report a low incidence of false-positive studies with thallium-201 imaging.

The cost of the investigation (about £45 for the isotope alone) probably precludes its use in the regular review of asymptomatic subjects. When, however, a pilot presents with atypical chest pain or an asymptomatic pilot has an equivocal ECG the demonstration of normal stress thallium-201 myocardial images may obviate the need for unnecessary coronary arteriography with its attendant risk.

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¹ Taradashi, M, *et al*, *Circulation*, 1976, **53**, suppl 2, p 217.

² Bailey, I, *et al*, *Circulation*, 1977, **55**, 79.

³ Lenaers, A, *et al*, *Journal of Nuclear Medicine*, 1977, **18**, 509.

⁴ Ritchie, J L, *et al*, *Circulation*, 1977, **56**, 66.

⁵ Rosenblatt, A, *et al*, *American Heart Journal*, 1977, **94**, 463.

⁶ McKillop, J H, *et al*, *Radioactive Isotope in Klinik und Forschung*, 1978, **13**, 257.

⁷ Wainwright, R J, *et al*. Presented to the British Cardiac Society, November, 1977.

Surgery for intermittent claudication

SIR,—Mr T F Ford and his colleagues (6 May, p 1189) introduce their short report on venesection for patients with intermittent claudication by saying of reconstructive surgery that "the results are not satisfactory." This is a misleading oversimplification. It is perfectly true, as the authors indicate, that reconstructive surgery is not appropriate for the majority of patients with this condition as distinct from the later complications of obliterative arterial disease—rest pain and ulcer-gangrene. It is also true that femoro-popliteal bypass has fallen out of favour for claudication because the five-year patency rates are of the order of 40-60%. The patient is likely to outlive his graft and be faced with a more severe ischaemic problem without any saphenous vein being available.

This is not the case when the cause of the claudication lies in the aortoiliac segment. Aortoiliac or aortofemoral reconstruction carries 70-90% five-year patency and further reconstruction is not pre-empted. The relief of symptoms can therefore be dramatic and sustained provided that patients are selected with care. It would be a pity if Mr Ford's pessimistic view should discourage the referral of patients with claudication for specialist assessment.

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Umbilical cord prolapse

SIR,—With reference to your leading article (11 March, p 601) on prolapse of the umbilical cord a number of methods have been suggested to prevent compression of the cord by the presenting part such as the Trendelenburg, knee-chest, and elevated Sims's position. A further manoeuvre is to maintain the fetal head above the pelvic brim by placing two fingers within the vagina. This last method is effective but unpleasant for the mother and wearying for the physician, particularly if the patient has to be transported for some distance.

We have described¹ a method which has been used successfully in cases of prolapse of the umbilical cord in which vaginal delivery was not imminent. The method is as follows. Immediately on diagnosis of prolapse of the cord, a No 16 Foley catheter with a 5-ml balloon is inserted into the urinary bladder and 500-750 ml of isotonic saline is rapidly introduced by means of an infusion set, after which the balloon is inflated and the catheter clamped. This is done in a moderate Trendelenburg position. The quantity of saline is determined by the appearance of the distended bladder as a visible swelling above the pubis. Usually 500 ml is sufficient. The distended bladder maintains the raised position of the presenting part, thus relieving pressure on the cord, without the necessity for the fingers of the assistant to remain in the vagina for a lengthy period. There is the added advantage that when the bladder is distended uterine contractions often diminish or disappear temporarily. At caesarean section the bladder is emptied before opening the parietal peritoneum.

To date we have treated 28 cases of prolapse of the cord by this method with only one neonatal death. The time lapse from diagnosis of the prolapse to delivery varied from 25 to 115 min. The method relieves pressure on the cord and can be safely maintained over a long period of time with little discomfort to the mother and no strain on the attending physician.

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¹ Vago, T, *American Journal of Obstetrics and Gynecology*, 1970, **107**, 967.

Cough mixtures

SIR,—In her article (29 April, p 1123) Dr Anne E Tattersfield advocates the use of "either linctus simplex or a linctus containing antihistamines such as diphenhydramine (Benlyn) linctus or pseudoephedrine and triprolidine (Actifed) compound linctus" in alleviating cough.

One sees patient after patient who has had bottle after bottle of Benlyn and/or Actifed without the slightest effect. The Department of Health and Social Security¹ reports 17 million prescriptions annually for cough mixtures, the cost of which must be in the region of £10-11m. Surely the time has come when this useless expensive treatment should be discontinued; certainly it is not to be encouraged.

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¹ Department of Health and Social Security, *Health and Personal Services* 1976. London, HMSO, 1977.

A British "Doctors' Ten"

SIR,—I was interested to read the letters from Dr I D Adams and Dr Barbara Covell (20 May, pp 1352-3) referring to the promotion of running events for interested members of the medical profession in view of the increasing awareness of the value of exercise in the promotion of physical health.

Having no particular enthusiasm for running, I wonder whether a similar event for cyclists would receive worthwhile support. This could be in the form of a group ride over a specified distance to be covered within certain time limits or a specific individual time trial over an accurately measured distance. If there are sufficient doctors interested in taking part in an event of either nature I would be prepared to organise one.

Would anyone interested please write to me, stating their preferences.

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Shortage specialties

SIR,—The recruitment to geriatric medicine has been regarded as one of the problem areas of hospital staffing and has been of concern to the Department of Health and Social Security and to regional health boards. Some areas have assumed that the report of the Royal College of Physicians suggesting the creation of posts for physicians "with an interest" would solve the problem and wish to proceed to appointment. Examination of the 1976 figures of staffing of specialties in England and Wales suggests that an alternative course of action may be more appropriate.

The table below shows numbers of consultants and senior registrars (with whole-time equivalents) and honorary (university) posts in four specialties in September 1976. In comparing geriatric medicine with paediatrics and general medicine as examples of established specialties, it is readily seen that the deficit is greatest in the number of university posts. In this respect radiology, another rapidly expanding specialty with serious recruitment problems, shows an even more striking deficit in the same area, even though the numbers of consultants and senior registrars are much higher than in geriatrics and exceed those in paediatrics.

It would appear that in the established and well-staffed specialties there is a large university contribution of one honorary post for every five consultants (WTE) which is lacking in geriatrics (1:26) and radiology (1:53). In the senior registrar grade the differences are even more marked. Perhaps it would be pertinent to consider at this point whether the "shortage specialties" are unattractive to "good candidates" or whether "good candi-

Numbers of consultants and senior registrars (with whole-time equivalents) and honorary (university) posts, September 1976

Specialty	Consultant grade			Senior registrar grade		
	Consultants	Whole-time equivalents	Honorary posts	Senior registrars	Whole-time equivalents	Honorary posts
General medicine	1048	888	177	203	169	73
Paediatrics	407	359	70	103	88	18
Geriatrics	317	307	12	57	54	3
Radiology	736	689	13	169	164	1