0.9% after immunoglobulin administration reported by Dr Tovey.

During the past three years the maternity hospitals of the Manchester region sought our advice regarding 27 patients with Kleihauer counts higher than the standard 100 fetal cells per 50 low-power fields. Increased doses of anti-D immunoglobulin (up to 2000 µg in some cases) were prescribed for these patients, based on the counts and on serological estimates of the percentage of Rh-positive cells present in the maternal circulation. The adequacy of the dosage was monitored by observing falling Kleihauer counts, disappearance of Rh-positive cells, and the appearance of free anti-D immunoglobulin in the patients' serum over the course of a few days.

Follow-up samples six or more months later were obtained from 19 of these women and anti-D was found in only one of them (stillbirth, adherent placenta, no fetal movements for a week, probably immunised before treatment). The doses of anti-D immunoglobulin prescribed were calculated as described by Mollison¹ and the successful results of this small series confirm the correctness of his observations and suggestions. Some of these women had Kleihauer counts as high as 3000 and there is little doubt that the standard 100-µg dose of immunoglobulin would have failed to protect most of them from immunisation.

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¹ Mollison, P L, *British Medical Journal*, 1972, 3, 31.

Which drug for hypertension?

SIR,—Like Dr J R T Gabriel (29 July, p 358) I think that your leading article (8 July, p 75) requires comment; however, I would not fully agree with his conclusions either. Your article carefully outlines the arguments against thiazides and then ignores these to recommend them on the basis of price and long-established use. The price differences are exaggerated, since 50 mg or less of atenolol (not 100 mg as quoted) is probably equipotent with 5 mg of bendroflumazide, and there are, of course, cheaper beta-blockers if price is to be a major criterion for selection. Furthermore, beta-blockers can no longer be considered newcomers with more than 10 years of experience with propranolol behind us and several years of closely monitored use of other beta-blockers. These considerations, together with the evidence for the cardioprotective action of beta-blocking drugs following myocardial infarction, have, as Dr Gabriel says, led many, I think most, clinicians to prefer to include a beta-blocking drug in antihypertensive treatment when not contraindicated.

Where I would disagree with Dr Gabriel is on the role of the combined beta-blocker and diuretic. This combination, which is incidentally already available from one company and I understand will soon be produced by others, undoubtedly has an important role in improving patient compliance. However, I do not think that the evidence for specific benefit from treatment with a particular type of drug is sufficiently strong to justify exposure of the patient ab initio to the risks, which must of course accompany the benefits, of both groups.

I would see the combination tablet as a substitute for beta-blockers alone in patients proving resistant to monotherapy and therefore as the second drug prescribed except in severe hypertensives, where it might be felt that a beta-blocker alone was likely to be insufficient.

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Paget's disease in Australian immigrants

SIR,—Dr M J Gardner and others (24 June, p 1655) suggest that an environmental factor may be responsible for the lower prevalence of Paget's disease of bone in British migrants to Australia compared with those remaining in the United Kingdom.

Using the data from their previous paper¹ I estimated the number of cases of Paget's disease in male patients to be expected from the age-specific rates quoted for male residents in the UK ($7\% \times 13\ 160$ patients). Comparing UK-born males who stayed in the UK with those who later migrated to Western Australia there was no significant difference between the two populations ($\chi^2 = 1.18$; $0.2 < P < 0.3$).

Their further comparison of UK migrants in Australia with native-born Australians would seem to be of questionable validity, as native-born Australians are an admixture of British, Scandinavian, Eastern European, Mediterranean, Aboriginal, and other ethnic groups, whereas those Australians born in the UK clearly come from more restricted ethnic origins. As stated by the authors themselves, the prevalence of the disease is far lower in populations from countries outside the UK than it is inside the UK.

I suggest that it is premature to implicate environmental factors to explain the slight difference in the prevalence of Paget's disease in the different groups studied. An investigation of the ethnic origins of the Australian-born control group would be more relevant.

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¹ Barker, D J P, et al, *British Medical Journal*, 1977, 1, 1181.

Training in community medicine

SIR,—From the rarefied atmosphere of the eagle's nest Dr J Stuart Horner (12 August, p 498) sees the future of community medicine in a light which is far from rosy; but, sad to relate, the worm's eye view of clinical medical officers and patients is even gloomier. Looked at from this humble position possibly the most depressing feature is the almost total lack of heed which has been paid by "planners" in community medicine to the wiser words in the Court Report¹ about the future direction of their specialty.

The Court Committee stressed: (1) "that there must be a rethinking of the ways in which clinical preventive services are organised" and (2) "the need for work that carries challenge and responsibility," and surely this means clinical challenge and clinical responsibility.

Like any other communal resource com-

munity medicine can only be effective when it is substantially applicable to the needs confronting it, and clearly therefore a primary requirement is re-evaluation of current community health needs. Today the captains of death are the degenerative disorders and not infective and communicable diseases, and as Professor Alwyn Smith argued² the control of community health must now depend relatively more on intervention in the course of disease rather than primary prevention. No longer can preventive medicine be effectively administered without the considerable personal co-operation of the "at-risk" individual in the maintenance of satisfactory personal health; and thus the approach to social medicine in the community will involve either the education of "at-risk" individuals from an early age or the early detection of disability ensuing from progressive disorders. Undoubtedly this shift towards a more personally directed type of preventive medicine must ultimately involve an individual approach by the doctor, which will certainly not be achieved by physicians who sit remote from the people who need to be protected.

The new science of social medicine and the old practice of public health is and was respectively as personal and impersonal as they sound, and therefore the fact that many of the senior posts in community medicine are at present affording asylum to erstwhile senior non-clinical medical staff of the former public health service is a brake on the progress of clinical community medicine, which will only be released by someone with the clinical authority of, say, the clinical community paediatric specialist envisaged in the Court Report.

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¹ Committee on Child Health Services, *Fit for the Future*, London, HMSO, 1976.

² Smith, A, *The Science of Social Medicine*, p 91. London, Staples Press, 1968.

Melatonin as a tumour marker in a patient with pineal tumour

SIR,—A possibly misleading impression is given by the title of the article by Dr S G Barber and others (29 July, p 328). Kennaway¹ measured melatonin in the plasma of two patients with pineal tumours by radioimmunoassay: one was a 15-year-old boy with a "pinealoma" but on which histological examination was not performed; the other was a 43-year-old man with a histologically diagnosed malignant pineoblastoma. In neither case, before treatment in one and after ventriculoatrial shunt in the other, was melatonin detectable in plasma at a number of different times throughout the day and night. My own experience of plasma melatonin assays in cases of clinically suspected pineal tumour is inconclusive and lacking in clinical detail but perhaps relevant. In two young men with suspected pinealoma plasma melatonin levels were very high in one case, during both the day (1200) and the night (2400), and low in the other.

Tumours of the pineal region are histologically heterogeneous. Clearly a statistically reasonable number of cases with well-defined tumour histologically will be required to evaluate plasma melatonin as a biochemical marker.