action of propranolol in hypertension as I myself remain to this day. However, we theorised rather optimistically that the drug's central tranquillising effect might have something to do with it. That effect, we thought, might have rather more value in an overstressed London businessman than in a peaceful Jamaican farmer.

Ten years later Dr Grell comes up with no less than nine Jamaican patients in some of whom there is a good fall in blood pressure while in a few there is actually a rise in supine systolic pressure. Perhaps he is simply rather better at getting his patients to take their tablets than we were. But I would point out that our study of propranolol in hypertension was actually double-blind, unlike previous studies which, like the present one of Dr Grell, were totally uncontrolled. The effect on a patient's blood pressure of an enthusiastic and (I imagine) sympathetic doctor like Dr Grell should not be underestimated. This effect is particularly marked when at the same time the patient's anxiety decreases as he gradually gets used to having his blood pressure taken.

Those who assess new antihypertensives over the next 10 years should bear these two phenomena in mind. In short, all trials of antihypertensive drugs should be double-blind.

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

Carcinoma of the male breast and oestrogen metabolism

SIR,—Tamoxifen has been generally available for just over five years, the original clinical studies having been carried out at this hospital about seven years ago. Given the rarity of male breast carcinoma it is not surprising that Drs D B Jefferys and J Efthimiou and Dr R Abele and others (24 June, p 1697) and Drs D A L Morgan and Anne Hong (15 July, p 206) could report on only one or two cases treated with the drug.

I have treated eight patients with metastatic male breast carcinoma with tamoxifen and have a further three patients taking the drug as adjuvant therapy following simple mastectomy and radiotherapy. However, I feel that no meaningful conclusions can be drawn until between 20 and 30 patients have been treated.

Historically, a similar situation appertained to stilboestrol, reports on the usefulness or uselessness of the drug being based on the treatment of less than 10 patients. A series from this hospital showed an overall response of 38% to stilboestrol therapy in 55 patients with metastatic male breast carcinoma.¹ However, no response was obtained in patients with bone metastases and from the experience of Treves² and this hospital³ it would seem that ablative operations may still be the treatment of choice in that situation.

The response of 38% to stilboestrol in advanced male breast carcinoma is very similar to the female response rate and it will be surprising if an approximately similar rate is not achieved for tamoxifen, as a 30% rate for advanced female breast carcinoma is commonly achieved.

In a collaborative study, just being completed, 11 patients with male breast carcinoma

have had serum levels of 17- β -oestradiol, follicle-stimulating hormone, luteinising hormone, and testosterone estimated. These levels have been compared with those from 40 normal controls (10 for each decade from 30 to 80 years). The results of this study will be published in due course.

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¹ Ribeiro, G G, *British Journal of Cancer*, 1976, 33, 465.

² Treves, N, *Cancer*, 1959, 12, 820.

³ Ribeiro, G G, *British Journal of Surgery*, 1977, 64, 381.

Behcet's disease

SIR,—With reference to your leading article on this disease (22 July, p 234), it may be worth mentioning two other forms of treatment which have been reported as being of benefit.

The first is the use of fibrinolytic agents—phenformin and ethyloestrenol¹⁻³ and streptokinase.⁴ The rationale for this is that vasculitis and deep venous thrombosis are prominent features and that fibrinolysis has been shown to be impaired in some patients with the condition.⁵⁻⁷

The second line of therapy has recently been reported from Japan, where the disease is rather more common.⁸ In this report the authors record overall benefits with the use of colchicine in 131 cases and remark that the drug is now "widely used" for Behcet's disease in Japan. The theoretical reason for this is colchicine's inhibition of polymorph chemotaxis, which is reportedly elevated in the disease.⁹

While both of these therapeutic regimens are as yet unproved by controlled trial and analysis, they seem to be valuable methods to consider for patients with this condition, especially since they are relatively free from serious side effects.

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¹ Cunliffe, W J, and Menon, I S, *Lancet*, 1969, 1, 1239.

² Kirk, J, and Handley, D A, *Australian Journal of Dermatology*, 1972, 13, 5.

³ Cunliffe, W J, et al, *British Medical Journal*, 1973, 2, 486.

⁴ Chajek, T, and Fainaru, M, *British Medical Journal*, 1973, 1, 782.

⁵ Sobel, J D, et al, *Dermatologica*, 1974, 148, 93.

⁶ Ashbeck, P, et al, *Haemostasis*, 1977, 6, 303.

⁷ Stathakis, N E, et al, *Blut*, 1977, 34, 215.

⁸ Mitsuhashi, Y, et al, *Lancet*, 1977, 2, 1037.

⁹ Sobel, J D, et al, *Journal of Clinical Pathology*, 1977, 30, 250.

Prevalence of multiple sclerosis in West Yorkshire

SIR,—Last year we contacted the general practitioners in the Calderdale area of West Yorkshire who have computer-produced age-sex registers and asked them for the number of patients in their practices and the number of their patients with accepted multiple sclerosis (MS). Like Drs David I Shepherd and Allan W Downie (29 July, p 314) in north-east Scotland, we found a higher prevalence rate of MS than we had expected—120 cases in a surveyed population of 157 400 or a rate of 76 cases per 100 000 population. We found some practices within the area to have unexpectedly high prevalence rates, one as high as 217 per 100 000. In one practice centred on Hebden Bridge we were able to examine all

patients firmly diagnosed by consultant physicians as having MS. This mixed urban-rural practice of 16 500 patients is the only general practice covering the area and had 21 patients with a diagnosis of MS. The female:male ratio was 3:1 and mean age at presentation 29 years. Two patients had been diagnosed before they moved into the area. Excluding four patients who do not meet all of Schumacher's diagnostic criteria,¹ principally because of recent onset, a prevalence rate of 103 per 100 000 is still higher than expected.

We share Drs Shepherd and Downie's view that general practices possessing age-sex-morbidity registers can be productive epidemiologically. In addition we feel that information obtained from such registers is most useful when it comes from practices which cover a circumscribed geographical area exclusively, as comparison with larger studies is often possible.

We thank the Calderdale practitioners for their help in giving figures and Mrs C M Ingham for secretarial help.

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¹ Schumacher, G A, et al, *Annals of the New York Academy of Sciences*, 1965, 122, 522.

"A-Z Pregnancy and Babycare"

SIR,—A number of statements have appeared recently in the press to the effect that the Royal Society of Medicine does not support this publication wholeheartedly and, by inference, that it lacks confidence in Health Care Periodicals Ltd and in its managing director, Mr J Scott-Clark.

It should therefore be put on record: firstly, that the decision that the society should engage more actively in health education and in publishing, both for members of the medical profession and for the lay public, was taken by the council more than two years ago and has repeatedly been reaffirmed by them and by the Scientific and Executive Committee; secondly, that the honorary editors of the society who, under the bylaws, are given such authority, approved the publication of the *A-Z Pregnancy and Babycare* in February 1977; thirdly, that its editor-in-chief, Dr Hugh Jolly, was invited to accept that position by the honorary editors and did so in order to assist the society; and, fourthly, that the society stands fully behind Health Care Periodicals Ltd in the publication and distribution of the book.

It should also be known that for some years the society's Open Section has accommodated members from many walks of life and has arranged meetings for the discussion of subjects of common concern to the medical profession and the general public; that some of its principal lectures are addressed to the laity; and that it has organised lunchtime lectures by its fellows on medical subjects for lay audiences as a contribution to health care. These activities continue and they were fore-runners of the enlarged publication programme of which the *A-Z Pregnancy and Babycare* is but one part.

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