data). Under these circumstances the usual effects of noradrenaline, causing marked reductions in heart rate and cardiac output, do not occur. Thus atropine, alone or after beta-blockers, can raise blood pressure and heart rate while maintaining cardiac output.

From these observations therefore we would endorse the use of atropine in doses of at least 3 mg as bolus injections. Furthermore, as an alternative to isoprenaline in patients still hypotensive we would recommend graded infusions of noradrenaline to restore blood pressure provided atropine has been given previously. Under these circumstances heart rate and cardiac output are likely to be satisfactorily maintained and blood pressure restored.

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¹ Richards, D A, Dobbs, J, and Prichard, B N C, *British Journal of Clinical Pharmacology*, 1978, **5**, 357P.

² Jose, A D, *American Journal of Cardiology*, 1966, **18**, 476.

³ Chamberlain, D A, Turner, P, and Sneddon, J M, *Lancet*, 1976, **2**, 12.

Facet joints and low back pain

SIR,—My orthopaedic colleagues and I have been investigating this problem for several years and would strongly endorse the views of Mr J A Robertson and Mr A H G Murley (13 May, p 1283). However, we do not agree with the negative approach of "organised neglect." Conservative measures such as those outlined are always instituted in the first instance, but a significant number of patients are severely disabled by continuing pain. For these we recommend a facet arthrogram,¹ and, if local anaesthesia of the appropriate dorsal primary rami relieves the symptoms, proceed to rhizotomy with a radio frequency probe based on the work of Shealey.² Dr M E Sluijter, of Amsterdam, and I have simplified this technique and performed it safely in over 200 cases in both the lumbar and cervical regions. Our results will be published shortly on completion of a survey one year after these procedures were undertaken.

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¹ Mehta, M, *Intractable Pain*, p 242. London and Toronto, Saunders, 1973.

² Shealey, G N, *Journal of Neurosurgery*, 1975, **63**, 448.

Methods of endometrial assessment

SIR,—I was very interested to read the article by Mr J D Hutton and others on "Endometrial assessment with Isaacs cell sampler (15 April, p 947). I was, however, disappointed to see that the authors made an unfavourable comparison with the diagnostic potential of the Vabra curettage method based on, I suspect, non-comparable parameters.

In their discussion the authors state that "diagnosis of endometrial state was possible in 91% of our patients compared with 77% of similar age assessed by Vabra curettage," giving a reference to a clinical study by Whitehead *et al*¹ which is "in press." This particular article can therefore not be commented on, but as all but one² of the clinical articles on Vabra curettage (about 50 in all)

are based on *histological* diagnosis, everything points towards the likelihood that the 77% in the study cited was similarly based on histological diagnosis. This figure, in fact, corresponds very well to the results obtained from patients aged over 40 years by other authors. Thus Holt,³ for example, was able to make a histological endometrial diagnosis in 80.1% of his patients. It is therefore probable that the authors, using the Isaacs cell sampler, were comparing a 91% satisfactory cytological diagnosis with a 77% histological diagnosis. This, for obvious reasons, is not a valid comparison.

It should be noted that the Vabra method may in fact also be used for cytological examination of the endometrium. Jensen² found that if a histological examination was not possible owing to inadequate aspirate (as, for example, in postmenopausal patients) a cytological examination was possible in 100% of cases using the Vabra curettage method.

It is clearly important not only to distinguish between various endometrial biopsy methods but also to relate them to their specific diagnostic applications.

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¹ Whitehead, M I, and Campbell, S, in *Proceedings of the Second International Meeting on Endometrial Cancer and Related Topics*, ed R W Taylor, M Brush, and R J King. London, Bailliere, Tindall and Cassell, in press.

² Jensen, J G, and Jensen, F, *Danish Medical Bulletin*, 1973, **20**, 123.

³ Holt, E M, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, **77**, 1043.

Diet and asthma

SIR,—I should like to modify the impressions created by your leading article on this subject (18 March, p 669)—namely, that food allergy is rare except when caused by chemicals and dyes and that it does not merit the clinician's careful attention. You also suggest that only 15% of asthmatic children show positive reactions to skin tests.

The punch-card records of 170 unselected children with bronchial asthma under 15 years of age seen by myself were examined. Of these, 147 (86.5%) showed positive skin responses to prick tests with common allergens. Twenty-one children (12.3%) were thought at the first interview to suffer from clinically relevant food allergies. Of this group only six gave positive skin tests to foods, although 18 had the usual positive skin-test responses to inhalant allergens manifested by atopy. On the other hand in the original group of 170 children 22 (15%) gave positive skin-test responses to foods at the initial interview but were thought not to be suffering from clinical food allergy. Of a similar random group of 250 asthmatic adults 204 (81.6%) had positive prick tests to common inhalant allergens. Forty adults (16%) were at initial interview thought to be clinically food sensitive, but only nine of these (3.6% of the total sample) had positive skin tests to foods. On the other hand 43 patients (17.2%) had positive prick tests to food without any obvious history of food allergy.

The conclusion to be drawn from the above figures is that, as in all areas of medicine, the history is paramount and it behoves us well to listen to what the patient or his relatives may tell us. Often young children

are aware that foodstuffs can produce adverse effects which their parents have ignored; on the other hand even adults may not realise that some of their symptoms, whether commonplace or bizarre, may be caused by foods. Although diagnostic diets may be dull and inconvenient, they are well worth the time and effort spent on them, as they serve to reveal unsuspected food allergies in some patients but convince others that their dietary phobias are unfounded.

M A GANDERTON

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SIR,—Your leading article on diet and asthma (18 March, p 669) rightly draws attention to Freedman's important work on hypersensitivity to food additives in orange drinks as a cause of asthma.¹ Unfortunately you have embellished this report with an introductory paragraph and end piece which are misleading and were not part of Freedman's original publication. Freedman carried out experimental provocation of asthmatics without the use of a placebo. Detection of the ensuing bronchospasm by spirometry (in which a 12% reduction of FEV₁ at any time up to 30 min after challenge was accepted as a positive response) does not increase the objectivity of the results, which depend on conscious effort by the patient. Indeed, since tartrazine and sodium benzoate were given in three incremental doses at 40-min intervals a 12% reduction at any time in two hours would have been accepted as a positive response. Fortunately, two-thirds of the responses observed by Freedman were considerably greater than the minimum accepted.

Since you accept the validity of Freedman's work, why do you dismiss the importance of allergy to foods themselves? The innumerable publications on food allergy include many in which the methods of investigation were at least as valid as those used in Freedman's trial. Even the methodology of sublingual testing as usually practised is scarcely less objective.²

I fear that it is conformity to established medical thought which has caused you to believe work on an acceptable topic but uncritically to reject equally laudable work which current medical religion regards as heresy.

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¹ Freedman, B J, *Clinical Allergy*, 1977, **7**, 407.

² MacKarness, R, *Not All in the Mind*. London, Pan Books, 1976.

Treating pressure sores

SIR,—In your leading article (13 May, p 1232) while reviewing the different methods of treatment of pressure sores, you make no mention of Op-site dressing (a polyurethane sheet coated with low-allergy surgical adhesive). In our geriatric research unit we have treated over 40 cases with superficial sores in the past 18 months with over 90% success. The method we use is to clean the sore with half-strength physiological saline and cover it with Op-site dressing, which is changed weekly. Sores so treated heal within two weeks compared with three weeks for controls.

As you rightly point out, 70-90% of

pressure sores are superficial, so that Op-Site is an important addition to the present methods of treatment. Although its use is at present restricted to hospitals, I understand that it is being considered for prescription on EC10.

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Levodopa in senile dementia

SIR,—Further to our previous paper (4 March, p 550) we wish to report briefly the effect of continued treatment with levodopa in five of the patients with senile dementia who had shown a favourable response in the original trial. After a break of one month 750 mg of levodopa was given daily for a further six months. Five control patients with senile dementia matched for age and sex were selected and both groups were rated monthly on the Crichton Intellectual and Behavioral Rating Scales. The intellectual but not the behavioural rating was blind.

As in the original trial no marked changes were apparent in behavioural ratings in either drug-treated patients or controls. Although the mean intellectual scale scores declined a little in the drug-free period between the original and the more extended trial, they improved again when drug therapy was resumed so that mean scores for the drug-treated group over the six-month period were comparable to the scores during the active preparation phase of the original trial. There were continued slight improvements in intellectual functioning in three out of the five experimental subjects during the six-month treatment period. Of the two patients who did not show improvement in terms of mean scores, one showed a very spectacular decline in functioning between the last two ratings and the other showed a very steady deterioration in both intellectual and behavioural function.

In conclusion, although on average the original small gains made in intellectual performance in the drug-treated group appeared to be maintained over several months, the clinical relevance of these findings may be questionable. We are doubtful whether levodopa should be recommended for the routine treatment of this condition at present.

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Annual General Meeting of the Royal Society of Medicine

SIR,—May I use the courtesy of your columns to ask as many fellows of the Royal Society of Medicine as possible to come to the Annual General Meeting on 11 July to discuss the following two motions:

- (1) that the Council be required to consult each individual fellow by postal circular before major policy decisions are taken, especially with regard to the society's property, journal, library, or finance;
- (2) to amend Bye-law XIII.9 to read: It shall be the duty of the Executive Director to submit to the President each year, for presentation to the fellowship before the Annual General Meeting for discussion at the Annual General Meeting, a

report on the activities, property, and finances of the society.

I put these forward because I believe that major changes have been made in our society without the fellows being properly consulted, however long the problems may have been discussed. I do not think it is right that major decisions should be rubber-stamped by poorly attended special meetings. Similarly I believe that, as in most other bodies, the RSM should prepare an annual report for discussion at the Annual General Meeting and not, as at present, publish it in the autumn.

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GMC's finances

SIR,—I have in an idle moment been glancing through the General Medical Council's Annual Report for 1977. I wonder how many members of the BMA are aware that of the £634 716 paid in annual retention fees no less than £125 053 (19.7%) is actually spent on their collection. Could the BMA advise the GMC how to reduce this proportion?

Incidentally, the cost of maintaining the register is only £78 692.

MARY PACK

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Medical Act 1978

SIR,—Dr E Kandiyali (10 June, p 1554) has expressed the anxieties of overseas doctors and particularly junior hospital doctors regarding the limited register which will be set up by the Medical Act of 1978. We hope that we can give some reassurance.

When the new arrangements start overseas doctors already on the temporary register will fall into two groups—consultants and others. The former will have the right to full registration under the Act on the basis that they have already satisfied appointments committees of their ability to assume ultimate responsibility for a patient.

Other hospital doctors can apply for limited registration at any time up to six months from the end of their existing temporary registration. In their particular case limited registration will not be restricted to the five-year "permitted period." The transitional arrangements in part 1 of schedule 5 of the Act protect their position. In the normal course of events they will apply to the GMC for full registration. As Dr Kandiyali says, the criteria are ill defined in the Act itself; they are left to the General Medical Council.

That is in line with BMA policy, which is that the standards for registration should be set by the reformed GMC—that is, by the profession and not by Government. Doctors on the limited register will be eligible to stand for election to the GMC and to vote. Even more important, they will have the right to appeal to a Review Board for Overseas Qualified Practitioners if the GMC denies them full registration. That board must include at least one overseas graduate and the GMC must take note of its opinion.

Those doctors who come to this country after the Act is operative will know before they leave home that their limited registration

will be restricted to five years, but they too will have the right to apply for full registration and to appeal.

Last year the Representative Body resolved that the BMA should seek, through a reformed GMC, a system of registration for overseas graduates which is fair in operation. Getting the Act passed was merely the first step. The law now requires the GMC and the Department of Health and Social Security to consult with the BMA and others on the various detailed rules for its working and for the conduct of elections. These must then be approved by the Privy Council or by Parliament, as the case may be.

Dr Kendiyali's presence on the working party, and our own inclination, will help to ensure that justice is done to those he represents.

JOHN HAPPEL

Alresford, Hants

JOHN MARKS

Joint Chairmen,
BMA Working Party on the GMC

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Shortage specialties: radiology

SIR,—Dr J L C Dall (3 June, p 1489) clearly highlights the serious deficiency of academic appointments in the shortage specialties. In comparison with whole-time equivalents in general medicine and paediatric medicine he points out that only 4% of senior posts in geriatric medicine are academic appointments against 19% in each of the specialties of general medicine and paediatric medicine. He indicates that the problem is even more serious in radiology, where only 2% of the 736 consultants in England and Wales hold academic posts.

It is relevant to compare radiology with other service specialties and particularly with laboratory medicine. In England and Wales there are a total of 1401 consultants in pathology, haematology, biochemistry, neuropathology, etc, and 32% of these posts are academic appointments. The position is the same for senior registrars, where 5% of posts in radiology are academic appointments against 28% in laboratory medicine, 44% in general medicine, 32% in general surgery, and 37% in paediatric medicine.¹

Radiology has expanded rapidly over the years and the specialty now plays a major role in diagnosis and patient management. The specialty now includes ultrasound with its many exciting developments; nuclear medicine in some departments; and now computerised tomography. Many doctors request these sophisticated investigations and have unrestricted use of expensive resources. It is now even more important that these rapidly emerging techniques are properly and critically evaluated. Moreover, it is equally important that there is not only continuing teaching of clinicians requesting the investigations but also of trainee radiologists who will be responsible for their quality. Such evaluation and education should properly be the role of adequately funded academic departments with the necessary time and expertise.

There are many excellent young trainees in radiology who are well suited to academic careers. It is essential that they be given such an opportunity in well-funded academic departments. On a recent visit to Australasia as the Rohan Williams Travelling Professor it was alarming and of serious concern to Britain to see the large number of able UK-