sive. Most of them would also be willing, for a variety of reasons, to make a full-time commitment to the NHS. This they should have the right to do by choice, whereas the new contract would compel them to be dependent for their status as full-timers on the fortuitous availability of extra notional half-days (NHDs).

We established consultants would, of course, be entitled to keep our present contracts, but we should insist, in the interests of our successors, on the provision of a choice between the new contract and an "open" one. To fulfil its purpose and remain compatible with the new contract it would have to be priced at the equivalent of not less than 14 NHDs.

Presumably the Review Body will in any case have to price the present full-time contract in relation to the new contract, and logic dictates that the value of the former cannot be fixed at less than that of 14 NHDs. It might quite reasonably be argued that 15 would be fairer, but let us not yield to avarice! The equivalent of one extra NHD could be awarded to consultants who work single-handed or otherwise in peculiarly difficult circumstances.

If the Review Body recommends as I predict, there is no reputable reason why such a choice should not remain available indefinitely.

D HUNTER SMITH

Thursby,
Carlisle, Cumbria

Money for old rope

SIR,—I should like to contribute to the discussion provoked by Dr S P Linton (24 June, p 1701). I am a general practitioner trainee and must agree with his views on the state of vocational training in general practice. I would suggest to Dr J T Hart (8 July, p 130) and Dr M S T A Lawrence (22 July, p 283) that paper plans and educational theory are very different in the reality of day-to-day general practice. The trainer-trainee apprenticeship is unique in that both are equally qualified to practise medicine, and for most of his duties the trainee takes full patient responsibility. The trainee relieves surgery work load and home visits as well as participating in the on-call rota and acting as locum for absent partners. His opinion may also be sought for his current knowledge of therapeutics and hospital management. These advantages far outweigh the relatively small effort required by his trainer. Indeed, I have heard many practices confide that should they lose their trainee they would require an extra partner. In this context it is interesting to examine the *BMJ*'s "situations vacant" columns over recent years. An analysis of posts offered for the month of June shows the following weekly averages:

	Partnerships offered	GP trainee posts
1974	39	12
1975	45	16
1976	44	19
1977	36	21
1978	40	30

Excluding posts for assistants and also trainee posts as part of approved three-year schemes, it can be seen that while the number of practice partnerships has remained static there has been a steady growth in trainee posts. In these inflationary times it is perhaps not surprising that practices opt for a trainee,

whose salary is met by the family practitioner committee and for whom they also receive a training grant. It is the trainees who are conscientious and operate this unfair system at financial disadvantage in order to further their vocation.

Boston, Lincs

S P DEACON

Points

Allergic alveolitis

Dr F S MOONEY (St Helens Hospital, St Helens, Merseyside) writes: Dr D J Hendrick and his colleagues (8 July, p 81) . . . claim that budgerigar-fancier's lung is the commonest variety of allergic alveolitis in Britain . . . In 1975¹ I drew attention to the occurrence of this disease in coalminers at necropsy. Since then further cases have come to light. In fact, out of a total of 127 consecutive necropsies on coalminers, 10 were found to have both naked-eye and histological evidence of extrinsic or allergic alveolitis. Two of these, incidentally, also had carcinoma of the lung. Once again there was no history of significant exposure to dusts other than that of coal. Dr Hendrick and his colleagues have apparently discovered four cases of budgerigar-fancier's lung in 117 cases. Important though this is, it seems to me that there is evidence that its occurrence in coalminers may be even higher.

¹ Mooney, F S, *British Medical Journal*, 1975, 2, 487.

Carbamazepine and heart block

Dr D V HAMILTON (Norfolk and Norwich Hospital, Norwich) writes: Dr B Beermann and Dr O Edhag (15 July, p 171) suggest the avoidance of carbamazepine in patients with atrioventricular block grades II and III. I have recently reported the occurrence of complete heart block in a patient with ischaemic heart disease treated with carbamazepine for trigeminal neuralgia.¹ I would advise caution in the use of this drug in all patients with ischaemic heart disease and especially the avoidance of doses of carbamazepine exceeding 600 mg/day in such patients.

¹ Hamilton, D V, *Lancet*, 1978, 1, 1365.

Synovial cyst causing an inguinal mass

Dr CHARLOTTE FELDMAN (London SW19) writes: . . . If Drs R A Williams and L J Marks (8 July, p 91) refer to a case of rheumatoid arthritis I reported in 1961¹ they will find that even greater diagnostic difficulties may be encountered when generalised lymph node enlargement (not uncommon in rheumatoid arthritis) and synovial cyst of the hip joint coexist.

¹ Feldman, C, *Annals of Physical Medicine*, 1961-2, 6, 23.

Treatment of vaginal candidosis

Dr P D SIMMONS (Department of Genital Medicine, St Bartholomew's Hospital, London EC1) writes: Only a male microbiologist would suggest treating vaginal candidosis with nystatin, two pessaries night and morning for six weeks (Dr R Y Cartwright, 8 July, p 108). Gravity continues to act towards the centre

of the earth and pessaries follow the same path: pessaries inserted in the morning fall out. Recalcitrant candidosis is better treated by a long course of nightly nystatin—for example, two pessaries at night for two weeks followed by a two-week course using one pessary and two weeks using one pessary on alternate nights.

Humidifier fever

Mr G S ABBEY (Managing Director, A and A Industrial Equipment Ltd, Leeds) writes: . . . We would comment on the statement in your leading article (6 May, p 1164) that where water is allowed to stagnate and be used for humidification purposes with a spinning disc type of humidifier stagnant water which can be a breeding ground for algae, could introduce algae and spores into the atmosphere resulting in sickness of a type described in your article. This can only happen should maintenance of the unit be neglected, allowing the growth of algae etc. The point we would like to make is your failure in the article to mention the numerous biocides which are available and which, themselves being harmless, will immediately eliminate all algae and spores. . . .

Dopamine dosage

Drs J M CHAPMAN and J R DAVIES (Anaesthetic Department, Bristol Royal Infirmary) write: Dopamine infusions are widely used in the treatment of circulatory failure. As the drug is so potent, intensive monitoring and drip counter control of the infusion are essential. . . . If an individual concentration is calculated for each patient from body weight, then 1 drop/min can be the same as 1 µg/kg/min. To achieve this with a drip set delivering 60 drops/ml the amount of dopamine in milligrams in 100 ml of infusate must be six times the patient's weight in kilograms. The method may be adapted for other drip sets by ensuring that the dopamine content of each drop in micrograms is the same numerically as the patient's weight in kilograms, when the same drop-to-dose relationship will apply. Children and infants may require double or fourfold concentration to reduce fluid input, but the essential simplicity remains.

Treatment of axillary hyperhidrosis

Dr G N VERNON (Staff Pharmacist, Vale of Leven District General Hospital, Alexandria, Dunbartonshire) writes: . . . There are two points in the paper by Dr Scholes and others (8 July, p 84) which I feel need clarification. (1) The 20% solution of aluminium chloride hexahydrate in alcohol does not necessarily take 21 days to prepare at room temperature; by using a magnetic stirrer we are able to prepare the solution in 2-3 days—quite a considerable difference. (2) The authors state that using absolute alcohol means paying excise duty, which increases the cost of the preparation; consequently they now use a lower-proof spirit (95-99.5%). I was under the impression that excise duty was repayable if the alcohol was used in a medicinal preparation and was not recoverable.¹

¹ HM Customs and Excise Form Ex 224.