CORRESPONDENCE

If my wife had cancer of the breast T B Brewin, FRCP; A R Kittermaster, FRCPATH	1050
Hyperprolactinaemia and pituitary tumours W F Kelly, MRCP, and G F Joplin, FRCP..	1050
Safety in laboratories J M Harrington, MD.....	1051
No-fault liability M D A Vickers, FFARCS; J L Taylor, MB..	1051
Antibiotic-associated colitis T T Irvin, FRCS; S Behrman, FRCP....	1051
Intravenous diazepam and Cyclimorph A S Gardiner, FFARCS.....	1052
Treatment of Q fever W P G Turck, FRCP.....	1052
A misleading name? H Berry, DM.....	1052
Prediction of gangrenous and perforating appendicitis in children D P Drake, FRCS, and J G Knott.....	1052
Bromocriptine in presenile dementia P Phuapradit, MRCP, and others.....	1052

VD journals Joyce Wright, DM.....	1053
Exotic diets and the infant A Long.....	1053
Looking inside arteries A May, FRCS.....	1053
Treatment of tuberculosis D Robinson, MD.....	1053
Pneumonia D Craddock, FRCGP.....	1054
What kind of cot death? D R Chambers, MB, and others; P J Elton, MB.....	1054
Age and urine concentration after desmopressin J P Monson, MRCP, and P Richards, FRCP..	1054
Cure of heterophobia by sexual surrogate therapy C L Brewer, MRCPsych.....	1055
Fetal malformation after Debendox treatment in early pregnancy S Mellor, MRCP; R W Smithells, FRCP, and Sheila Sheppard, MB.....	1055

Who discovered the circulation of the blood? P G Benson, MB.....	1056
Topical glucocorticosteroids for psoriasis D B Brookes, MRCP, and R H Seville, FRCP	1056
Fellowship in medical communication? S J Golding, MB.....	1056
Continuing study for doctors? E A Williams, FRCOG.....	1056
Do we really care? A Tabbinor, FLIA.....	1056
Distinction awards B H Price, FRCS.....	1057
Functions and priorities of the BMA A M Mander, MRCOG.....	1057
Study of doctors' career decisions Rosemary Hutt, MA.....	1057
Redundant doctors T McFarlane, MRCOG.....	1057
Points from letters Origins of the OED (J W D Bull); Skateboard injuries (R M Watkins); Cauda equina tumours (G Symonds); New "Highway Code" (P Bowsher).....	1057

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

If my wife had cancer of the breast

SIR,—What a pity that Professor Harold Ellis (8 April, p 896) should inject an emotional and irrational note (I can talk like this because we were once registrars together) into an otherwise warm, sane, and balanced essay.

Mastectomy and local excision seem to be followed by similar survival rates, but local recurrences are fewer after mastectomy. Post-operative radiotherapy and no postoperative radiotherapy are also followed by similar survival rates, but again the local recurrence rate is less after radiotherapy. Quite good evidence is available on both counts and the advantages and disadvantages of each choice seem to be rather evenly balanced. Professor Ellis seems at first to accept this. Then suddenly all his calm judgment and lack of prejudice fly out of the window and we hear that (although "a mutilating operation will be required") he will be "very anxious indeed" (my italics) "for his wife not to be irradiated at this stage."

I am reminded of another surgeon writing about breast cancer 20 years ago who spoke on one page (if I exaggerate I do so only very slightly, I promise you) of the remarkable and heartening response of 50% of advanced cases to adrenalectomy (his operation) and on the next page of how he could not recommend hypophysectomy (a treatment he was unable to perform himself) because it completely failed in half the cases in which it was tried.

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SIR,—Professor Harold Ellis (8 April, p 896) presents a soundly conventional approach to

the treatment of a woman with breast cancer, but why was a male surgeon selected to write on this subject under the general heading of "If I had . . ." ? I hope a woman surgeon will be invited to give her views on breast cancer in the near future—or has she already been retained for "If my husband had carcinoma of the prostate" ?

Having said that, as a histologist endlessly intrigued by the differing inflammatory and fibrotic reactions round cancer cells—and as a morbid anatomist too often seeing the best-laid plans of mice and men go sadly astray—may I air a less conventional male view on breast cancer? I believe, if I were a woman and if I had clinically localised cancer of the breast, I would not have a mastectomy. I would have a lumpectomy, probably not thereby altering my life expectancy but certainly leaving me a "complete" person. Also my whole family and circle of friends would not necessarily know that I had cancer, as they would follow a mastectomy. These advantages I would gladly accept against an undetermined increase in the odds of a local recurrence. I would look to my general health in the belief that this affects the natural defences against cancer and I would not damage those defences by taking cytotoxic immunosuppressants. Finally I would inquire from my biochemist colleagues what non-toxic substances—such as amino-acids—are needed for the formation of the complex proteins that are cancer antibodies. I would then take a cocktail of "essence of antibodies" once a day in the firm belief that it would help my body fight my disease.

Off beat, and some would say a gamble; but the whole of life is a gamble, so I would want to back the horse which offered the only reasonable chance of a complete cure. With

support from their medical and surgical advisers perhaps some women might feel the same?

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Hyperprolactinaemia and pituitary tumours

SIR,—We read with interest the article by Dr T Bergh and others (8 April, p 875) describing the outcome of drug-induced pregnancies in women with prolactin-secreting pituitary tumours.

Since none of the women had pituitary surgery or radiotherapy, the publication of complications of tumour expansion during pregnancy is of major importance now that bromocriptine is available to induce fertility. Seventeen pregnancies went to term in 14 women; there were symptoms of visual defects in two patients and severe headache developed in a third patient; two patients had radiological evidence of expansion of the sella turcica; a total of four patients were judged to have had features of tumour expansion out of the 25 pregnancies observed.

In an attempt to prevent tumour expansion during pregnancy and yet not to impair fertility we have treated a comparable series of 21 young women with low-dose (20 000 rads) pituitary implants of yttrium-90. Follow-up is from one to 76 months (mean 27). There have been no complications arising from the operation and no significant impairment of other pituitary functions if normal before operation. There was, however, a significant fall in median serum prolactin concentration by 60% as at the latest assessment ($P < 0.01$), which compares favourably with published results of transfrontal and trans-sphenoidal surgery.¹ Thirteen of our patients desiring fertility have been followed up with these results: nine (70%) became pregnant, and, since four patients became pregnant twice, a

total of 13 pregnancies have occurred, in three cases without any additional therapy. Of the 13 pregnancies, 10 have so far resulted in live births, one is continuing, and there was one first-trimester miscarriage and one therapeutic termination. No symptoms of pituitary tumour expansion occurred in any of these implanted patients; visual acuity and visual fields were rechecked and fossa radiographs were repeated without evidence of deterioration.

We would like to point out that the hazards of radiation treatment mentioned by Dr Bergh and his colleagues (references 45-48 dealing with visual loss, brain necrosis, and development of sarcomata) all apply to the use of external irradiation and not, as might be inferred from the text, from yttrium-90 implants.

In summary, we believe that low-dose implantation of yttrium-90 can be regarded as a useful form of treatment in young women with prolactinomas who desire fertility and that tumour expansion in these treated patients is less likely. We are currently preparing a detailed report for publication.

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¹ Von Werder, K, et al, *Journal of Endocrinological Investigation*, 1978, 1, 47.

Safety in laboratories

SIR,—In your leading article (8 April, p 871) your assumption that "there is no evidence that laboratory-acquired infections are still a serious problem in laboratories of hospitals and the PHLS" is based on meagre evidence indeed. During the course of a three-year study of health and safety in British medical laboratories I was astounded at the wide variation in the safety standards obtaining in such laboratories. Hard facts about the occupational risks from common infectious agents are difficult to assemble and have never been adequately compiled. Pulmonary tuberculosis, however, is five times more common in medical laboratory workers than in the general population.¹ We found no evidence of excess mortality from infectious disease, though there did appear to be an excess risk of dying of lymphoma or committing suicide.²

Perhaps more disturbing in view of the ignorance of risks related to common infections were the findings that safety cabinets and centrifuges were rarely serviced appropriately, that 65% of laboratories permitted mouth pipetting, and that the compulsory use of protective clothing for specific purposes was rarely invoked.³ In a prospective study of a random sample of 12% of NHS and PHLS laboratories infective and parasitic diseases were the chief cause of time off work.⁴ This was primarily due to diarrhoeal illness and was significantly in excess of comparable populations working for two large public undertakings not handling infectious material. Regarding accidents resulting in injury, such events affected one in four laboratory workers in the course of a year—mainly due to lacerations to the hands, face, and eyes.⁵

In view of these findings it is surprising that laboratory workers seem to maintain such good health. They certainly seem to be at high risk, inflicting considerable injury upon themselves, and have markedly increased rates of

diarrhoeal disease. Further research is clearly needed, but the current position leaves no grounds for complacency.

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¹ Harrington, J M, and Shannon, H S, *British Medical Journal*, 1976, 1, 759.

² Harrington, J M, and Shannon, H S, *British Medical Journal*, 1975, 4, 329.

³ Harrington, J M, and Shannon, H S, *British Medical Journal*, 1977, 1, 626.

⁴ Harrington, J M, and Shannon, H S, *Proceedings of XVIIth International Congress of Occupational Health*, Brighton, 1975.

⁵ Harrington, J M, MD Thesis, University of London, 1971.

No-fault liability

SIR,—I would like to congratulate you on your leading article on this topic (1 April, p 805) and commend the matter once again to the BMA for consideration. The BMA gave evidence to Lord Pearson's Royal Commission on Civil Liability and Compensation for Personal Injury¹ and advised against introducing the concept of no-fault compensation for injuries consequent on medical treatment.² However, an article by your legal correspondent shortly afterwards warmly supported it.³

Anaesthetists have a particular interest in this matter: there is quite a spectrum of accidents in which fault is difficult to identify or quantify, and a "forensic lottery" is most unsatisfactory as an element of public policy. The full lessons of an accident may not be learned by the profession at large for a very long time if the facts cannot be publicly admitted because of fears over possible litigation. For these and other reasons, the Association of Anaesthetists of Great Britain and Ireland supported no-fault compensation for medical accidents in its evidence to the Royal Commission. While the commission, having agreed with the BMA, may now feel irked to be castigated for its "disappointing recommendations," it is heartening to think that opinions may now be changing.

You are also right to draw attention to the problem of compensation for volunteers injured as a consequence of medical research. To restrict compensation to instances where causality can be proved is to exclude a substantial part of the potential problem. It is to be hoped that Lord Pearson's recommendations will be the subject of active and informed debate within the profession. The decision to accept or not accept them could have a most profound impact on medical practice in this country.

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¹ Annual Report of Council, 1974-5, *British Medical Journal*, 1975, 2, 216.

² BMA evidence to the Royal Commission on Civil Liability and Compensation for Personal Injury, 1974.

³ *British Medical Journal*, 1975, 4, 529.

SIR,—It is unfortunate that your leading article "No-fault liability" (1 April, p 805) should repeat the common misconception that since April 1974 the tort of negligence in respect of personal injuries has ceased to exist in New Zealand.

The position is that where a claim in respect of an injury is accepted by the Accident Compensation Commission then the claimant

may not proceed in tort. The court has also the discretion to refer claims to the commission. Cases do arise, however, in the medical as well as in other spheres where the commission rejects the claim on the grounds that it did not arise from an accident as defined in the Act. In such circumstances it remains open for the claimant to sue in negligence so that the situation is that a doctor still requires cover against the risk of negligence actions.

You also tell us that the profession will have to think deeply about the "recommended strict liability for dangerous drugs." The commission's recommendation is that there should be strict liability for all drugs, which perhaps requires the profession to think still more deeply.

J LEAHY TAYLOR

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*.*We did not say that the tort of negligence in respect of personal injuries has ceased to exist in New Zealand. What we said, correctly, is that the right to claim damages for accidental injuries has been abolished. Certainly doctors will still be open to actions in negligence for injuries held not to be accidental and, for example, where negligent failure to diagnose an illness allows it to run its natural course unchecked. Our comment on strict liability for dangerous drugs should have read "for dangers from drugs."—ED, *BMJ*.

Antibiotic-associated colitis

SIR,—Dr A Kappas and his colleagues at the General Hospital in Birmingham have noted that there appears to be an unusually high incidence of pseudomembranous colitis in their practice (18 March, p 675). This they attribute to improved diagnosis. What they do not appear to have considered, however, is that the use of antimicrobial agents at this hospital may also be unusual. In 15 patients developing pseudomembranous colitis after colorectal surgery a total of 53 antimicrobial agents were used either before or after operation.

The choice and use of postoperative antibiotics are governed by the judgment of the individual clinician, but perhaps the time has come to reappraise the use of prophylactic therapy. The use of preoperative antibiotics is based on the evidence that it leads to a reduced incidence of postoperative wound infection, but there is little evidence that such treatment prevents complications in healing colorectal anastomoses. Abdominal wound infection is rarely a life-threatening problem. Pseudomembranous colitis is a serious problem, and if the prophylactic use of antibiotics in surgical patients is a significant factor in the pathogenesis of this disease I would suggest that it be discontinued.

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SIR,—Your leading article (18 March, p 669) on this topic is both illuminating and timely. If diarrhoea is accepted as the first clinical manifestation of this disorder the latter calls for ever-present vigilance when antibiotics are prescribed, since the incidence of diarrhoea was found to be around 20% in two series of