with angina pectoris, especially for patients unable to tolerate beta-blockers. Even if the occasional patient does develop side effects such as those described, the fact that these are easily recognised and, in our experience to date, have always been reversible should provide reassurance to those who have doubts about prescribing this drug because of the development of neuropathy.

D M FRASER
HUGH C MILLER

Royal Infirmary,
Edinburgh

¹ Fraser, D M, Campbell, I W, and Miller, H C, *British Medical Journal*, 1977, 2, 675.

Treatment of arthritis associated with psoriasis

SIR,—As a dermatologist, may I comment on several points in your leading article on this subject (4 February, p 262)? It is true that chloroquine can occasionally convert localised psoriasis into a generalised exfoliative state, but a better reason for not using this drug is the hazard of irreversible retinopathy with long-term treatment. Prednisolone, even in the 2.5-5.0 mg daily dose mentioned, can destabilise psoriasis too, so that in my view the indication for this drug needs to be stronger in the psoriatic with polyarthritis.

Regarding the hazard of joint infection after steroid injection through psoriatic skin, it should be recognised that psoriasis, unlike eczema, is rarely secondarily infected. Occasionally psoriatic scale carries pathogenic cocci, but if a bacteriological swab is negative the risk of joint infection should be negligible.

Turning to gold, I agree that documentary proof of its efficacy in psoriatic arthritis is lacking, but it is my own strong impression that the drug is as effective as in rheumatoid arthritis. Certainly psoriatics are not more prone to gold toxicity, dermatological or otherwise.

Lastly, I believe the statements on the toxicity of methotrexate are somewhat misleading. Such statements are meaningless unless they distinguish between mild and severe and acute and long-term toxicity. In fact, in the dosage used generally for severe psoriasis or arthritis (0.2-0.4 mg/kg body weight given once weekly) nausea for 24-48 h following the weekly administration of the drug is much the commonest problem. Bone marrow depression is very uncommon and the cited acute gout, gastrointestinal haemorrhage, and perforation are all very rare. The real problem with long-term treatment is the hazard of the development of hepatic fibrosis and then cirrhosis.

HARVEY BAKER

Department of Dermatology,
London Hospital,
London E1

Choosing an antidepressant

SIR,—We were somewhat surprised to find that your recent leading article on this subject (21 January, p 128) contained no mention of their adverse effects in overdose. Tricyclic antidepressants account for about 20% of overdose admissions to our intensive care unit and about 10% of deaths from drug poisoning.¹ Concerned at this increasing problem, we have been monitoring the effects of the

newer antidepressants reported as overdoses to us. Maprotiline, like the tricyclic antidepressants, causes coma, convulsions, and cardiac arrhythmias.² Our observations on mianserin have now been extended to 44 patients and these confirm our original findings² that mianserin when taken in overdose does not cause the severe complications seen with tricyclic antidepressants. Similarly, follow-up of 28 cases of flupenthixol poisoning has failed to show any serious toxicity. The number of reported cases with the other new antidepressants has been too small for any definite conclusions to be drawn.

The incidence of self-poisoning in depressed patients cannot be ignored. In those with suicidal thoughts or with a history of a previous suicidal attempt it would seem more prudent to prescribe an antidepressant with lower toxicity than one of the well-tried antidepressants you recommend.

P CROME
R BRAITHWAITE
BRENDA NEWMAN
S MONTGOMERY

Poisons Unit and Department
of Psychiatry,
Guy's Hospital,
London SE1

¹ Office of Population Censuses and Surveys, *Mortality Statistics*. London, HMSO, 1977.

² Crome, P, and Newman, B, *British Medical Journal*, 1977, 2, 260.

Predictive tests in Huntington's chorea

SIR,—I am sure that many practitioners as well as myself are interested in and grateful for your updating of this important subject in your leading article (4 March, p 528). As you conclude, "There remains the difficult problem of the ethics of such testing. When a definitive test is eventually introduced—as will surely happen—its application will cause controversy."

Some of the main difficulties were described in a contribution "Huntington's chorea and pregnancy" you kindly published about a decade ago,¹ when I commented on the suggestion that Huntington's families "would have done all they could to avoid having children... had they been aware of the hereditary nature of the illness." Perhaps a quotation from that communication might be salutary and pertinent, particularly as very recently I had a case in which the particular strain of Huntington's chorea made itself evident later than usual—that is, at 44 years rather than some 34 years—further emphasising the appalling time factors in this "potential time-bomb" disease."

"The main problems here are those of prediction at as early a stage as possible, and then consideration of what recommendations can or should be made in the individual case before the damage may be done.... Considering the possible mental anguish and the exceptionally high incidence of suicide in Huntington's families, the dilemma is whether it is humane and ethical to direct a young person's thoughts to the, at best (or worst), fifty-fifty chance that he or she might deteriorate into the condition witnessed in a relative, and should govern life accordingly. Thus an individual who might never have consciously or otherwise contemplated the possibility of personal involvement might have life and hope blighted, and survival without development of the disease might be little compensation for a lifetime of anxiety, dread, and single status.

"The essential differences from the more usual decision, whether or not to tell a patient of his malignancy, are the inevitability and limited

duration in those cases, compared with the fifty-fifty uncertainty and possibly several decades of waiting involved in Huntington's chorea, with both the individual and his potential progeny possibly being involved. I wonder how others manage these problems. Who is actually to tell the individual (possibly a genetic counselling clinic), and, apart from the sympathetic factual approach, does one attempt to gradually orientate the patient and hope for more peaceful acceptance, including the possibility of sterilisation, or could guidance be effectively given discreetly through other relatives or through friends? I have used various of these methods, each case being considered and tackled individually, but I feel that there must be very careful thought for the actual present as well as for future possible generations."

Rightly do you suggest that "the time has come when we should debate possible guidelines for handling the results before the [predictive] test is introduced."

MONTAGUE SEGAL

Halifax General Hospital,
Halifax, W Yorks

¹ Segal, M, *British Medical Journal*, 1968, 2, 48.

Vitamin E in treatment of Huntington's chorea

SIR,—Mrs Margery Hall's comment (18 February, p 446) on our report (21 January, p 153) of a trial of vitamin E in Huntington's chorea calls for a reply.

We were not attempting a comparison of a dietary alteration but merely the comparison of large doses (80 times the recommended daily intake) of tocopheryl acetate with placebo on the symptoms of the disease. Hoffer's observation¹ was of a single, open, uncontrolled case; our trial was an attempt to investigate the claim that large doses of vitamin E have an effect and this we did by a recognised controlled, double-blind, cross-over technique which, whatever its shortcomings, is of potentially more scientific value than a clinical impression gained on one patient.

ADRIAN CARO
SHEILA CARO

Huntington's Chorea Research
Project (East Anglia),
Dereham Hospital,
East Dereham, Norfolk

¹ Hoffer, A, *Journal of Orthomolecular Psychiatry*, 1976, 5, 169.

Blood pressure and kilopascals

SIR,—We were disturbed to read the article by Dr John Price (4 March, p 554) supporting the measurement of blood pressure in kilopascals.

We have had several examples of confusion in clinical practice since the International System of Units was introduced into clinical chemistry here, despite comprehensive instruction of staff and issue of nomograms and conversion tables. However, it is an accepted fact that the change has taken place and it would probably cause more confusion to change back than to continue as at present.

There is a certain logic in the use of the mole, but we fail to see any logic in the practical use of the kilopascal. This is a theoretical physical concept and as such may be useful to physicists, but in clinical practice we measure blood pressure by the height of a column of mercury which is measured in

millimetres. If Dr Price or anybody else can produce a genuine pascal meter we would be interested to see it. We are most alarmed by the prospect of considerable confusion which could be dangerous to patients if this unit is introduced for measuring blood pressure.

BARCLAY C ABERNETHY
A TODD
D D KENNEDY

Fife Area Laboratory,
Kirkcaldy, Fife

Radiological protection of the thyroid

SIR,—There is an increase in the use of radiopharmaceuticals labelled with iodine-125 (half life 60 days). In most clinical nuclear medicine procedures the radionuclide is released gradually from the pharmaceutical, and this is the case with labelled fibrinogen, which is now widely used in the investigation of coagulation disorders.

Practice varies with regard to blocking of the thyroid with stable iodine and we have modified our practice^{1,2} to make certain that the radiological hazard to the thyroid is kept to an absolute minimum. Our practice now is to give a tablet of potassium iodide (60 mg) at least one hour before the commencement of an investigation using ¹²⁵I-fibrinogen and then to give a further tablet each Monday, Wednesday, and Friday for the following four weeks.

We appreciate that our approach is more than strictly necessary and perhaps inconvenient to staff and patient. We are confident, however, that the thyroid uptake of radioiodine in these circumstances is negligible and there is no radiological effect.

WILLIAM R GREIG
C R M PRENTICE

Department of Nuclear Medicine,
Royal Infirmary,
Glasgow

¹ Prentice, C R M, in *Recent Advances in Clinical Nuclear Medicine*, ed W R Greig and F C Gillespie, p 133. Edinburgh, Churchill Livingstone, 1975

² Negus, D, et al, *British Journal of Surgery*, 1968, **55**, 835.

Staff representation in the NHS

SIR,—May I express my complete agreement with Scrutator's comment in "The Week" (18 March, p 730)? For it is also my view that "a much more radical reform of staff representation in the NHS is needed than the tinkering with existing Whitley councils proposed in [Lord McCarthy's] report."

LAURIE PAVITT

House of Commons,
London SW1

Distinction awards

SIR,—My experience of the working of the distinction awards system as a one-time member and chairman of a local committee is so much at variance with that of Mr B H Price (11 March, p 652) that I must state my opinion. As I have now been long retired I

have no axe to grind except for the purpose of trying to chop down a system which I think has been dishonourable and discreditable to British public life, on account of its corruption and secrecy.

While it is common knowledge that awards have been given to those of high professional attainments, I am convinced that the system is also used to ensure amenability and docility towards the establishment. A consultant who is doing good work and who is thought worthy of an award by his colleagues may be denied one because he has stood up against authority because of what he considers to be the interests of his patients, while another consultant who is prepared to be a "yes-man," willing to toe the party line and spend his time in so-called "administration" instead of with his patients, may be sure of an award and other privileges.

Few can deny that the atmosphere of secrecy conflicts with the principle of "justice appearing to be done." The linking of a high award with the remuneration of a university chair or a senior clinical appointment would be acceptable to most and might attract more competition than has been the case in the past.

Surely the time has now come for professional opinion to be tested again, not by the kind of unsuitably worded and valueless BMA questionnaires of the past, but by asking a simple question such as, "Do you consider the present system of giving distinction awards should be continued?"

BRYAN WILLIAMS

Boxgrove, Sussex

In defence of the receptionist

SIR,—The "knocking" of family practitioners' receptionists has reached almost epidemic proportions recently in the wake of the sociological survey on their work which was commissioned by the Department of Health and Social Security, and surely it is high time practitioners stopped being apologetic about this problem and began to protest. With the existing system of completely open access by the patient to the family doctor a competent receptionist, advised by the doctor, is an essential part of the system, and without her few doctors would survive long enough to give the continuity of service which is the hallmark of good general practice.

It is indeed the maligned receptionist who creates order out of the chaos of limitless demand, thus ensuring the survival of the family practitioner service, let alone its effective continuity along with the preservation of the doctor's sanity and his coronary arteries. The receptionist is surely the only way in which a fair sorting out of the demands of the patients can be met. Somehow, somewhere along the line, priority must be worked out between the patients whose medical needs require attention and those whose needs are less immediate; between the patient who is really unfit to come along to see the doctor and the patient who is either just unwilling or uncertain. To suggest, as is frequently done, that a patient should have direct access to the doctor during consulting hours in order to state his claim for priority shows a lamentable ignorance of the sustained clinical activity required of the doctor during his attendance at the surgery.

We must make it clear that the doctor's receptionist does a specialised and essential job under circumstances which are often difficult and sometimes unpleasant. Is it too

much to ask the DHSS to help promote greater understanding of the receptionists' problems so that patients can be more co-operative and the service can thus run more smoothly, to the patients' advantage?

D M BRIERLEY

Worcester

Is the GP really necessary?

SIR,—I have read with interest Dr I F M Saint-Yves's letter (11 March, p 653), because I have been pondering just this thought. I wonder whether he would develop his thinking for us. He seems to suggest that a general practitioner becomes a generalist within hospital facilities of the sort we were accustomed to call general physician or general surgeon. This may be right. Thought needs to be given to our new direction.

The past 100 years have seen the conquest of infection via sanitation, then antibiotics. It may well be that to a great extent we can leave its daily application to others. Our job is at the frontiers of medicine, to recognise and explore new problems and answers. This means a global awareness of the hazards that confront the earth's and man's condition today. I wonder whether we have really taken this on yet. The doctor's job is more than care; this is the special province of other vocations. Our job is the ceaseless search for cure. What then is the relationship between the earth's sickness and man's sickness?

A development of view in GPs and their practice of medicine of the dimension suggested by Dr Saint-Yves would renew heart in their work and free them from static parochialism. It would also give the needed job satisfaction to our increasingly skilled paramedical staff.

MARGARET MARSH

South Croydon, Surrey

Devolution and the BMA

SIR,—The Scottish Council of the BMA is opposed to the devolution of the Health Service. However, so far as I am aware, the Scottish members of the BMA have not been approached on this vital issue and thus Council does not have the necessary authority to speak on their behalf. I, for one, strongly support devolution, especially in medicine. If the Scottish members are not to be consulted, this leaves them with but one alternative, to resign from the BMA, if they support devolution.

IAN F M SAINT-YVES

Menstrie,
Clackmannanshire

*.*The Scottish Secretary writes: "On 8 January 1976 all Scottish Divisions were asked to send in comment on the White Paper 'Our Changing Democracy: Devolution to Scotland and Wales.' Next Scottish Council considered devolution and agreed a report which was published in full in the *BMJ* of 20 March 1976. Then in July 1976 at the Annual Representative Meeting in London, which included 54 Scottish Representatives, the report was approved unanimously. Since the Bill was published I have received some 10 letters from doctors objecting to the report of Scottish Council."—ED, *BMJ*.