Association on Mental Deficiency (AAMD). The concept of mild retardation is quantitative and embraces, using conventional standards, some 2.2% of the population in addition to the 0.4% who are even less gifted. Not all of this considerable population is in receipt of special services, even at school age; but prospects for training for skilled employment and independent social adaptation tend to be limited. Fortunately, the AAMD has omitted from the revised classification of mental handicap¹ the term "borderline mental retardation," but this is still in common use and embraces much of the "dull normal" stream.

It seems contrary to the general sense of the leading article thus arbitrarily to exclude any causal role in mental retardation to malnutrition when this can admittedly cause some deficiency in the developing brain. It would seem more reasonable in the present state of science to keep an open mind on this question and to view it as one of the many possible modes of operation of the impact of adverse social and economic factors among underprivileged groups and disadvantaged classes.

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¹ *Manual on Terminology and Classification in Mental Retardation*, ed K J Grossman. Washington, DC, American Association on Mental Deficiency, 1973.

Factors affecting length of hospital stay

SIR,—May I comment on Mr H B J Chishick's second letter (17 June, p 1622) as his first (29 April, p 1145) referred to a letter of mine (25 March, p 789)?

He seems to share the common delusion that the only obstacle to reducing the waiting time for cold surgery is "unnecessary delay in discharging patients." This is almost never true because the real limiting factor nowadays is the work capacity of the operating theatres and anaesthetic services (perhaps not the latter in cataract surgery). To dwell on figures of bed occupancy, turnover intervals, mean duration of patient stay, or cost per patient is a great waste of many well-meaning people's time, and generates a vast amount of totally unproductive heat.

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Effects on fetus of stilboestrol in pregnancy

SIR,—With reference to the paper by Mr J M Monaghan and Mr L A W Sirisena (17 June, p 1588) your readers may be interested to know of research carried out by Henderson *et al*¹ in the USA into whether there was a higher incidence of abnormalities in the sons of women who had taken diethylstilboestrol (DES) during their pregnancies as compared with the sons of controls.

They found that the only significant difference was in the incidence of diseases of the urogenital tract—55 out of 225 exposed males (25%) compared with 17 out of 111 controls (15%). Their most striking finding was the difference in incidence of abnormalities of the penile urethra—10 of the exposed males compared with none of the unexposed males. These abnormalities con-

sisted of one case of hypospadias (the number which could be expected among the total of 306 males surveyed) and nine cases of urethral stenosis, a finding which was highly significant.

No cases of malignancy have been reported, but this is presumably not yet ruled out as a possibility owing to the youth of the subjects involved. No systematic follow-up of such patients is possible in the USA since there is on centralised record keeping. This could perhaps be undertaken in the UK since it appears that many women who took DES are already known and could therefore be contacted for information concerning their sons.

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¹ Henderson, B E, *et al*, *Pediatrics*, 1976, **58**, 505.

Inappropriate use of tricyclic antidepressants

SIR,—The short report by Dr J C Little and others (17 June, p 1593) pointing out their difficulty in obtaining depressed patients for a clinical trial raises an important question. They requested general practitioners to refer those patients whom the GP thought suitable for tricyclic antidepressant therapy. The table in the report shows that 12 of the 35 patients referred (33%) were either unsuitable for treatment with tricyclics or were suffering from conditions in which tricyclic treatment was actually contraindicated. If these patients had not been referred for these specific investigations their GPs would presumably have initiated tricyclic therapy and this suggests that there may be a disturbingly high inappropriate use of these drugs in general practice.

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"Innovation in the Pharmaceutical Industry"

SIR,—Dr B W Cromie (17 June, p 1618) corroborates the views expressed at a Council for International Organisations of Medical Sciences/World Health Organisation meeting six months ago on "Trends and prospects in drug research," at which speakers with a knowledge of the pharmaceutical industry were uniformly pessimistic.¹

As he indicates, there are many contributory factors besides the drug control authorities. However well intentioned individually, the constraints have collectively created a paradoxical situation in which the industry is no longer able to develop the drugs that society needs. The cost, delays, and uncertainties make drug research progressively less attractive and the large multidivisional enterprises that make up the research-based industry now see other more promising areas for investment than pharmaceuticals. Once they start to run down their investment the industry will rapidly decline and would take years to rebuild.

In the past the industry has attracted a great deal of criticism, but it has largely been responsible for the tremendous therapeutic advances of the past 30 years. It still offers the best prospect for further progress, but if the profession, politicians, and public want progress to continue they must promote or at

least permit a climate in which a vigorous industry can operate. This is the fundamental problem and it is urgent.

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¹ *Lancet*, 1977, **2**, 1335.

Utility of needle aspiration of tumours

SIR,—One statement bothers me in your excellent leading article on this subject (10 June, p 1507) although I admit that from the surgeon's point of view it is probably true that "when challenged, most of those who seek cytological specimens would agree that a histopathological diagnosis is necessary before ablative surgery or other radical treatment, such as chemotherapy or radiotherapy." However, from the cytopathologist's point of view when surgical biopsy fails to confirm a positive diagnosis of carcinoma made on needle aspiration cytology biopsy of the tumour must be repeated in order to find the malignant tissue. False-positive cytological diagnoses of cancer are very rare in my experience, giving this procedure a specificity of almost 100%. The drawbacks of aspiration cytology compared with surgical biopsy are (1) its lower sensitivity—that is, more false-negative reports—and (2) its narrower diagnostic facility—for example, adenocarcinoma cannot be so readily differentiated from squamous carcinoma. On the other hand it needs no anaesthetic and it can be done on outpatients at negligible cost.

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Factors influencing the incidence of neonatal jaundice

SIR,—Dr B S B Wood (3 June, p 1488) criticises our study on neonatal jaundice (13 May, p 1235) because it was retrospective. However, while accepting that a prospective study is preferable, the large number of cases included strengthens the value of our conclusions and a prospective study of 12 000 neonates would be expensive and time consuming to carry out. Our arbitrary allocation of an average normal bilirubin level to those infants in whom the measurement was not considered necessary is said to be "not acceptable." This procedure merely allowed us further to quantify the importance of the different factors found to be independently associated with changes in the jaundice rate and it did not bias the identification of these factors.

Dr Wood reports that breast-feeding produces a twofold increase in jaundice and we did not study the influence of breast-feeding. We have now been able to add this factor to our analysis for 9300 babies born between 1971 and 1975. The breast-feeding rate was 55% and significant jaundice ($\geq 205 \mu\text{mol/l}$ ($\geq 12 \text{ mg/100 ml}$)) was detected in 13.2% of breast-fed and 11.4% of bottle-fed infants. Multivariate analysis confirmed breast-feeding as an independent factor associated with increased jaundice, but the estimated average increase in peak bilirubin concentration due to it was only $5 \mu\text{mol/l}$ (0.3 mg/100 ml). This

effect is small and less than that of oxytocin, sex of the baby, epidural anaesthesia, and gestational age.

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going arterial reconstructive surgery in the groin were given an injection of French Patent Blue (2 ml Patent Blue with 4 ml 1% lignocaine in four divided doses) into the web spaces of the first and third toes of each foot one hour before operation. Whether because of faults in dosage, injection site, or timing the lymphatics were not satisfactorily shown up. I would be interested to hear of any experience with similar cases and whether visual lymphography can help in the prevention of this postoperative complication.

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Non-epileptic television syncope

SIR,—Dr J B P Stephenson (17 June, p 1622) points out that not all seizures occurring in front of the television set are due to epilepsy. However, I would question whether the attacks he describes were associated with TV viewing. As he himself has demonstrated, these "anoxic" spells are not rare, and many of our patients spend a substantial portion of their waking hours in front of the TV. The occasional coincidence of any form of seizure while watching TV is therefore inevitable.

Nevertheless, there could conceivably be a connection between TV and these non-epileptic seizures. It might be of interest to inquire what programme was being broadcast. Recently I saw a child with a history of vasovagal episodes whose father had been diagnosed as having television epilepsy. In fact he was an artistic, introspective, and very fastidious man who suffered faintness, dizziness, nausea, and overbreathing while under emotional stress. Each of his TV "seizures" was precipitated by a frightening or distasteful episode in the programme he was watching—for example, a horror film in which a very lifeless leg hung over the edge of the bath while the taps kept running and the water overflowed.

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Lymphatic fistula: a complication of arterial surgery

SIR,—Many reconstructive operations designed to restore circulation to the leg involve a dissection in the groin which may divide major lymph trunks and produce a lymphatic fistula. This is probably quite a common problem but, surprisingly, it does not seem to have been recorded. We have recently encountered two such cases, and report them so as to invite discussion of the correct management.

A patient with severe rest pain in the left leg received a femorofemoral cross-over Dacron implant. Five days after the operation a lymphatic fistula developed in the groin which drained 100–350 ml a day for 30 days. The fistula closed without treatment on the 36th day.

Following arterial catheterisation for investigation of myocardial ischaemia our second patient developed a large right common femoral aneurysm, which required resection. Two days after the operation lymph began to drain from a fistula at a rate of 150–250 ml a day. In spite of strict bed rest the fistula continued to drain and after 27 days the area was irradiated for five days (total dose 1500 rads). One day after completion of the radiotherapy the fistula closed.

In an attempt to forestall this complication by demonstrating the inguinal lymphatic channels at operation four patients under-

operating units invariably regret them but feel powerless to change. There seems to be no organised medical public opinion to back their protest. I feel that we should endeavour to make the windowless operating theatre as unpleasant a piece of social history as the high-level block of flats has already become.

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¹ *Anaesthesia*, 1977, 32, 598.

Myelography and epidural double-catheter venography

SIR,—I was interested to read the report by Dr J B Eastwood and others of bilateral central fracture dislocation of the hips following radiculography with meglumine iocarmate (Dimer-X) (18 March, p 692) and the remarks of Dr A K Clarke and others (29 April, p 1143) concerning the diagnostic possibilities of ascending lumbar venography in diagnosing lumbar disc herniation.

I agree with Dr Clarke that epidural venography may be regarded as a very reliable technique. In my opinion the method can be used as an alternative to—or even as a substitute for—lumbar myelography. In this department we have performed epidural venography by means of two catheters (introduced from each groin) and simultaneous contrast injection on 217 patients suspected of lumbar disc herniation.¹ In our operated patients the diagnostic accuracy was 93.7%. The double-catheter method provides the possibility of obtaining homogeneous filling and excellent opacification of the epidural veins at any lumbar level. The catheters are introduced into the lateral sacral veins (heterolateral catheterisation) or into the internal iliac veins (homolateral catheterisation). Also a combination of catheter positions with one catheter in one of these veins and the other one in the ascending lumbar vein provides excellent diagnostic results. The double-catheter method offers the investigator a choice of over 20 catheter position combinations to obtain good quality venograms. The diagnostic quality has proved to be definitely superior to the single catheter method. In my opinion single injection, especially in the ascending lumbar vein, does not provide optimal results. As a rule one or two antero-posterior series are sufficient to establish the diagnosis. I consider double-catheter epidural venography to be a simple and extremely reliable technique. The complication rate is very low and the procedure can easily be performed on outpatients.

I do not agree with Dr R G Grainger (3 June, p 1488) that epidural venography provides significantly less detail in diagnosing lumbar disc herniations than lumbar myelography. The double-catheter method provides more detailed evidence, especially in cases of lateral disc herniation.

Disc herniation is an extradural disease, the operation is performed extradurally, and epidural double-catheter venography is an extremely reliable extradural diagnostic method, so why not stay extradural as a first option in our diagnostic approach? In this way we can avoid unnecessary admission to hospital and prevent the complications of myelography. Headache, occurring after myelography in 25–30% of the cases, is also avoided. It is my firm belief that epidural

Windows in operating theatres

SIR,—I was interested to read Mr G A D Lavey's letter (13 May, p 1285) expressing his concern at the lack of windows in their new twin operating theatre unit.

Here in Gwynedd in Wales we are in the process of building a new district general hospital which is due to be commissioned in the summer of 1980 and which was also to have windowless theatres. However, at a very late stage a united stand has, I think, led to a change of heart by those in authority and windows may now be provided in the interval between the completion of the basic contract and before the opening of the hospital.

There has for some time been a general feeling of unease at the thought of windowless theatres among the staff here, which was crystallised by an excellent article by Dr Philip Keep entitled "Stimulus deprivation in windowless rooms."¹ He stated that a year's experience of working in a windowless theatre and intensive therapy unit in Norwich had convinced the users that such a unit is unacceptable and that no further windowless units should be built. We then decided to make every effort to get our own theatres changed and this effort has probably been successful. It took many months and several important lessons were learnt on the way.

It is vitally important that the operating theatre users be united on the issue. There are some who are obviously indifferent or prefer a windowless theatre. These can be accommodated in an operating room with blinds. It still allows the free choice of natural light to those who hate the conditions of a submarine.

It must not be forgotten that the nursing and ancillary staff can be great allies. Unlike the medical staff they spend their whole working life in such an unpleasant environment and they have strong and powerful unions to support their case.

It is almost impossible to effect change during the main contract as the penalty clauses inflicted by the contractors are prohibitive. The obvious time is during the project stage of a new hospital; otherwise it has to wait until the main contract has finished.

When the situation is brought to notice it is surprising the degree of support it generates from all over the country. I spoke recently at an Association of Anaesthetists meeting at the Royal Society of Medicine on the subject and, although there was a degree of indifference from the officers on the platform, there was outstanding support from the floor. As the medical representative on the commissioning team of our new district general hospital I have visited many new hospitals in various parts of the country. Those who have windowless