The makers of Pamergan, May and Baker, have had a total of five adverse reports on this drug between 1963 and 1976. Three of these involved neonates, one was a report of laryngitis associated with Pamergan use, and the fifth was a case of apnoea. I was unable to obtain the reference referring to this incident. No case was fatal.

The Committee on the Safety of Medicines have had four reports concerning Pamergan. None of them were really relevant to respiratory depression. The poisons unit at New Cross Hospital checked its case records and could find no incident of acute poisoning due to Pamergan.

To summarise, I have been unable to find figures comparing the relative frequency of vasovagal faints during the insertion of an intrauterine contraceptive device and profound respiratory depression following parenteral Pamergan or pethidine. I agree that the former are rare, but, from the evidence (or rather the lack of it) that I have been able to find so far, profound respiratory depression seems to be even more rare. It is certainly important for anyone using Pamergan AP100/25 to have nalorphine ampoules available should it be necessary to use this narcotic antagonist to counteract respiratory depression.

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¹ Goodman LS, Gilman A, eds. *The pharmaceutical basis of therapeutics*, 5th ed. New York: Macmillan, 1975:266.

² Batterman RC. *Arch Intern Med* 1943;71:345-56.

³ Prescott F, Ransom SG, Thorp RH, Wilson A. *Lancet* 1949;i:340-4.

Placement of subnormal offenders

SIR,—Contrary to what Dr D A Spencer writes (8 December, p 1511), may I reassure readers that it remains the practice of this prison hospital to seek via the RHA consultant opinion on all court report cases which clinically appear to merit hospital admission, with a view to submitting positive medical recommendations to courts.

Regrettably we are experiencing considerable difficulty in obtaining beds both for subnormal and for ill defendants.

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False friends

SIR,—Peter Newmark's reference to *faux amis* or misleading cognate words (1 December, p 1405) opens up a subject that always strikes a chord with those colleagues struggling with their French, though one example he did not give is one he would almost certainly meet if pitchforked into a French family with academic connections: *passer un examen* is not to pass an examination in the sense we understand it but only to sit for it, and serious French examinations being what they are the chances of success may be slim. Congratulations should thus be withheld at this stage. *Succéder* — or *réussir à* would be the welcome words and occasion for rejoicing.

English seems to need fewer words than French, this being my own simple explanation why the BBC news in French is run through at literally breathless speed, even with some Franglais words to help matters along. None

the less there can be both delicacy and aptness in some French words. An old lady may, for instance, be *une dame d'un certain âge*, while "taking off" in the aeroplane sense is *décollage*, *colle* being glue, a feeling airline pilots know only too well—in the old days pilot experience was in terms of millions of miles flown whereas nowadays it is the number of times he gets off the ground without incident.

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Sodium valproate and platelet counts

SIR,—The report of the presence of platelet antibodies in the blood of patients on sodium valproate by Dr R M Sandler and others (8 December, p 1476) possibly explains the finding of reduced platelet counts without obvious thrombocytopenia in similar patients on sodium valproate. Following reports of occasional thrombocytopenia during sodium valproate therapy, platelet counts were included in 1469 full blood counts made between January 1978 and May 1979 on blood samples received from hospitals dealing entirely with epileptic and non-epileptic mentally handicapped patients.

While the mean platelet counts for non-epileptics and epileptics treated with anti-convulsants other than sodium valproate were not significantly different ($p > 0.05$), the mean platelet counts from epileptics not on sodium valproate and from epileptics on sodium valproate were significantly different ($p < 0.02 > 0.01$). We have no explanation for a second finding in our investigation—namely, that the second platelet counts in our patients were significantly higher than the first counts. It is tempting to suggest that our request for care during venepuncture and mixing of blood samples may have had some influence. If this is true, then our new Coulter Super Plus Counter, which automatically counts and sizes platelets in addition to the other measurements, may give an answer to this problem.

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Long-term outcome after severe head injury

SIR,—The report by Mr Walpole Lewin and others (15 December, p 1533) on the long-term outcome after severe head injury they observed in 291 survivors out of 479 patients with prolonged amnesia or unconsciousness lasting a week or more is of considerable interest. Their results closely agree with our observations of severe head injury among patients in Sweden, details of which we hope to publish later. Out of 295 consecutive patients admitted to the intensive care unit in Sundsvall, Sweden, between 1961 and 1977, all with severe head injuries (criteria for admission unconsciousness or decerebration lasting more than half an hour), 40% died, although age was a critical factor.

Of the 117 Swedish survivors who were subsequently traced, 14% were in permanent institutional care or in receipt of a permanent disability pension. In the Oxford series 12% were classified as severely disabled or worse. In the Swedish series 44% of the follow-up

group (25% of admissions) had no residual symptoms; in the Oxford group 20% only had no residual disability. The similarity of results would suggest that, given appropriate medical and nursing care, the probable outcome can be predicted within an hour of injury rather than after a week, but that if unconsciousness becomes prolonged there is an increased likelihood that the patient will have a residual neurophysiological disability, if he survives—in the Swedish series 64% of the 121 patients who were unconscious the day after injury died.

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An academy of medicine

SIR,—Having written in support of an academy of medicine in 1973¹ I am stimulated to comment on your leading article on this subject (22-29 December, p 1611), which merits special attention and whose main theme I strongly support. Over the years I too have found that there is no generally recognised source of medical and allied opinion on many of the problems confronting the National Health Service.

While individual royal colleges are more numerous than before the second world war, in my view not all of these speak for a really narrow segment of medical opinion. For example, the Royal College of Physicians and Surgeons of Glasgow includes in its membership and fellowship a wide variety of hospital physicians and surgeons, including dental surgeons, pathologists, radiologists, and also general medical and dental practitioners working outwith hospitals.

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¹ Blackburn EK. *Br Med J* 1973;iii:181.

Tamoxifen-induced hypercalcaemia and response to treatment

SIR,—During the last 25 years it has been debated whether hormone-induced or exacerbated hypercalcaemia in women with advanced breast cancer and bone metastases is a predictive factor for response. The literature contains conflicting evidence and there have been suggestions that this phenomenon may precede a good response or, more commonly, a poor one to treatment with oestrogens, androgens, or progestogens.¹⁻⁴

In the report by Dr A H Villalon and his colleagues (24 November, p 1329) concerning tamoxifen-induced hypercalcaemia four cases are reported. In only two cases was tamoxifen continued and in one of these it was in combination with chemotherapy. Thus only one patient (with an oestrogen-receptor-positive tumour) was assessable for response to tamoxifen alone. Moreover, all patients received prednisolone for an unspecified period and this steroid does occasionally produce sclerosis in bone metastases as shown by Stoll⁵ and our own unpublished observations. Hence this report does not provide acceptable evidence that tamoxifen-induced hypercalcaemia predicts a tumour response to this agent. While we have seen one patient who had a remission following tamoxifen-induced hypercalcaemia,⁶ four other patients

who continued treatment with tamoxifen alone did not have a response.

We agree that tamoxifen-induced hypercalcaemia probably is not uncommon, but as yet there is no firm evidence to support the suggestion that induced hypercalcaemia is indicative of a good response to tamoxifen or other additive hormones used in the treatment of breast cancer.

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- ¹ Kennedy BJ, Tibbetts DM, Nathanson IT, Aub JC. *Cancer Res* 1953;13:455-59.
- ² Pearson OH, West CD, Hollander VP, Treves N. *JAMA* 1954;154:234-9.
- ³ Hall TC, Dederick MM, Nevinny HB. *Cancer Chemother Rep* 1963;30:21-3.
- ⁴ Heuson JC. In: Atkins H, ed. *The treatment of breast cancer*. Lancaster: Medical and Technical Publishing Company, 1974:128-9.
- ⁵ Stoll BA. *Hormonal management in breast cancer*. Tunbridge Wells: Pitman Medical Publishing Company, 1969.
- ⁶ Minton MJ, Cantwell BMJ, Knight RK, Rubens RD, Hayward JL. *Lancet* 1978;i:396-7.

A protection against beriberi

SIR,—In their article "Gastrology, the use of culinary terms in medicine" (22-29 December, p 1636), the authors venture that "throwing away excess water from parboiled rice must be a British trait."

This is in fact an age-old practice prevalent in Southern India and no doubt acquired by the British in the days of the Raj. The rice is boiled in an earthenware pot and the excess water put to a variety of uses or just discarded. It formed an excellent starch in the laundering of clothes. It was also the original base for the celebrated mulligatawny (Tamil pepper water) soup, which in its original form is a fiery liquid seasoned with chilli and garlic and recommended as an aid to digestion.

The pernicious habit of discarding the excess water from the rice is in fact contributory to the beriberi prevalent in the area, later aggravated by the introduction of machine polishing of rice. This is highlighted by an interesting episode from the Carnatic Wars. Robert Clive, a few English officers, and a force of native sepoys were besieged for a prolonged period at Trichinopoly. The sepoys, as a token of their loyalty, gave the officers the rice and subsisted on the congee or excess water in which it was cooked. The English began to develop symptoms of beriberi while the sepoys remained relatively healthy.

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Thrombocytosis, circulating platelet aggregate, and neurological dysfunction

SIR,—Although the connection between neurological dysfunction and platelet dysfunction described by Dr F E Preston and others (15 December, p 1561) is most probably vascular, the possibility of a common cause in an abnormality of prostaglandin production has not been excluded. Prostaglandins are known to have effects on platelets and on neurones and to respond to treatment with aspirin, which these patients all received. Perhaps a continuation of their studies

accompanied by prostaglandin estimations may elucidate the question.

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If I was forced to cut

SIR,—The articles published by a special correspondent in the series "If I was forced to cut" have all produced suggestions for making savings and also drawn attention to aspects of the individual specialties of the doctors interviewed which they feel must be protected or expanded.

The "more penetrating analysis" by Dr D L Freedman (15 December, p 1589) suggests that the first method to make overall savings of Health Service finances should be to reallocate available resources to departments which are economically essential. The only example quoted is the withdrawal of rehabilitation resources from geriatric medicine. Less than 5% of patients referred to an active department of geriatric medicine will require long-stay care. This is one of the more expensive forms of treatment provided by the NHS and your leading article (p 1532) states that it probably costs more for each long-stay patient than for a heart transplant. Withdrawal of rehabilitation services from geriatric medicine will lead to a marked increase in the numbers requiring long-stay hospital beds.

The rising proportion of the very old in the population, with their higher need for institutional care,¹ makes efficient use of hospital beds essential. It is not simply the number of beds which is important but the quality of hospital care and of supporting services. Scotland has a geriatric bed norm of 15 beds per 1000 over 65,² compared with the unmet English norm of 10 beds per 1000 over 65. Even where departments of geriatric medicine in Scotland have this greater number of beds, waiting lists for transfer from other hospital departments and from the community exist.³⁻⁵

It has been clearly shown in England that in active departments of geriatric medicine which have less than 10 beds per 1000 over 65 but whose beds have full access to district general hospital rehabilitation and investigatory facilities it is possible to provide a full service without a waiting list.⁵⁻⁷ This both benefits the ill elderly person and produces considerable financial savings for the NHS. It has also been achieved without excessive provision of community supporting facilities and is not simply a case of transferring the cost to a different authority.

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- ¹ Clark M, Hughes AD, Dodd KJ, et al. *Health Trends* 1979;11:17-20.
- ² Department of Health for Scotland. *Hospital Plan for Scotland*. Cmnd 1602. London: HMSO, 1962.
- ³ McAlpine CJ. *Br Med J* 1979;ii:646-8.
- ⁴ Wilson LA. *Br Med J* 1979;ii:939-40.
- ⁵ O'Brien TD, Joshi DM, Warren EW. *Br Med J* 1973;iv:277.
- ⁶ Hodgkinson HM, Jefferys PM. *Br Med J* 1972;iv:536-9.
- ⁷ Bagnall WE, Datta SR, Knox J, Horrocks P. *Br Med J* 1977;ii:102-4.

Medical audit and clinical competence

SIR,—I was interested to read Dr I J T Davies's comments on audit (5 January, p 49). He writes, "We should realise that audit as

generally understood denotes the process of identifying individuals whose standards of practice fall below the minimum acceptable to the majority. It has little or nothing to do with promotion of the highest standards of competence. . . ."

If looked at in the manufacturing context of quality control, I agree with him. But in the medical sense it is too narrow a definition. Audit may be concerned with the structure surrounding, the process of, and outcome derived from medical decision making. Whatever method or methods of audit are used, they should certainly expose sub-standard situations. However, in addition, for those whose standard of practice is already satisfactory, audit allows an appraisal of their work in the hope and expectancy that the mere satisfactory may be converted into good or excellent. The word audit is as good a word for expressing this as any other. I accept that many have been doing this for years.

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Payment for general practitioners in hospitals

SIR,—I fail to understand how the chairman of the GMSC Hospitals Subcommittee (5 January, p 51) can claim that Circular HC(PC) (79)5 was "overwhelmingly welcomed" by the Conference of Local Medical Committees since it was not published until two months later.

My own recollection is that representatives barely had time or opportunity to study the report of the Review Body, which gave the first official indication of what was to come. That report commented adversely on the lack of sufficient information on which to price satisfactorily the new arrangements but gave only the barest outline of what the arrangements were. Maybe there was some cause for congratulation at progress made after 30 years, but in the absence of detailed information this can hardly be interpreted as unqualified approval.

If "the vast majority of general practitioner hospitals have provided a casualty service for which they received no payments," talk of increased payments, many "of the order of several hundred per cent," is meaningless. What is important is that the new arrangements should provide the proper rate for the job. My LMC is not convinced that this is possible within the framework laid down in the circular and has sent the GMSC a detailed list of criticisms.

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Pay of related ancillary workers

SIR,—My wife and I should like to thank publicly Michael and Mary Glanvill for their spirited and courageous fight for related ancillary pay. That it has been curtailed by the decision of the Court of Appeal (15 December, p 1595) does not detract one iota from the determination they have shown over 13 long years, despite the dejection and frustration felt by the lack of support from the BMA and GMSC.