The Department understands that in general the shortage is not expected to be troublesome but may cause difficulties in some fields of surgical or medical practice where alternative drugs are less satisfactory.

The decision as to the most appropriate treatment for particular patients rests, of course, with the doctor responsible. I believe, however, that in the circumstances all doctors will wish to do all that they can to preserve the limited stocks of cocaine by using alternative drugs wherever possible.

H YELLOWLEES
Chief Medical Officer,
Department of Health
and Social Security

London SE1

Medicine or meetings

SIR,—Professor J Dobbing's excellent letter (16 September, p 827) debunks the cult of holding international medical meetings at other people's expense. He invokes a plague on such gatherings. However, he closes his letter by listing the eight countries he has visited in the last year and the further eight to which he has committed himself. I have reread his letter to see if this is facetious hyperbole, but I am still not sure if this is the case. Professor Dobbing must either be joking or his life contradicts his views and he holds a post that is clearly redundant.

D E B POWELL

Bridgend General Hospital,
Bridgend, Mid Glamorgan

SIR,—I wish to express my complete support for all that has been said concerning medical meetings by Professor J Dobbing (16 September, p 827). The great majority of such meetings, both national and international, are very useful from a social and get-together point of view, but the actual material presented in a great many or even most of the meetings very often leaves much to be desired. I very much doubt if more than 10% of all material presented at a great many symposia would ever be considered for publication in a reputable journal. Small meetings of experts and active negotiators should be encouraged, as meetings hastily convened very often are sterile in the actual end result so far as material on medical advances is concerned; serious thought should be given to whether or not meetings on a large scale are in fact essential. The money spent every year by various bodies on these conventions must be quite staggering.

JOHN S STEVENSON

Department of Bacteriology,
Stobhill General Hospital,
Glasgow

SIR,—Professor J Dobbing (16 September, p 827) is a leading authority in a field which attracts much international interest, and evidently he goes to far too many international meetings which he believes are a waste of time and money. He wants to know why they should be organised at all.

I think it is obvious that the point of meetings (instead of printed publications) is that they give one a chance to press the author on points which are glossed over and to find out why he prefers one interpretation of data to another. Of course Professor Dobbing is right about small specialist meetings being the only type at which this is

possible at the highest level among experts, and it would be astonishing if he learnt anything new about his own subject from review lectures given to audiences of hundreds, or even thousands, of non-experts.

Few of us are leading experts in anything and none are expert in everything. It is useful to young researchers, or those who are changing their field of interest, to go to a good meeting at which the field is generally reviewed and the experts can be tackled on specific points. If, in the original communications session, a tyro presents a "puny paper" or "meaningless slides" he is entitled to constructive criticism from experts like Professor Dobbing. I hope the organisers of the eight meetings he went to in the past year and the eight to which he is committed paid his fare out of the registration fees of non-expert delegates and that they got their money's worth out of him. And surely in so many meetings there were *some* non-puny papers, even from people he had never heard of. If he learnt nothing he probably wasn't listening.

JOHN GARROW

Clinical Research Centre,
Harlow, Middx

Children who cannot read

SIR,—Your leading article on this subject (1 July, p 3) seems to have generated considerable correspondence. I would not have thought that the concept of developmental dyslexia was medically unacceptable. However, as the BMA Council (22 April, p 1077) states, "there is likely to be a consensus among doctors that a group of children exists who are disabled by severe reading difficulties (and often problems of writing and spelling) which are sufficient to impair their ability to benefit from ordinary schooling, and to impose limitations on their educational achievement and enjoyment of life. . . . In common with other handicapping conditions in childhood, the needs of the child with reading disability are best served by early identification of the problem, comprehensive interdisciplinary assessment, and remedial management, with reassessment at appropriate intervals."

Identification of the problem should not prove insurmountable,^{1,2} but the question of suitable remedial management is beginning to cause me some concern. It has been brought to my notice recently that there are a number of persons setting themselves up as "dyslexia therapists" with nothing more than a 2-4-day workshop as a training qualification. It is not suggested that these short courses should not be run, because they obviously promote further knowledge and understanding of the problem, but it is felt that the organisers should make it clear to the participants that such courses do not constitute a training qualification. The dyslexia clinic at this hospital has been running a one-year training course in the teaching of children with specific learning difficulties since 1973. It has been our experience, however, that even one year is insufficient for a full understanding of the problems these children are encountering and a further period of 1-2 years' teaching experience is necessary before one can be said to be a specialist teacher in this highly specialised field.

The matter is of some urgency for teacher training establishments, especially since the

publication of the Warnock Report³ on special education which recommends many amendments to teacher training curricula. Since so many of these children have earlier speech and language difficulties it is felt also that the College of Speech Therapists should be considering an addendum to their training programme, especially in the area of prophylaxis.

BEVÉ HORNSBY

Dyslexia Clinic,
Department of Psychological Medicine,
St Bartholomew's Hospital,
London EC1

¹ de Hirsh, K, Jansky, J J, and Langford, W J, *Predicting Reading Failure*. New York and London, Harper and Row, 1966.

² Hornsby, B, MSc thesis, University of London, 1973.
³ Department of Education and Science, *Special Educational Needs*, Report of the Committee of Enquiry into the Education of Handicapped Children and Young People. London, HMSO, 1978.

Use of digitalis in general practice

SIR,—I feel that the study by the Liverpool Therapeutics Group (2 September, p 673) is a useful and praiseworthy one and surely will help "to promote a more critical attitude to prescribing widely used drugs such as digitalis."

The results of the assessment were necessarily determined by the decisions made to continue digitalis therapy, discontinue it, or adjust the dose. The authors rightly point out that their criteria for discontinuation did not enable them to say how many of the patients could have had the drug withdrawn. The decision to continue digitalis therapy unchanged involved the largest group of patients (231 (59.1%)).

Evaluating the need for continued digoxin treatment is a difficult matter, especially so in patients with sinus rhythm and no signs of overt cardiac failure. The authors quote some studies demonstrating successful discontinuation of digoxin in the majority of patients with sinus rhythm, and I should like to add our own study¹ concerning discontinuation of maintenance digoxin therapy in 22 elderly cardiac inpatients with sinus rhythm and no overt cardiac failure. A comparison was made between clinical and radiological symptoms and signs indicating congestive heart failure before and after discontinuation of digoxin. Of the 22 patients, 16 tolerated discontinuation without detriment. Treatment was resumed in five cases but only three of these five patients presented unequivocal clinical or radiological evidence of deterioration following discontinuation of digoxin. One patient died suddenly of myocardial infarction.

There appears to be some doubt as to whether an initial inotropic action of digitalis is sustained during maintenance treatment. One study² demonstrated that in patients with cardiomyopathy or coronary artery disease and chronic congestive heart failure acute digitalisation does not necessarily lead to marked or lasting haemodynamic improvement. Another study³ concluded that chronic digoxin administration did not appear to cause a significant increase in left ventricular contractility. It was recently demonstrated⁴ that both acute and chronic digitalisation reduce myocardial blood flow and previous work⁵ showed that myocardial oxygen consumption is increased by digitalis unless increased contractility is counterbalanced by a reduction in heart size. In our study¹ mean

heart size decreased after discontinuation of digoxin, contrary to expectations.

These observations underline the inherent dangers of digitalis therapy, especially in coronary heart disease and respiratory insufficiency. It seems important to make sure that the only patients who are allowed to go on taking digoxin are those who otherwise would deteriorate clinically. At the moment the only way to achieve this goal is to discontinue the drug under conditions enabling close observation of the patients.

R KRAKAUER

Middelfart Sygehus,
Middelfart, Denmark

¹ Krakauer, R, and Petersen, B, *Danish Medical Bulletin*, in press.

² Cohn, K, et al, *American Journal of Cardiology*, 1975, 35, 461.

³ Davidson, C, and Gibson, D, *British Heart Journal*, 1973, 35, 970.

⁴ Steiness, E, et al, *Acta Pharmacologica et Toxicologica*, in press.

⁵ Covell, J W, et al, *Journal of Clinical Investigation*, 1966, 45, 1535.

Relevance of duration of transient ischaemic attacks in carotid territory

SIR,—We read with great interest the article by Dr M J G Harrison and others (17 June, p 1578) concerning the duration of individual transient ischaemic attacks (TIAs). Their and our data¹ are in agreement on several points. (1) Most carotid territory TIAs are very brief, usually lasting less than 30 min. This raises the question of adequacy of the usual 24-h criterion for TIAs. (2) The long TIAs, which are associated with normal or only minimally diseased carotid arteries, may be secondary to cerebral emboli from aorta or heart. In our series several patients with long attacks had arteriographic demonstration of intracranial arterial occlusions suggesting cerebral embolism. (3) About half of patients with bona fide carotid territory TIAs will have significant arterial disease in the extracranial internal carotid.

We do not, however, think that their conclusion that "stenosis of the cervical portion of the internal carotid artery was significantly more prevalent among patients whose attacks had been brief" is fully warranted. While it is true that patients with carotid stenosis have brief attacks, it also is true that most patients without significant stenosis have brief attacks. Of their 79 patients with brief attacks (groups 1 and 3), 41 had significant arterial disease (stenosis or occlusion) of the carotid-middle cerebral system and 35 had no or only minimal disease. If one considers only whether or not there was stenosis of the extracranial portion of the internal carotid artery, of those patients with brief attacks 30 had stenosis, 32 had normal or only minimal atheromatous changes, and two had complete occlusion. On the other hand, of the 37 patients with only long attacks six had significant arterial disease and 27 had no or minimal disease. Therefore we would conclude that most carotid territory TIAs are brief regardless of the degree of arterial disease in the carotid system; that long attacks are significantly related to no or minimal arterial disease; and that as a predictor of carotid-middle-cerebral arterial stenosis or occlusion TIAs of brief duration are statistically no better than TIAs of any duration.

Both series consisted of patients with only transient ischaemic attacks and not strokes. One might ask, if patients were followed to stroke would the duration of attacks change?

We have studied 64 patients with cerebral infarction in the distribution of the internal carotid artery and who had arteriographic demonstration of internal carotid artery stenosis or occlusion. Of the 33 (55%) patients who had prior transient ischaemic attacks, information on duration was available in 23. Only four patients suffered attacks longer than one hour. Thus the relation between duration of transient ischaemic attacks and stenosis appears to remain the same throughout the natural history of carotid stenosis.

GARY W DUNCAN

Department of Neurology,
Vanderbilt School of Medicine,
Nashville, Tennessee

MICHAEL PESSIN

Department of Neurology,
New England Medical Center,
Boston, Massachusetts

J P MOHR

Department of Neurology,
University of South Alabama,
Mobile, Alabama

¹ Pessin, M S, et al, *New England Journal of Medicine*, 1977, 296, 358.

Waiting lists for cardiac surgery

SIR,—The question of the varying length of waiting lists for cardiac surgery has recently received wide public attention and has been highlighted in your columns by the letter from Mr K K Nair and Dr S R Dunn (23 September, p 890). Unfortunately they, like others before them, have suggested a radical solution before considering the real nature of the problem. Surely it is important first to identify the reasons for the variations before proposing a remedy.

The absence of a waiting list in some areas may be due to one of a number of possible reasons. (1) The incidence or prevalence of heart disease may be substantially lower in some parts of the country than in others. (2) General practitioners and consultant physicians may not refer suitable patients to a cardiologist in some areas. (3) Cardiologists in some regions may adopt a more conservative approach to the management of heart disease. (4) Patients may be directed to a surgeon in another region either by the general practitioner, consultant physician, or cardiologist. This may occur if a particular unit is known to have a special interest or unusual expertise in the management of a particular problem.

If reason (1) were correct this might represent an argument for the closure of some units and expansion of others rather than the adoption of a national waiting list. However, although existing epidemiological data indicate that some regional differences in the prevalence of, for example, coronary disease do occur, this is insufficient to account for the great variation in waiting lists. The first reason is therefore not tenable. Assuming then that reasons (2), (3), or (4) are operating the solution surely lies at a local level in improved liaison between general practitioners, consultant physicians, cardiologists, and cardiac surgeons.

The adoption of a national waiting list would, I believe, not be accepted by cardiologists, cardiac surgeons, or patients. The difficulties of long-term follow-up of postoperative cases would be compounded and continuity of care would be sacrificed.

CLIVE A LAYTON

Cardiac Department,
London Chest Hospital,
London E2

Carcinoid of the breast

SIR,—Mr P G Devitt (29 July, p 327) reports on an argentaffin carcinoma of the breast. However, the histology as presented in the illustration is unconvincing. An acinar, trabecular, or insular pattern is not obvious. If the strands of dark cells in the photomicrograph are argentaffin cells, then the search for a primary midgut carcinoid should be continued. Primary carcinoids of the breast have been reported, but all were argyrophil only.^{1 2} Interestingly, primary carcinoids have been reported more often than secondary ones. Extramammary carcinoid presenting as a breast mass is exceedingly rare.^{3 4}

All carcinoids are malignant and therefore an attempt should be made to remove the entire tumour (or all of the tumours), especially in younger patients. However, most midgut carcinoids seem to grow very slowly, although there are exceptions. Metastasis of jejunoileal carcinoids is probably to lymph nodes initially and then to the liver. Mesenteric deposits are an important cause of symptomatology and mortality. Apart from retraction and kinking of bowel, the ileal carcinoid provokes a fibroelastic occlusive lesion of mesenteric arteries and veins with ensuing ischaemic enteritis or gangrene.⁵

T F C S WARNER

Department of Pathology,
University Hospital,
Indianapolis, Indiana

¹ Cubilla, A L, and Woodruff, J M, *American Journal of Surgical Pathology*, 1977, 1, 283.

² Kaneko, H, et al, *Cancer*, 1978, 41, 2002.

³ Harist, T J, and Kalisher, L, *Cancer*, 1977, 40, 3102.

⁴ Warner, T F C S, et al. In preparation.

⁵ Anthony, P P, *British Journal of Surgery*, 1970, 57, 118.

Radiology work load

SIR,—It would be wise to consider the implications of the content of the letter from Dr M Lea Thomas (2 September, p 706).

Firstly Dr Lea Thomas states that he "lets out" x-ray rooms to various clinical specialties as a means of overcoming the work load imposed on the radiologist. An important role of the department of radiology in any teaching hospital is the training of radiologists for the future, the majority of whom will work in district general hospitals when they achieve consultant status. It is obvious that Dr Lea Thomas can have no working knowledge of the very different staffing structure in these hospitals, in which the clinical specialties are covered by general physicians and surgeons with "an interest in" a particular specialty, such as chest diseases, cardiology, gastroenterology, etc. They do not have the support from experienced senior registrars and indeed the registrar establishment often falls short of acceptable requirements. How can these clinicians, who are as much overworked as any radiologist, be expected to gain and maintain the expertise to utilise the diagnostic x-ray facilities necessary to their varied requirements? These clinical services certainly need a well-trained radiologist as an integral part of the team. If St Thomas's Hospital opts out in this fashion should the college still regard it as a suitable training unit for future radiologists? We would question the advisability of this course.

Again, are we to withdraw this diagnostic service from general practitioners? In our long experience of district hospital radiology these