12-week period. Half-way through his first 2-3-1 exchange session he noticed marked improvement of his vision and this improvement was permanent. He is now able to carry on with his job.

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Vincristine-induced neuropathy in lymphomas

SIR,—Dr M G Mott (29 April, p 1145) raises the interesting question whether a sex difference in sensitivity to vincristine could provide an explanation for our findings (11 March, p 610). We described a 61% incidence of neuropathy in patients with lymphoma treated with vincristine compared with an 11% incidence in a group of other malignancies treated with vincristine. As Dr Mott states correctly, the lymphoma group was predominantly male, whereas in our comparison group were 23 patients with breast cancer who were exclusively female.

However, in eight female lymphoma patients (the five original cases plus three more recent ones) there were three cases of vincristine neuropathy. Comparing these with the one case of neuropathy in 23 breast cancer patients there was a significant difference ($\chi^2 = 5.81$; $0.01 < P < 0.025$). Furthermore, there was no significant difference in the incidence of vincristine neuropathy in male lymphoma patients (13/20) and female lymphoma patients (3/8) ($\chi^2 = 1.77$; $0.2 > P > 0.1$).

Thus the higher incidence of vincristine neuropathy in the lymphoma group does appear to be disease-related rather than sex-related.

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Geriatric beds

SIR,—You reported a written answer given by Mr Roland Moyle in the House of Commons on 3 March, listing the numbers of available geriatric beds in NHS hospitals (8 April, p 930). Regrettably those of us who are interested find quite often that such figures are incorrect. In the case of my own Northamptonshire Area Health Authority the figure quoted for beds per 10 000 population aged 65 and over is wrong, the table over-crediting Northamptonshire with geriatric beds and under-crediting Buckinghamshire.

The figure of 112.62 beds per 10 000 population aged 65 and over is almost certainly based on the area SH3 figures for 1976 and the Office of Population Censuses and Surveys population estimates for Northamptonshire for the same year. The SH3 data includes a hospital managed by the Northamptonshire AHA but sited in Bucks. The population of elderly in north Bucks who are within the Northamptonshire AHA catchment is not credited. If the total geriatric beds managed by the Northamptonshire AHA is divided by the OPCS elderly population for Northamptonshire only, excluding those in north Bucks, a figure of 112.62 is obtained. By excluding the hospital in Bucks from the calculation the

numbers of beds per 10 000 elderly is 100.60, a considerable discrepancy.

I write for two reasons. Firstly, the figures are incorrect. Secondly, Mr Penhaligon, who asked the Secretary of State for information, may with others believe the figures to be reasonably up to date. Since 1976 bed numbers under the Northamptonshire AHA have been reduced quite drastically and the population has increased.

Clinicians and community physicians should scrutinise these sorts of figures closely. There are possibly even more ludicrous examples of error in other areas. I have already a complete inpatient and day case diagnostic index of patients under my care in 1977 from the Oxford Regional Health Authority; one would expect that in these modern times up-to-date and accurate figures could be provided for members of Parliament and the public at large. I am not interested in a blood glucose of a week ago; members of Parliament are probably not really interested in the geriatric beds available a year ago or more.

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Ultrasound and work load in the radiology department

SIR,—You recently published a Personal Paper by Dr B Goldberg on the "department of inappropriate investigations" (12 November 1977, p 1274), which referred to the waste of material and manpower within x-ray departments. Important issues were raised and the lack of response in your correspondence columns on the subject is very disquieting.

Radiology departments are currently undergoing a crisis which only a rationalisation of services can ameliorate. Demands for routine and special x-ray investigations continue to rise, but attempts to increase the radiology consultant establishment (in parallel with the increase in clinical consultant appointments) are frustrated at district management team level (as at Epsom in 1977) or by current Department of Health and Social Security policy of not permitting an increase in new radiology consultant posts in the south of England until those in the north are filled.

The new imaging techniques now available have considerably broadened the diagnostic range of radiology, but adequate facilities to operate them efficiently are denied us. The potential cost benefit of ultrasound in particular is considerable. Many patients are saved contrast x-ray examinations and in others laparotomy is made unnecessary. Consequent improved planning of surgical lists saves theatre time and reduces patient postsurgical morbidity. Local surgeons have estimated that since the introduction of ultrasound the length of stay of many surgical inpatients has been reduced by 2-3 days.

Paradoxically, these savings are reflected in an increased diagnostic work load within the radiology department. Some x-ray departments sadly already consider themselves over-committed with routine x-ray work, leaving ultrasound to the regrettably narrow monopoly of the obstetrician. Conversely, where responsibility has been correctly accepted no proportional increase in manpower or facilities is forthcoming. (Even where radiographers are trained in basic ultrasound techniques money cannot be found to employ them.)

Radiology departments must remain progressive and absorb modern technological developments. Clinicians and radiologists should therefore unite in a common objective of getting the best that a modern imaging department can offer. Patients should be educated into not expecting to receive benefit from the routine "therapeutic" x-ray (can the media help here?). Above all, the function of x-ray departments in their wasteful medicolegal relationship to accident and emergency departments¹ needs courageous attention and action. It is better to come to terms openly with the "inappropriate investigations" so that radiologists are able to pass to the patients the benefits of their skills and knowledge.

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¹ Gompels, B M, *British Journal of Radiology*, 1976, **49**, 98.

Pituitary tumours and pregnancy

SIR,—The article by Dr T Bergh and others (8 April, p 875) brings into question the commonly advanced view^{1,2} that infertile patients with prolactin-secreting tumours of the pituitary should routinely undergo radiotherapy or surgery before ovulation induction therapy in view of possible dangers with pituitary enlargement in pregnancy. We also have had reservations about the wisdom of surgery or radiotherapy in such cases and like them have adopted a conservative approach, particularly since the natural history of these lesions is by no means established.

Thirty-four patients who presented with grossly elevated plasma prolactin levels have been under surveillance for up to three years. In 15 there is definite radiological evidence of an abnormal pituitary fossa, in eight the appearances are regarded as suspicious of a pituitary adenoma, while in 11 the sella appears normal. Serial radiological investigations have revealed evidence of progression of the lesion in only two patients. In one of these who also showed impairment of her visual fields institution of bromocriptine therapy resulted in suppression of prolactin levels, improvement in the visual fields, and changes in the appearance on computerised tomography which suggest that the tumour is less active. One other patient under treatment for 24 months shows tomographic evidence of slight but definite improvement in the radiological appearances.

When a woman presents with infertility due to hyperprolactinaemia and radiological evidence of a pituitary tumour we exclude suprasellar extension of the lesion by means of air encephalography or computerised tomography; more recently computerised cisternography has been employed. Assessment of her visual fields and investigation of pituitary function by means of stimulation tests were carried out. In the absence of any contra-indication we then proceed to treatment with bromocriptine. During the course of subsequent pregnancy visual field assessment is performed at monthly intervals, supplemented if need be by limited radiographic examination of the pituitary fossa. In the event of local complications arising during the pregnancies we plan surgical intervention or induction of labour depending on the stage of gestation.

Five of the 15 patients in this category have