was careful to point out that an allergic reaction to the infused blood or plasma could not be excluded.

Formal patch-testing conducted on the patient in question failed to evoke a response to nickel, dichromate, or cobalt. The results of patch-testing to gold leaf and gold chloride (1% aqueous solution) were also negative. The lack of response to the application of gold leaf or ring scrapings was also noted by Comaish,² and in a review of the literature of contact hypersensitivity to metallic gold Young³ found that patch-testing was often positive only to gold salts rather than metallic gold and often positive with one salt and not another. I regarded the administration of sodium aurothiomalate as a form of exposure to gold salt in a woman one might have regarded as being allergic to gold jewellery.

NORRIS RENNIE

Centre for Rheumatic Diseases,
Glasgow

¹ Stoddart, J C, *Lancet*, 1960, 2, 741.

² Comaish, S, *Archives of Dermatology*, 1969, 99, 720.

³ Young, E, *Dermatologica*, 1974, 148, 294.

Lymph-node puncture

SIR,—I have used the ordinary disposable Gillette venepuncture needle size 19G × 2 for doing lymph-node punctures and have found it more useful than the conventional lymph-node puncture needle with the stylet.

The advantages are: (1) it is a disposable needle and easy to hold when attached to a syringe; (2) a local anaesthetic is not required; (3) even a small lymph node can be successfully punctured; (4) a sufficient amount of material is easily obtained by a few forward and backward movements of the needle inside the lymph-node substance; and (5) it does not distort the morphology of the lymph node, so that the same node can be removed for a proper histological examination if required.

P C SRIVASTAVA

Burton District Hospital Centre,
Burton-on-Trent, Staffs

Chemoprophylaxis of malaria

SIR,—In his letter (1 January, p 49) commenting on your recent leading article on this subject (20 November, p 1215) Professor W Peters asks what recommendations this company is now making for Fansidar, particularly with regard to the dosage in non-immune subjects.

Our current prescribing information for the drug does include recommendations for its prophylactic use in high-risk subjects in areas where resistance to other antimalarial agents is known to occur or in cases of chloroquine intolerance. For semi-immune subjects the recommended dosage interval is once every four weeks—a regimen for which there is ample evidence of efficacy, as indicated in your reply to Professor Peters. For non-immunes the evidence we have is that the once-weekly dose of one tablet and the once-fortnightly dose of two tablets are equally effective; the choice between these regimens rests on patient preference or convenience.

The work in non-immunes is still largely unpublished except for the extensive study by Ebisawa *et al*¹ among Japanese and native dam construction workers in Laos, in an area

where chloroquine resistance was known to occur. The study incidentally underlines the importance of regular dosage by non-immunes; the few instances of breakthrough infection recorded in this group on the weekly prophylactic regimen over an 18-month period were all attributed to missed doses.

The occasional breakthrough infections observed during Fansidar prophylaxis in south-east Asia have nearly always been due to *Plasmodium vivax* and are effectively suppressed by the subsequent dose of the drug.^{2 3}

I hope this will serve to put our position on record.

VICTOR BERGSON
Medical Adviser,
Roche Products Ltd

London W1

¹ Ebisawa, I, *et al*, *Japanese Journal of Experimental Medicine*, 1971, 41, 209.

² O'Holohan, D R, and Hugoe-Matthews, J, *South-east Asian Journal of Tropical Medicine and Hygiene*, 1973, 2, 164.

³ Lewis, A N, and Ponnampalam, J T, *Annals of Tropical Medicine and Parasitology*, 1975, 69, 1.

Subclinical hypothyroidism

SIR,—Professor R Hoffenberg writes an excellent review of Dr D C Evered's monograph on diseases of the thyroid (15 January, p 176). I was interested in Professor Hoffenberg's "personal protest against the continued use of the term 'subclinical hypothyroidism.'" He expresses fear that "its acceptance will only give rise to misunderstanding and unnecessary thyroxine therapy." Some other thyroid experts share his view, but unnecessary thyroxine therapy based on a misunderstanding can scarcely be an adequate reason for rejecting the validity of a concept.

Nilsson *et al*¹ do not question the validity of subclinical hypothyroidism (or premyxoedema) but are rightly more concerned with the practical significance of the condition. Their study offered no support for my contention that hypercholesterolaemia can be a premonitory sign of hypothyroidism.² Other leading investigators such as Hall's group in Newcastle³ or Bastenie in Brussels⁴ have failed to relate an increased incidence of coronary artery disease in autoimmune thyroiditis to hypercholesterolaemia. I continue to see patients suffering from premyxoedema with hypercholesterolaemia and degenerative arterial disease.⁵⁻⁷ Recently Professor Baschieri⁸ and his colleagues in Pisa and Padua have found that 31% of unselected patients with hypercholesterolaemia have a raised basal serum thyroid-stimulating hormone (TSH) concentration or an exaggerated response of TSH to the thyrotrophin-releasing hormone. Those who know Professor Baschieri's work will protest against any summary dismissal of a concept that may play a key role in the prevention of degenerative arterial disease.

P B S FOWLER

Charing Cross Hospital,
London W6

¹ Nilsson, G, Nordlander, S, and Levin, K, *Acta Medica Scandinavica*, 1976, 200, 63.

² Fowler, P B S, and Swale, J, *Lancet*, 1967, 1, 1077.

³ Tunbridge, W M G, *et al*, VII International Thyroid Conference, Boston, USA, June 1975.

⁴ Bastenie, P A, *et al*, *Lancet*, 1971, 1, 203.

⁵ Fowler, P B S, Swale, J, and Andrews, H, *Lancet*, 1970, 2, 488.

⁶ Ikram, H, Banim, S, and Fowler, P B S, *Lancet*, 1973, 2, 1405.

⁷ Greenwood, T W, and Fowler, P B S, *Proceedings of the Royal Society of Medicine*, 1976, 69, 225.

⁸ Baschieri, L, *et al*, *Revue Française d'Endocrinologie Clinique*, 1975, 16, 211.

Too many doctors and in the wrong places?

SIR,—The debate about RAWP¹ has died down and the special pleading by the London regions that shocked and astounded the rest of the country has been in large part successful. Mr David Ennals, like Sir Keith Joseph four years before him, believes it will take 10 years to redistribute the resources of the NHS. Perhaps equality in this as in so many things is a mirage.

One outcome of the discussion is the realisation that we may be producing too many doctors and that the geographical distribution of those we do produce is obviously faulty. We are all familiar with the argument that the need for medical treatment is never-ending and that there will always be work for doctors; the question is (as with school teaching), can our society afford to pay for such a bottomless demand at the salaries that professionals themselves feel represent their value and standing in the community? I doubt it.

Many of us in Manchester, struggling to teach a yearly clinical intake of 270 students, hardly dare to complain or question the need for such a vast output (and big is certainly not beautiful or easy in this context) when there is an obvious shortage of doctors in the north-west of England.

Greater London, historically the site of most English medical education, has a rapidly shrinking population. It might not be very important that London medical schools should continue to produce most of our profession if it were not that for very many of them outer darkness seems to start north of Potters Bar. A few graduates escape to the northern regions of their childhood but most are conditioned by a London education to stay in or near that city. Moreover, as has often been stated, a "centre of excellence" raises the standards of the whole of medicine in its vicinity.

Similar arguments apply to other cities and regions, which is why at Manchester we have reluctantly accepted 270 students in each clinical year. But why couldn't the redistribution have been brought about by opening two or three more clinical schools in the north at such places as Preston and Stoke and closing or transferring half the London schools? It takes about 10 years to create a "centre of excellence" in medicine and it takes almost as long to divert the output of new doctors from one region to another. Why not St Thomas's for Preston and Barts for Bolton? After all, the oil sheikhs could always fly into Ringway Airport.

PETER O YATES

Department of Pathology,
University of Manchester

¹ Department of Health and Social Security, *Sharing Resources for Health in England*. London, HMSO, 1976.

DHSS maternity leave

SIR,—I find it laudable that the Department of Health and Social Security, together with the profession, are currently endeavouring to encourage a return to breast-feeding as opposed to "the bottle" for our new generation of babies. The DHSS even go so far as to suggest that a minimum period of three to four months of mother's milk is best.

I was therefore disgusted to find that the DHSS maternity leave scheme demands that