when approximately 84 million patients had received the parenteral form.

Typically, those who abuse pentazocine also abuse narcotics and other drugs.¹ Pentazocine alone does not produce a typical opiate abstinence syndrome,² and withdrawal symptoms are not usually severe and do not require treatment.³ In the group reported by Drs King and Betts the symptoms are described as severe, lasting more than two weeks, and resembling those of diamorphine withdrawal. Clearly this runs contrary to the general experience of pentazocine dependence. Subjective testimony alone cannot be regarded as sufficient evidence to establish which drug is being abused,⁴ since it is reported that analysis revealed no trace of pentazocine in six subjects alleging dependence on this drug, while in five there was evidence of morphine or pethidine usage.⁵

Finally, the authors give no indication of the relative frequency of alleged pentazocine abuse. Comparative data are needed to put their experience into correct perspective. If these data could be made available, then the report can be properly evaluated.

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¹ Chambers, C D, *et al*, *Health Services and Mental Health Administration Reports*, 1971, **86**, 627.

² Council on Drugs, *Journal of the American Medical Association*, 1969, **209**, 1518.

³ Lewis, J R, *Journal of the American Medical Association*, 1973, **225**, 1530.

⁴ *Lancet*, 1971, **1**, 439.

⁵ Roth, C H, and Trout, M E, *Hospital Formulary Management*, 1970, **5**, 13.

Which drug for hypertension?

SIR,—Your leading article (8 July, p 75) on the drug therapy of hypertension requires comment. It implies that until the results of the MRC trial of diuretic versus a beta-blocker are known a thiazide is the drug of choice for virtually all patients with mild to moderate hypertension. However, considerations of cost and long-established usage are not the only criteria for choosing a hypotensive agent.

While accepting that adequate information is not yet available concerning the "cardio-protective" aspects of beta-blocking treatment, many clinicians act ahead of established data and advise the incorporation of beta-adrenergic blockade in all hypotensive regimens when not contraindicated.

If, as the evidence quoted suggests, thiazides reduce the incidence of strokes and beta-blockers reduce the incidence of myocardial infarction, perhaps a tablet should be made containing a low dose of a long-acting beta-blocker and a thiazide. Our patients would then gain the benefits of both groups of drugs.

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Parathyroid adenoma

SIR,—The report by Dr K Y Ahmed and others (8 July, p 92) implies a degree of certainty in the histological diagnosis of parathyroid adenoma which few histopathologists share and suggests a definition of tertiary hyperparathyroidism based on this.

The distinction between parathyroid adenoma and nodular hyperplasia has become increasingly blurred since an "adenoma" producing tertiary hyperparathyroidism was described in 1963.¹ The difficulty is that an adenoma can be identified only by the demonstration of atrophy of residual parathyroid glands,^{2,3} and in many cases with a single prominent parathyroid nodule the remaining parathyroids are either normal or slightly hyperplastic.³ Arbitrary classification of these as adenoma is meaningless, and the concept that adenoma and chief cell hyperplasia are different manifestations of the same process² is supported by this evidence. Since the patient described had at least two hyperplastic glands in addition to that containing the "adenoma" the suggestion that the lesion can be sharply categorised as an adenoma seems unwarranted; cases like this of a nodule with a rim of compressed, apparently normal parathyroid occur in hyperplasia.³

Furthermore, the terms primary and secondary hyperparathyroidism are defined in a functional sense without regard to the appearances of the parathyroids, and it is logical to define tertiary hyperparathyroidism in the same way. The suggestion that tertiary parathyroidism should be restricted to cases with a histological "adenoma" would merely add confusion because of the uncertainty of the histological diagnosis.

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¹ St Goar, W T, *New England Journal of Medicine*, 1963, **268**, 943.

² Black, W C, and Utley, J R, *American Journal of Clinical Pathology*, 1968, **49**, 761.

³ Kay, S, *Human Pathology*, 1976, **7**, 127.

Propranolol in black hypertensives

SIR,—Ten years have gone by since Humphreys and Delvin¹ published their results of a trial of propranolol in the treatment of hypertension in 18 Jamaicans of negro extraction. They included in the discussion a statement based upon their observations in which they said, "We do not think that there is any justification for using propranolol as a hypertensive agent [in Jamaican patients] at the present time. . ."

I feel that our experience in Jamaica since then makes it timely to refute this point, although I apologise for the fact that I do so a decade later. Since 1968 the drug has been widely used as an antihypertensive agent in the Caribbean and our general opinion is contrary to that of our widely quoted colleagues.

In our unit we have found that, using propranolol alone as an antihypertensive drug, while a response may be achieved at a relatively low dose in some patients, in others only large doses will produce a significant fall in blood pressure. The table shows the mean antihypertensive effect in five patients on propranolol at a dose of 40 mg thrice daily and the mean blood pressure values of four patients on propranolol incrementally increased to a dose of 80 mg thrice daily. These results suggest that in Jamaican patients with hypertension there are two definable groups based on their dose responsiveness to propranolol. We are investigating the role of renin in this phenomenon. In addition, our studies show that by adding a thiazide diuretic to the therapeutic regimen, a procedure not explored

Hypotensive effect of propranolol in two different dosages (mean blood pressure in mm Hg)

Blood pressure	Week of therapy		
	0	8	10
40 mg thrice daily (5 patients)			
Systolic { Supine	162 ± 6	148 ± 9	139 ± 11
Erect	156 ± 4	134 ± 9	130 ± 6*
Diastolic { Supine	102 ± 4	93 ± 5	85 ± 7
Erect	107 ± 2	96 ± 6	90 ± 7†
80 mg thrice daily (4 patients)			
Systolic { Supine	163 ± 10	154 ± 6	173 ± 10
Erect	162 ± 10	139 ± 8	140 ± 7
Diastolic { Supine	106 ± 4	100 ± 2	99 ± 1
Erect	107 ± 3	100 ± 4	96 ± 4

*Significantly different from value at time 0; P < 0.005.

†Significantly different from value at time 0; P < 0.05.

by Humphreys and Delvin in 1968, an improved antihypertensive effect can be produced with propranolol.

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¹ Humphreys, G S, and Delvin, D G, *British Medical Journal*, 1968, **2**, 601.

Water-soluble lumbar myelography

SIR,—Dr R G Grainger (3 June, p 1488) rightly stresses the importance of careful radiological technique in minimising the side effects of water-soluble myelography in the investigation of the lumbago-sciatica syndrome. We have found the overall morbidity of water-soluble myelography to be very low and therefore cannot support Dr A K Clarke and his colleagues (29 April, p 1143) in putting forward lumbar venography as an *alternative* investigation. Lumbar venography is a useful technique in those rare cases in which the appearances on a water-soluble myelogram are thought to be equivocal and surgical treatment is under consideration.

The reports of serious fractures resulting from muscle spasm after the use of meglumine iocarmate (Dimer X)¹⁻³ are very worrying. The particular advantage of metrizamide myelography is that muscle spasm does not seem to occur and therefore these rare but nevertheless disastrous fractures should be completely avoidable. With the availability of metrizamide we can see no place whatsoever for the continued use of meglumine iocarmate in the investigation of low back pain and sciatica.

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¹ Hugander, A, *et al*, *Zeitschrift für Rechtsmedizin*, 1974, **75**, 219.

² Eastwood, J B, *et al*, *British Medical Journal*, 1978, **1**, 692.

³ Motrey, B F, and O'Brien, E T, *Journal of Bone and Joint Surgery*, 1977, **59A**, 1099.

Housing, health, and illness

SIR,—Dr J A Muir Gray (8 July, p 100) has performed a valuable service by drawing attention to the role of the medical adviser to a housing authority. We are interested in his observation that at Oxford the community physician could intervene effectively only by using his powers to take cases to committee.

This situation occurs because points for medical problems contribute little to the points total. Data from six housing authorities in Wales (see table) that use the points system show that the total number of points which can be granted on medical grounds, and therefore the effectiveness of normal medical intervention, varies markedly.¹ Within these authorities the maximum number of medical points attainable as a percentage of the lowest

resident accommodation for nursing and domestic staffs, catering facilities, laundry, administration—which should be assessed as well as space for doctors. Where there is surplus capacity in good order the upgrading, modification, or increase of accommodation should be economically feasible for some categories of patients.

There could well be a pause in the building of new general hospitals until the NHS is 50 years old if the inquiry revealed reserves. We don't know; and the evidence of surveyors and engineers is required before that of doctors or administrators. Think of the resources of some of the great mental hospitals with rapidly reducing bed demands over the next 20 years.

Let us hope that slow "phasing out" can be avoided, that viable ancillary units of general hospitals are fully exploited, and that "area" boundaries are ignored. Resulting economies might even allow patients travel vouchers for their visitors where distance proved a problem.

HARLEY STEVENS

Peppard, Oxon

more prosperous future, free of public spending cuts.

D G SEYMOUR

Dundee

Out-of-hours use of clinical pathologists

SIR,—Your anonymous correspondent (15 July, p 207) may, if he becomes a consultant and director of a laboratory, then bless the time that he has spent doing on-call work and benchwork in general. He is a poor pathologist who is not as competent a technician as any of the rest of his staff. If he is not, how can he keep a check on the standard of work being carried out in his laboratory? How can he train and instruct his juniors? (I hope he has put in time doing some of the washing-up as well.) I agree that it seems wrong that he should be compelled to do on-call work at night because the employing authority can't or won't pay their technicians; but it is certainly not wrong that a pathologist in training should gain plenty of experience in emergency work at night. It is not at all the same thing as doing it in the middle of the day.

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Locum consultants

SIR,—The Negotiating Subcommittee of the Central Committee for Hospital Medical Services has for some years now been endeavouring to improve the terms and conditions of service of locum consultants.

Whatever their experience and qualifications, those who act as locum consultants are paid at a rate which is equivalent to the mid-point of the consultant salary scale. The service depends largely upon a pool of retired consultants to do this work and this results in a considerable reduction in remuneration for those who were previously at the maximum of the salary scale and, in many cases, also in receipt of a distinction award. The profession in its evidence to the Review Body for the 1978 review asked that, in future, locum consultant remuneration should be related to the maximum of the salary scale. However, the Review Body declined to make any recommendations in its report.

A further point is that when locum consultants undertake to work away from home the cost of hotel accommodation must be borne by the individual and they are therefore invariably considerably out of pocket, and this considerably reduces the incentive for doing the work.

The Department of Health has declined to take any steps to improve the arrangements for locum consultants, as there appears to be no evidence that employing authorities have difficulty in recruiting such locums. The Negotiating Subcommittee is not convinced that this is the true situation and I should be glad to hear from consultants of any difficulties which authorities have experienced in obtaining locums to cover their work in their absence.

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Value of medical points in relation to qualifying threshold for rehousing in six housing authorities in Wales*

Housing authority	Maximum medical points	Qualifying threshold for rehousing (points)	Maximum medical points as % of qualifying threshold
A	30	45–50	60–67
B	5	35–40	13–14
C	15	32–36	42–47
D	3	8–17	18–38
E	15	28	54
F	20	37–50	40–54

*Based on data from Appendix 3 of reference 1

qualifying threshold for rehousing ranges from 13% to 60%. Other methods of housing allocation also exist: of the 39 Welsh authorities studied,¹ 29 used the points system, four used the merit system (all cases reviewed by committee), and six used the date-order system (usually first come, first served). The effectiveness of medical intervention under the latter two systems is difficult to assess.

In individual cases in which medical factors have been influential in rehousing it would appear necessary to ensure, as Dr Muir Gray has done, that new accommodation provides a satisfactory outcome. Unfortunately some studies indicate that conditions in new housing estates do not always improve the respiratory² or mental³ health or the general amenities⁴ of those rehoused.

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¹ Welsh Consumer Council, *Council Housing: Survey of Allocation Policies in Wales*. Cardiff, WCC, 1976.

² Yarnell, J W G, and St Leger, A S, *British Journal of Preventive and Social Medicine*, 1977, **31**, 183.

³ Martin, F M, Brotherston, J H F, and Chave, S B, *British Journal of Preventive and Social Medicine*, 1957, **11**, 196.

⁴ Goodman, M, *Proceedings of the Royal Society of Medicine*, 1976, **69**, 637.

Getting the NHS back on course

SIR,—The excellent article by Sir Francis Avery Jones (1 July, p 5) mentions the need to refit older buildings and suggests that instead of new general hospitals the next step should be the measurement of existing facilities and equipment. He would have a national Domesday-type survey of general hospitals with a modest number of questions to be answered.

This is a plea for a survey extended to all manner of hospitals that have accommodated 100 patients or more, with emphasis on their basic services. Hospitals do not run without them and, apart from site acquisition, they absorb a large proportion of the initial capital outlay. It is these essentials—public services, access, power plant, maintenance, transport,

Thirty years of the NHS

SIR,—Like Dr Adrian Rogers (1 July, p 59) I face a potential 30 years in the NHS, but this appears to be the only point which we have in common.

It is true that the NHS is under-financed, but its underlying concept of divorcing the delivery of health care from the ability to pay remains a great achievement. I find it difficult to believe that handing its potentially profitable sectors over to private entrepreneurs would improve the service for the population as a whole.

The medical challenges of the next 20 years will be found among the aged, the chronically disabled, and the need to expand preventive medicine. Even in the USA private enterprise has shown itself quite unable to deal with these problems, most of which have been entrusted to the public sector. Despite a vast expenditure the health achievements of the United States, as illustrated, for example, by their infant mortality rate, remain unimpressive. Do we really want to return to the gross maldistribution of health care of pre-NHS days to which Lord Taylor refers (1 July, p 33)?

Most of the deficiencies of the NHS have resulted from the willingness of successive governments to use it as a means of regulating the economy rather than as a system for promoting health. Over the 30 years of its existence the NHS and its finances have rarely been out of the news. Because of this the general public, far from being "deluded" and "blind," is particularly well informed about health matters and is better able to judge the value of its Health Service than many doctors, or even Sir Keith Joseph. After all, it would not be the Sir Keiths of this world or the medical profession who would find themselves second-class citizens under a private medical system.

Finally I would suggest to Dr Rogers that there are 1½ million unemployed people in this country, some of them health workers, who would be delighted with a "life sentence" of 30 years in any sort of work, whether superannuated or not.

I wish the NHS good health but a rather