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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

A confidence trick

SIR,—Mrs Barbara Castle, when Secretary of State for Health and Social Security, promised the British public that closure of private wards in NHS hospitals would release 4000 beds—"the equivalent of four 1000-bedded district hospitals" as she put it—for public use. She also promised that this move would help abolish the enormous national waiting list for hospital admission.

On 20 May of this year 10 beds on the private ward at the Gordon Hospital, a part of our hospital group, were due to be closed down. These beds will lie empty and gradually collect a veneer of dust. There is no question at all of their being used for NHS patients and to help reduce our rapidly lengthening waiting list.

Inquiries among my surgical colleagues throughout Britain have failed to reveal any example where the closure of a private ward has released a single bed for an NHS patient.

I am therefore forced to conclude that these closures are being made on purely political grounds and without any possibility of their being used to improve NHS facilities. The whole thing has been a confidence trick by the Government. I believe that the people of this country deserve to know that, yet again, they have been deceived by our masters.

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Deaths from asthma in children on aerosol corticosteroids

SIR,—Your leading article on this subject (30 April, p 1117) and another (25 December 1976, p 1523) entitled "Intranasal beclomethasone: wonder drug or hazard?" seem to show a change of view when compared with a previous leading article as recently as February 1975,¹ which began: "Steroid aerosols have revolutionised the treatment of severely asthmatic children." Such vacillation of editorial opinion could certainly cause confusion, doubt, and anxiety in the minds of those who care for the asthmatic child.

The 1975¹ article is a model of clarity with which I am in complete agreement except that reference to our pioneer publications^{2,3} was overlooked. Having already expressed my

views regarding the intranasal use of beclomethasone,⁴ I must again seek the courtesy of your correspondence columns because some attempt to assess this treatment in balanced perspective should be made. It is unfortunate that our review of 5½ years of experience with 600 asthmatics of all ages⁵ and five years' experience of 223 cases of perennial allergic rhinitis⁶ cannot be published in the *BMJ* because of lack of space, as our long-term findings may help in establishing the place of this treatment in modern therapeutics.

Steroid aerosols for asthma and rhinitis are now accepted in many countries as an important advance without significant side effects. Properly administered and carefully monitored,

such treatment offers release from steroid bondage. In contrast, what would be the fate of corticosteroid drugs if recently discovered and submitted to the Committee on Safety of Medicines or the Food and Drug Administration?

The report of Mellis and Phelan,⁷ to which you refer in your most recent leading article, is well detailed and I agree with their conclusion that timely and adequate corticosteroid treatment might have prevented the three deaths, in two of which there were clear warning signals. It is disturbing that two children had "normal" tetracosactrin adrenal function tests and that satisfactory but occasional pulmonary function tests were also misleading. Maybe self-monitoring of the peak flow rate would have provided an early warning, but the absence of mucus plugging at post-mortem suggests other causes of death than asthma.

You state in that article that aerosol corticosteroids were first introduced in 1968, but I am aware of only one centre where beclomethasone dipropionate was on trial at that time and was found ineffective,^{8,9} very nearly discouraging the makers from proceeding further.

At the start of our trial in mid-1970 and in our first publication in 1972¹⁰ enthusiasm caused us to withdraw steroids too quickly, but much slower withdrawal has been practised since and clearly published.¹¹ Good clinical judgment and monitoring at this crucial period is the best guide, some requiring considerably slower withdrawal than others. We have had no tragedies in 241 ex-steroid-dependent patients treated for up to 5½ years, but have repeatedly emphasised the risks in this group. In contrast, there were three deaths from asthma in the 359 non-steroid-dependent patients in our long-term studies.^{5,6}

The method adopted in Derby to avoid disaster has been to supply corticosteroid

directly to patients or parents, with clear instruction to take 30 mg of prednisolone (or equivalent) at the onset of a severe attack, contacting the practitioner or clinic staff later for guidance or help if necessary. Ex-steroid-dependent patients have a warning label on their steroid cards stating, "This patient was steroid dependent for . . . years and was transferred to Becotide inhaler on . . . and may be at risk because of adrenal atrophy for at least two years." In recent years patients subject to very sudden attacks are sometimes supplied with terbutaline for subcutaneous administration by patient, parents, or doctor when obviously necessary as well as oral steroids. Immediate relief is thus available at the crucial time. We have found no problems except tremor with this self-medication and consider this unusual approach fully justified when there are problems in obtaining prompt medical attention.

We find it safer to leave the remedy in the patient's own hands as it is so common for family doctors to be unreasonably reluctant to use steroids in high doses soon enough. Recent surveys of death from asthma in hospital¹² and at home¹³ have shown that steroids were frequently under-used or not used at all and that both doctor and patient underestimated the severity of the attack. In fact, we take all the precautions suggested in your excellent leading article of just over a year ago^{1,2} plus individual monitoring and instant availability of oral corticosteroid and injected bronchodilator. If such precautions were consistently adopted such tragedies might be less likely.

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- ¹ *British Medical Journal*, 1975, **1**, 413.
- ² Brown, H M, and Storey, G, *British Medical Journal*, 1973, **3**, 161.
- ³ Brown, H M, and Storey, G, *Clinical Allergy*, 1974, **4**, 331.
- ⁴ Brown, H M, *British Medical Journal*, 1977, **1**, 376.
- ⁵ Brown, H M, and Storey, G, submitted for publication.
- ⁶ Brown, H M, and Storey, G, submitted for publication.
- ⁷ Mellis, C M, and Phelan, P D, *Thorax*, 1977, **32**, 29.
- ⁸ Grant, I W B, et al, *British Medical Journal*, 1972, **2**, 110.
- ⁹ Choo-Kang, Y F J, et al, *British Journal of Diseases of the Chest*, 1972, **66**, 101.
- ¹⁰ Brown, H M, Storey, G, and George, W H S, *British Medical Journal*, 1972, **1**, 585.
- ¹¹ Brown, H M, and Storey, G, *Postgraduate Medical Journal*, 1975, **51**, suppl 4, p 59.
- ¹² Macdonald, J B, et al, *British Medical Journal*, 1976, **2**, 721.
- ¹³ Macdonald, J B, Seaton, A, and Williams, D A, *British Medical Journal*, 1976, **1**, 1493.

SOMA

SIR,—Two publishing firms have written to you (16 April, p 1027) since my article "SOMA: new hope for medical authors" appeared (2 April, p 887). Since the article was published I have received over 100 letters from authors or prospective authors concurring with the points made in my article. The two publishers who wrote (and there are over 30 medical book publishers in the UK) have indicated ways in which their firms offer to authors some terms which are somewhat better than those offered by other publishers—could there be a more potent argument in favour of SOMA than this? One of the aims of SOMA is to direct authors to those publishers whose terms are most favourable.

Some publishers offer royalties of 15% on the retail price of copies of books sold in the UK over 2500—would it be impolite to ask Mr Per Saugman, of Blackwell's, if his

company every pays royalties of more than 12½% to authors?

The Society of Authors has drawn attention to the fact that there is no standard contract agreed between the society and the Publishers Association—it is certainly implied by some publishers that such a contract exists and many medical authors believe this to be so; we are all grateful to the Society of Authors for correcting this widely held but false impression.

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Pituitary-dependent Cushing's disease

SIR,—Your leading article on this subject (23 April, p 1049), is open to criticism. The concept of "pituitary dependence" is now outdated and has been modified since recent discoveries have shown that the hypothalamus regulates pituitary function. This control over the anterior pituitary is mediated via the hypothalamic hormones, and indeed the isolation of material with corticotrophin (ACTH)-releasing activity (CRF) from the median eminence was the first successful demonstration of a hypothalamic hormone.¹ As this hypothalamic-pituitary mechanism has been better understood it has been a logical step to place more emphasis on the hypothalamus as the aetiological factor in many endocrine disorders. Present opinion therefore favours an underlying hypothalamic dysfunction as the cause of Cushing's disease. This view is supported by observations that the discontinuous pattern of ACTH secretion² reflects the secretory bursts of CRF from the hypothalamus³ and that the circadian rhythm of cortisol secretion may be retained in Cushing's disease.^{4,5} Studies indicate that the synthesis of CRF in the hypothalamus is probably mediated by serotonin,⁶ and serotonin antagonists have been shown to block hypoglycaemia-induced cortisol secretion.⁷ It seems likely that Cushing's disease may be due to a disorder of brain amine metabolism involving serotonin.⁸

The article then dealt with the surgical management of Cushing's disease without reference to the possible medical treatments. Drug therapy for Cushing's disease is gaining increasing recognition. The concept of "hypothalamic-pituitary dependent" Cushing's disease has encouraged the use of drugs which have an action upon brain amine metabolism. Bromocriptine is a dopaminergic-receptor stimulant which is useful in treating such hypothalamic-pituitary disorders as acromegaly and hyperprolactinaemia. This drug has been demonstrated to lower plasma ACTH levels in patients with untreated Cushing's disease⁹ and it is also useful in the management of Nelson's syndrome,¹⁰ which may develop after bilateral total adrenalectomy for Cushing's disease. More recently cyproheptadine has been suggested as the new drug treatment for Cushing's disease.¹¹ Cyproheptadine is a potent antiserotonin, and reports claim that it can induce remission in Cushing's disease.¹¹ Further use and development of such drugs for Cushing's disease offer a safer therapeutic approach, since they may make the risks of pituitary surgery unnecessary.

S P DEACON

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- ¹ Saffran, M, Schally, A V, and Benfey, B G, *Endocrinology*, 1955, **57**, 439.
- ² Hellman, L, et al, *Journal of Clinical Endocrinology and Metabolism*, In press.
- ³ Weitzman, E D, et al, *Journal of Clinical Endocrinology and Metabolism*, 1971, **33**, 14.
- ⁴ Hellman, L, et al, *Journal of Clinical Endocrinology and Metabolism*, 1970, **30**, 686.
- ⁵ Doe, R P, Vennes, J A, and Flink, E B, *Journal of Clinical Endocrinology and Metabolism*, 1960, **20**, 253.
- ⁶ *Lancet*, 1975, **2**, 1135.
- ⁷ Plonk, J W, Bivens, C H, and Feldman, J M, *Journal of Clinical Endocrinology and Metabolism*, 1974, **38**, 836.
- ⁸ Scapaginini, U, et al, *Neuroendocrinology*, 1971, **7**, 90.
- ⁹ Lamberts, S W J, and Birkenhager, J C, *Journal of Endocrinology*, 1976, **70**, 315.
- ¹⁰ Lamberts, S W J, and Birkenhager, J C, *Lancet*, 1976, **2**, 811.
- ¹¹ Krieger, D T, Amorosa, L, and Linick, F, *New England Journal of Medicine*, 1975, **293**, 893.

* * * The majority of patients with pituitary-dependent Cushing's disease have a small pituitary tumour at the time of presentation. Bromocriptine and cyproheptadine may reduce ACTH levels in some patients, but whether they influence the growth of the tumour remains to be determined. Preoperative control of cortisol overproduction was considered in the leading article and two well-tried drug regimens were mentioned: metyrapone-aminoglutethamide and metyrapone alone. Transsphenoidal hypophysectomy and interstitial irradiation are safe procedures that rapidly correct the syndrome.—Ed, *BMJ*.

A case of a twisted ankle

SIR,—As I understand it, the patient in your interesting Clinic in General Practice (14 May, p 1260) needed a little magic: an x-ray of her ankle for wholly sympathetic and proper psychosocial reasons. X-ray is shorthand for radiological consultation, especially in hard times when we are trying to make expensive radiology departments into care-effective diagnostic centres rather than photographic workshops.¹ Why was your article not a dialogue between the two doctors immediately concerned in the problem, the general practitioner and the radiologist?

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- ¹ *Lancet*, 1976, **1**, 520.

A case of right iliac fossa pain

SIR,—We were dismayed that the article on a case of right iliac fossa pain (23 April, p 1066) was principally concerned with excluding organic disease rather than with making a positive diagnosis on which rational management could be based. None of the doctors really thinks that the patient has appendicitis, yet they are prepared to subject a young girl to numerous investigations, even appendicectomy.

The consultant psychiatrist regards "whole-person" medicine as a "seductive concept." Is he really going to "exclude organic disease" before taking a full family and personal history? The exclusion of organic disease is indeed a seductive concept and the hypochondriacal patient will always feel, and make the doctor feel, that some stone may have been left unturned.

The associated features of the symptom and its setting must be considered. Is it really an