secondarily raised. This flux in electrolyte state is coincident with the onset of psychological symptoms, and possibly causative. Depending on the individual aldosterone response, there may be a return to the original sodium and fluid state or it may go beyond this to cause retention and oedema. This would account for the variable findings of previous workers, showing that weight increase and fluid retention are not universally associated with mood change.

Complete ablation of the menstrual cycle using a oestrogen-progesterone combination may improve symptoms in certain patients, though symptoms are made worse in many, especially during the phase following norethisterone withdrawal.

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¹ Munday, M, *Current Medical Research and Opinion* 1977, 4, suppl 4, p 16.

² Backstrom, T, and Carstensen, H, *Journal of Steroid Biochemistry*, 1974, 5, 257.

³ Dalton, K, *The Premenstrual Syndrome and Progesterone Therapy*. London, Heinemann Year Book Medical Publishers, 1977.

⁴ Gillman, J, *Journal of Endocrinology and Metabolism*, 1942, 2, 157.

⁵ O'Brien, P M S, et al, *British Journal of Obstetrics and Gynaecology*, in press.

Epilepsy and learning

SIR,—Your leading article (3 March, p 576) usefully drew attention to an important aspect of the management of children with fits. However, your statement that "sodium valproate is the first choice in new patients" is more categorical than seems justified on present evidence—apart from taking no account of the type of fits being treated.

There is no doubt that sodium valproate is a very useful new anticonvulsant, but it has been in widespread use in Britain for only a few years. Reynolds¹ has pointed out the long delay which may occur between the introduction of an anticonvulsant and the recognition of all its long-term unwanted effects. Your editorial implies that sodium valproate is less likely to cause school problems than phenytoin; but you quote no evidence to support this view, and you admit that evidence about long-term effects of sodium valproate on behaviour is scanty. A trial comparing learning performance in matched epileptic children taking phenytoin, sodium valproate, and carbamazepine (which also deserves consideration) is needed before such a recommendation can be made.

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¹ Reynolds, E M, *Lancet*, 1978, 2, 721.

SIR,—The British Epilepsy Association was pleased to see in the conclusion to your leading article (3 March, p 576) the sentence "Epilepsy is not just fits."

One of the things epilepsy may also repre-

sent is the need for specialised educational help. It is with this in mind that we wish to publicise more widely the establishment of a new school for children with epilepsy, which will take its first pupils in September. It is Mossbrook School, Sheffield, which will accommodate about 35 pupils with epilepsy on a residential basis. The age range will be primary and middle school and the ability range "dull to normal," with epilepsy as the principal disability. It is envisaged that Mossbrook School will be a "feeder" school for the David Lewis School, Cheshire, which caters for older pupils with epilepsy.

Doctors can help the association and the Department of Education and Science to judge the need for this new facility and identify children likely to benefit from its existence. We would be very pleased to hear from any doctors, especially paediatricians, in the Sheffield area—or elsewhere—who could give a rough estimate of the numbers of children known to be in need of a special school because of a primary disability of epilepsy. Numbers only are needed at this stage, and confidentiality will be absolutely respected.

ANDREW GORDON CRAIG

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Glossopharyngeal neuralgia with syncope

SIR,—Drs R R Jacobson and R W Ross Russell report relief with carbamazepine in the rare combination of glossopharyngeal neuralgia, arrhythmia, and syncope (10 February, p 379). Unfortunately, this drug may lose its effect, as in our patient.¹

A woman who had repeated attacks of pain, bradycardia, and syncope responded at first to carbamazepine 200 mg, twice daily, but then stopped her treatment after three months. When her symptoms recurred with great frequency and intensity 16 months later both carbamazepine and atropine were ineffective. Finally, in January 1975 the right glossopharyngeal nerve was excised, with lasting relief; and at review four years later she was entirely free from symptoms. Thus surgery may be curative in this uncommon, bizarre, and disabling condition when medical treatment has failed.

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¹ Taylor, P H, et al, *Journal of Laryngology and Otology*, 1977, 91, 859.

Priorities in road accidents

SIR,—Dr J C Allen in his letter (24 February, p 548) is mistaken in interpreting silence for apathy. There has, after all, been very little recent correspondence in your journal, or any other scientific journal for that matter, on the flat earth theory because most sensible people have long ago realised that this theory is untenable.

Dr Allen, of course, is perfectly entitled to exercise his personal liberty when driving a car with regard to the wearing of a seat belt, just as I am sure he drives on the right-hand side of the road in England (and on the left-hand side in France) and, of course, drives through all red traffic lights, particularly when a juggernaut is crossing on the green. What

Dr Allen is not entitled to do is to impose a burden on others in the guise of "personal liberty."

Is he prepared to carry the full cost of plastic surgery when he breaks his windscreen with his face, or the cost of an intensive care unit (in the region of £100 a day minimum) when he stoves his chest in against his steering wheel? Can he and his family carry the financial burden of caring for him for the rest of his life as a paraplegic or quadriplegic? And has he made complete provision for the welfare of his widow and children, if any?

If Dr Allen is not prepared to accept the full financial responsibilities for his exercise of personal liberty, then he must be prepared for a "justifiable intrusion" into that liberty by those of us who will have to carry the burden of his own crass stupidity. Perhaps if his nanny had knocked a little sense into him when he was a small boy he would talk less nonsense about the "Nanny State."

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Cimetidine and duodenal ulcer

SIR,—In their letter (3 March, p 618) Drs N R Peden and K G Wormsley express shock at my suggestion (10 February, p 410) that cimetidine might have a place in the diagnostic armamentarium. I did not state, as they say, that "it should be used as a diagnostic rather than a therapeutic drug." Neither is the case they quote of a patient receiving three separate month-long courses of cimetidine and subsequently being found to have a gastric lymphoma relevant to my suggestion of a single seven-day course.

The primary physician's diagnostic pathway is necessarily different from that of the hospital doctor. Heaven help us if all patients with upper abdominal pain were referred for endoscopic and radiological diagnosis even if every general practitioner had access to radiology and it was diagnostically reliable. The therapeutic trial has a long and valuable tradition in medicine. Of course, it does not give a definitive diagnosis. It is one step along the way. While a careful history is usually enough there remain a small number of cases in which differentiation of, say, oesophageal from cardiac pain, or gall bladder from duodenal pain, is difficult. It is in these that a short course of cimetidine may give added information if only in that it helps to indicate the direction in which further steps must go.

The case that Drs Peden and Wormsley make is surely against the use of cimetidine as a therapeutic agent without proper diagnosis, and this is a warning that general practitioners would wisely follow; but their case against using it as a diagnostic aid is much less secure.

M DRURY

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SIR,—With reference to Mr A S Bulman's letter (10 February, p 409), I should like to add a further report to the increasing number suggesting rebound cimetidine ulceration and complications.

A 34-year-old woman (weight 65 kg) was admitted for assessment for surgery following six months of ineffective cimetidine therapy (1 g per day) for a duodenal ulcer proved by barium examination. The cimetidine was discontinued on

admission and at endoscopy four days later multiple gastric and duodenal ulcers were seen. There were two chronic and two acute ulcers in the duodenum and eight acute ulcers over the antrum and pylorus. The acute ulcers varied in diameter from 4 to 8 mm. Acid studies on the day of endoscopy showed a basal output of 0.58 mmol (mEq) per half hour and a pentagastrin-stimulated peak acid output of 15 mmol per half hour. Three weeks later repeat endoscopy showed only four acute ulcers remaining and repeat acid studies showed basal output of 0.6 mmol per half hour and a stimulated output of 14.5 mmol per half hour. At surgery after a further three weeks all the acute ulcers were healed. Gastrin levels were without our normal range.

The finding of multiple acute gastroduodenal ulcers in an otherwise healthy patient suggests that the sudden cessation of the cimetidine therapy may be incriminated in their aetiology. The failure in this case to demonstrate any evidence of rebound hyperacidity is consistent with previously published findings.¹ Peptic ulceration is the result of alteration of the delicate balance of acid and mucosal resistance. The cimetidine-rebound phenomenon may be due to alteration of the latter rather than the former. The acid-lowering effect of cimetidine may, over a period of time, result in decreased mucosal acid resistance. When the drug is discontinued the increase in acid output to previously normal levels may be sufficient to cause ulceration of the mucosa, which has become unaccustomed to such acidity. Failure to demonstrate rebound hyperacidity does not exclude the postulated rebound phenomenon.

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¹ Aadland, E, and Bedstad, A, *Scandinavian Journal of Gastroenterology*, 1978, 13, 193.

The new consultant contract

SIR,—We are shocked and appalled by the new draft contract for consultants. It reflects a complete lack of understanding of the flexibility required by most consultants' work. It would destroy our professional status. We would have a legally binding contract to be in a particular spot at every given time in the week, with no regard to changing clinical pressures or emergencies, and we could be held in breach of contract for any transgressions. No apprentice in the 18th century ever had to sign so enslaving an agreement.

It is divisive among colleagues in a complex hospital environment where good professional relationships are crucial to the provision of continuity and excellence of care. They are now to be reduced to arguing among themselves whether X or Y should have extra NHDs, with all the bitterness this would provoke. The contract is also unrealistic. Most specialists in both medicine and surgery have experience and expertise that cannot be replaced by that of a colleague in the same hospital. If a cardiological registrar is having difficulty with a pacemaker it is no use calling the endocrinologist or the gastroenterologist or the geriatrician. Yet the contract specifically states that it is policy to reduce paid on-call commitment.

Though provision is made to allow consultants to do private practice and specific research projects, many other areas of work, some paid and some unpaid, crucial to the functioning of the medical community are not mentioned. Is regular category II work

private practice? When do we do domiciliaries, examine in qualifying or higher examinations, interview applicants for a job, edit journals, referee papers, work as an officer in a royal college, or lecture to nurses or postgraduates at other hospitals—to mention only some of the necessary functions of many consultants? The extension of this principle to university and Medical Research Council staff could be quite unworkable.

The only thing wrong with our present contract is money. To sell our professional status for this new contract in the hope of sustained better pay would be an irreversible disaster for all consultants and for the eventual "care" of the community. The BMA must convince the Government that it needs a profession and not hourly paid plumbers, and pay us appropriately. This contract is a disaster whatever the immediate bribe to enslavement, and we have no wish to be party to it.

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ALAN G COX	J COLEMAN
R A WILKINS	M J DENHAM
G SLAVIN	M CRAWFORD
H GORDON	A D B WEBSTER
M CARNEY	J NUNN
P J SANDERSON	J S MILLEDGE
A M DENMAN	L LOWE
R L HIMSWORTH	D TAYLOR-ROBINSON
S K GOOLAMALI	J N BLAU
F M POPE	D PINTO
A B PRICE	T J CROW
M M LIBERMAN	I R MACFADYEN
A E KARK	J D LEWIS
E A HUDSON	G L ASHERSON
L KLENERMAN	E JOHNSTONE
J S GARROW	M GUMPEL
R W E WATTS	H MEIRE
D S SMITH	I CHANARIN
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T WELCH	E B RAFTERY
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* *A letter by Mr David Bolt on some aspects of the contract was published in last weeks *BMJ* (10 March, page 688).—Ed, *BMJ*.

Proposed consultant contract—equal pay for equal work?

SIR,—The new consultant contract proposed by the health departments discriminates against those consultants who work the largest number of scheduled clinical and laboratory sessions each week. Two notional half days (NHDs) are to be allocated without assessment, one in respect of a consultant's continuing responsibility for patients in his care and for his department and one in recognition of all administrative and management functions not separately remunerated. However, while the two additional NHDs are to be reduced pro rata for scheduled NHDs less than eight, they are not to be increased for scheduled NHDs in excess of eight. Thus scheduled sessions above eight will be remunerated at 80% of the basic rate. The effect on the value of all sessions that are worked is illustrated in the figure: as the number of timetabled sessions increases above eight the overall rate of remuneration for all active sessions declines. If the maximum of 13 scheduled sessions is allocated the remunera-