approved name of their medication, and what busy general practitioner is going to write "dextropropoxyphene hydrochlor 32.5 mg, paracetamol 325 mg tablets" when what he means is Distalgescic?

WILLIAM E BENNEY

Cheltenham, Glos

Controversies in WHO tumour classification

SIR,—The World Health Organisation and those concerned with the production of the 18 "blue books" on the classification of tumours in different sites have done a great service. There has been a reduction of multiplicity of names and presumably improved communication.

However, histological examination and reporting are interpretative and subject to observer variation and do not have the degree of specificity implied by Professor L. Kreyberg and Dr W F Whimster (28 October, p 1203). Two cancers could differ only in their histological appearance and two other cancers with the same microscopic appearance may be very different. To place too much emphasis on histological typing is detrimental to the development of non-histological tests, which may be clinically useful and also have specificity.

"When I use a word," Humpty Dumpty said . . . 'it means just what I choose it to mean—neither more nor less.'" To define precisely in histological terms is not to define precisely, and the words often mean just what the histologist chooses them to mean.

J M GRAINGER

Department of Pathology,
National Women's Hospital,
Auckland, New Zealand

¹ Carroll, L., *Through the Looking Glass*. London, Dent, 1871.

Serious verapamil poisoning

SIR,—With reference to Dr C M Perkins's article on this subject (21 October, p 1127) we would like to comment on some of his statements. The author suggests that his is the first description of pure verapamil intoxication since in the two previous reports that he cites the poisoning was caused by Isoptin S dragees (verapamil 40 mg and pentobarbitone 20 mg). He describes a 19-year-old woman with a history of ventricular extrasystoles and a prolapsing mitral valve who suffered adverse effects from self-poisoning with 3.2 g of verapamil. She was successfully resuscitated by the intravenous administration of calcium gluconate.

In the *European Journal of Cardiology* last year¹ we described a case of attempted suicide in a 28-year-old woman who was admitted to hospital after she had taken 5.6 g of verapamil in the form of 70 80-mg tablets of Isoptin (verapamil without pentobarbitone). On admission she exhibited bradycardia and pronounced hypotension. An electrocardiogram showed atrioventricular dissociation which persisted for 7½ h after admission. She was discharged 36 h later. In our patient the pronounced negative inotropic effects appeared early but were short-lived. The transient hypotension responded well to an intravenous infusion of sodium chloride. The administration of β -adrenergic amines was not considered necessary in our case.

In our report we suggested that oral verapamil is relatively non-toxic but that this

is possibly only the case in patients with a normal heart and circulatory system. A more serious course may be expected in cases of concomitant β -adrenergic blocking therapy or digitalis therapy. The report by Dr Perkins confirms our suggestion and stresses the importance of an increased awareness of the adverse effects of these drugs and their treatment, especially in patients with a disturbed circulatory system.

ULF DE FAIRE
TORBJÖRN LUNDMAN

Department of Medicine,
Serafimerlasarettet,
Stockholm, Sweden

¹ de Faire, U, and Lundman, T, *European Journal of Cardiology*, 1977, 6, 195.

Royal College of Surgeons of Edinburgh: reform of fellowship examinations

SIR,—Without wishing to add to any misunderstanding about any proposals made by the Council of the Royal College of Surgeons of Edinburgh, there should be some form of reply to Professor Andrew Wilkinson's letter (4 November, p 1301).

The resolution was passed by a "large majority" of fellows present, but the voting body consisted only of 55 for and 19 against. For such an important decision to be made a "large majority" should be more representative of the college. Surely the large number of Edinburgh fellows throughout the world should have been consulted by some form of postal vote, if not some forward notice requesting comment. Although the council last year did consult widely about the possibility of a substitution of a new Part II, there has been no attempt this time to gather in opinion for or against the new additional examination, Part III. Certainly, as a fellow of one of the larger UK specialist associations and an ex-officio member of its executive committee, I know that we have not held any discussions about this.

The declared advantage of this new fellowship examination of not disturbing the present diploma examinations is true, but is this reason enough to add another patch to John Knox's breeches? The introduction of the new specialist diploma in order to secure reciprocity with other colleges and bodies in this and other countries is also not fully explained. What really are the advantages or otherwise of reciprocity? It certainly will not increase, in orthopaedics at any rate, the flow of postgraduates who still come here for advanced surgical and research experience from most of the English-speaking world, many of whom have already taken their specialist qualification in their own country. A few of these still take one of the college examinations—as they stand at present—as an additional challenge to achieve some extra standing. If on the other hand the passing of the new third FRCS examination implies greater opportunities of specialist appointments abroad this also has to be questioned. In North America recruitment from non-Americans into orthopaedic posts is rare and very much related to academic achievement and not surgical qualifications. In Australasia they too have frozen their training programmes because of overproduction. As regards the EEC, the various specialist associations and the Higher Surgical Training Committee are already negotiating recognition based on our

present specialist training and assessment programmes. Being optional surely does not give it much authority in the world. One cannot really see who is going to gain from a third examination. Certainly it is not reciprocity in any way when our young surgeons will have to interrupt their surgical training for three major examinations rather than using their enthusiasm, skills, and learning to contribute to their surgical discipline by research and writing.

I would suggest that we should be considering critically how to maintain our recruitment into surgical specialties at present-day standards as well as providing greater opportunity for the young surgeon to be creative in his ideas, rather than adding further examinations.

ROBERT B DUTHIE

Nuffield Department of Orthopaedic
Surgery,
University of Oxford

SIR,—I was interested to read Professor Andrew Wilkinson's justification for introducing a higher examination in the surgical specialties (4 November, p 1301) and I wonder whether other senior registrars will share my revulsion at the prospect of yet another hurdle to jump during training. We already have two highly selective barriers in the form of the primary FRCS, with a pass rate of about 20%, and "final" fellowship with a similar pass rate. The training programmes administered by the Joint Committee for Higher Surgical Training ensure that future surgeons will have adequate clinical experience, and finally appointment committees are free not to appoint candidates to consultant posts who fall short of the desired standards. Are further selection procedures really necessary?

Some indication of the price of yet a further examination can be gauged from a consideration of the present final fellowship examination in one specialty, ophthalmology. Some 250 candidates a year currently sit this examination at one or other of the four centres. On average each candidate probably misses eight clinics during the course of the examination, involving the cancellation of perhaps 20 (a conservative estimate) appointments per clinic. Thus a total of 40 000 appointments are cancelled annually in ophthalmology alone for the sake of the final fellowship. Vast amounts of operating time are also lost and the cost to the area health authorities who reimburse candidates' expenses is likely to be around £50 000 a year. An even greater loss of clinical time is incurred while these candidates take study leave to prepare for the examination.

Any move which serves to raise standards, of course, deserves serious consideration, but the existing strict criteria seem perfectly adequate and I suspect that the overall benefit to the community from these proposals will be nil. Motivation and a willingness to keep abreast of recent developments and techniques are at least as important qualities in a surgeon as the ability to pass examinations and diplomas, however "voluntary." I confess to a sneaking feeling that the interests of our patients might be better served by fostering these qualities and perhaps even adopting some means of monitoring them throughout a surgeon's later career.

ROBIN BOSANQUET

Manchester Royal Eye Hospital,
Manchester