Plasma PGF_{2α} concentrations in female genital tract malignancy

Patient No	Age (years)	Diagnosis	Plasma PGF _{2α} concentration (ng/l)
1	65	Carcinoma ovary stage III	88
2	41	Carcinoma ovary stage III	97
3	52	Carcinoma ovary stage III	70
4	58	Carcinoma ovary stage III	65
5	59	Carcinoma ovary stage III	45
6	16	Carcinoma ovary stage IV	61
7	76	Carcinoma ovary stage IV	92
8	62	Carcinoma ovary stage IV	59
9	65	Carcinoma endometrium stage I	34
10	64	Carcinoma endometrium stage I	39
11	57	Carcinoma cervix stage I	25
12	60	Carcinoma cervix stage IV	94
13	69	Mixed Mullerian tumour stage IV	94

Blood PGF_{2α} levels were measured by radioimmunoassay² in 13 untreated patients with gynaecological cancer presenting to this centre. The results are shown in the table and indicate a uniform elevation above the range (9–24 ng/l) established in our laboratory for normal adult women. A positive correlation with the stage of the disease is also apparent.

In common with other forms of malignant disease tumours of the female genital tract are associated with raised blood levels of PGF_{2α}. The mechanism of this association is unclear but most likely reflects abnormal PG production by neoplastic cells. One practical implication of this finding is the possibility that hypercalcaemia and osteolysis occurring in advanced malignancy³ may be caused by the osteolytic effect of PGF_{2α} and not be due to bone secondaries.

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¹ Williams, E D, Karim, S M M, and Sandler, M, *Lancet*, 1968, **1**, 22.

² Dray, F, Charbonnel, B, and MacLough, J, *European Journal of Clinical Investigation*, 1975, **5**, 311.

³ Powles, T J, *Proceedings of the Royal Society of Medicine*, 1977, **70**, 199.

Schizophrenia and neurosis

SIR,—Your leading article (8 July, p 76) on the predominance of neurotic complaints in a group of chronic schizophrenics treated in the community quotes, from Cheadle *et al*¹, surprise that this should be the case. It furthermore reiterates their assertion that neurotic symptoms are the major stumbling block to rehabilitation within the community.

Might I suggest that the work of Cheadle *et al* merely confirms something which has been known for the greater part of this century—that premorbid adaptation has a considerable bearing on recovery from schizophrenic breakdown? A 100-year review² of the literature on premorbid personality and schizophrenia illustrated well that in many

studies chronicity has a relationship to poor premorbid personality, and presumably the latter is a major determinant in so-called neurotic symptoms in the group studied.

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¹ Cheadle, A J, Freeman, H L, and Korer, J R, *British Journal of Psychiatry*, 1978, **132**, 221.

² Fritsch, W, *Fortschritte der Neurologie, Psychiatrie und ihrer Grenzgebiete*, 1976, **44**, 323.

Colonoscopy in the diagnosis of pseudomembranous colitis

SIR,—Dr A Kappas and his colleagues (18 March, p 675) are of the opinion that pseudomembranous colitis (PMC) is far more common than the sporadic published reports would suggest, a view which, as stated in your leading article in the same issue (p 669) has also been expressed by others.¹ Dr Kappas and his co-workers believe also that the only means of avoiding a high mortality rate is to establish the diagnosis promptly and give early supportive treatment. They conclude that careful, repeated sigmoidoscopy should be performed in all clinically suspected cases and in any patient with an unexplained complication after a colorectal operation.

But, as Bartlett and Gorbach in their excellent review of PMC pointed out,² one must also remember that the anatomical location of pseudomembranes includes virtually all portions of the intestinal tract. When the colon is attacked the more severe lesions occur in the proximal portion—the caecum and ascending colon. In patients with antibiotic-related disease the major impact of the disease is in the colon. This is evident also in some clinical studies. For example, Dr Kappas and his colleagues performed sigmoidoscopy on 20 patients with PMC but found membranes in only 13, while the appearances were normal in two. Price and Davies³ found typical plaques on sigmoidoscopy in only 14 out of 21 cases. Bearing in mind how serious a disease PMC can be, it does not seem to me that investigation by repeated sigmoidoscopy with biopsy and faecal toxin tests is sufficient to make an early diagnosis of PMC in all cases. Colonoscopy in skilled hands is safe,⁴ and I believe that the risk of perforation is not very great in the early stages of PMC with less severe mucosal changes. My own experience of colonoscopy for the diagnosis of PMC has been good, as the following case history shows.

A 27-year-old electrician was admitted with severe abdominal pain and bloody diarrhoea after three days' amoxicillin treatment (total dose 3.375 g). He had previously had abdominal pain and diarrhoea after penicillin treatment five years previously but had since been well except for symptoms of allergic rhinitis.

In the emergency room his temperature was 37.5°C, leucocyte count $21.9 \times 10^9/l$ ($29\,000/mm^3$), serum total protein 55 g/l. Sigmoidoscopy showed a totally normal rectal mucosa, but the contents of the sigmoid colon were brightly bloodstained. Next day I carried out a bedside colonoscopy with biopsy without x-ray or special bowel preparation. The rectum was normal, but at a height of 30 cm there was a heavily bleeding mucosa with gray plaques. The examination was stopped when it was seen that the whole descending colon was diseased except for some small areas with visible blood vessels. Although it was impossible to make a definite diagnosis because of the similarity of the colonoscopic picture to that of ulcerative

colitis and our case, a tentative diagnosis of PMC was made. The patient was treated with intravenous fluids and orally metronidazole 500 mg twice daily. The abdominal pain and bloody diarrhoea disappeared in five days and the patient made a full recovery.

The biopsy specimens taken at colonoscopy from diseased areas at the level of the sigmoid and ascending colon were later found to show the typical diagnostic features of PMC. After 10 days a control colonoscopy was performed, with normal findings. Faecal and biopsy specimen cultures taken during the first days in hospital showed only a growth of *Klebsiella pneumoniae* and *Pseudomonas maltophilia* with an otherwise normal flora. Unfortunately, no special investigations for the detection of *Clostridium difficile* or *Cl sordelli* were carried out.

I suggest that careful colonoscopy is indicated for the early diagnosis of potentially fatal PMC if the key investigation, sigmoidoscopy, gives negative results.

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¹ Tedesco, F J, Barton, R W, and Alpers, D H, *Annals of Internal Medicine*, 1974, **81**, 429.

² Bartlett, J G, and Gorbach, S L, *Advances in Internal Medicine*, 1977, **22**, 455.

³ Price, A B, and Davies, D R, *Journal of Clinical Pathology*, 1977, **30**, 1.

⁴ Britton, D C, *et al*, *British Medical Journal*, 1977, **1**, 149.

Sulphinpyrazone and prevention of death after myocardial infarction

SIR,—Your leading article (15 April, p 42) which discussed the report of the sulphinpyrazone trial¹ rightly calls for caution in accepting the favourable results without further information. One reason mentioned is the disparity between groups in the incidence and characteristics of arrhythmias. Another perhaps more obvious reason for doubting the results is the fortuitously high incidence of death in the placebo group (9.5%). For patients surviving the first month following myocardial infarction, especially when those with cardiomegaly were excluded, a death rate of 5% per annum or less might have been expected, more in line with the figure of 4.9% for the treated group in the trial. The data for the placebo group in the long-term practolol post-infarction trial² indicate the importance of heart size in prognosis (see table).

Death rate related to cardiac width (data from placebo group in Multicentre International Study¹)

Cardiac width (cm)	Deaths	No of patients	Death rate (%)
≤13	7	309	2.3
14–15	24	658	3.6
16–17	30	316	9.5
≥20	4	33	12.1

Armitage test for linear trend relating increasing death rate with increasing cardiac width significant at 1% level ($P < 0.001$).

A positive role for the platelet in the development of ischaemic heart disease seems very probable and the mode of action of sulphinpyrazone is therefore attractive. However, the long-term use of the drug following infarction should be postponed until a further large trial has confirmed benefit against placebo group figures which are more in accord with general experience. Perhaps

the British Cardiac Society should encourage the setting up of a multicentre study.

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¹ Anturan Reinfarction Trial Research Group, *New England Journal of Medicine*, 1978, **298**, 289.

² Multicentre International Study, *British Medical Journal*, 1977, **2**, 419.

Basal cell carcinoma in identical twins

SIR,—The case report by Dr K Liddell (8 July, p 97) on basal cell carcinoma in identical twins with a high degree of concordance for earlier medical history, anatomical site, and time of diagnosis was very illuminating. We would bring to your attention four twin pairs concordant for basal cell carcinoma in Finland. These were observed after computer-assisted record linkage between the Finnish Twin Registry (containing 17 357 like-sexed twin pairs born before 1958 belonging to unbroken (living) pairs in 1967) and the Finnish Cancer Registry (tumours diagnosed before 1975). Twin zygosity had been determined by questionnaire in 1975.¹ All cases of basal cell carcinoma (BCC) had been histologically verified. The following are brief reports of the four concordant twin pairs.

Identical male pair, born 1894. Lived together for 30 years. First twin had a BCC on the trunk in 1968; died from atherosclerotic nephropathy in 1970. Second twin had BCC on the nose in 1970.

Male pair of unknown zygosity, born 1901. First twin had BCCs in 1961 (ear), 1967 (face), and 1970 (forehead); died of cancer of the prostate in 1973. Second twin had BCC of the forehead in 1967.

Identical male pair, born 1912. Lived together 32 years. First twin had BCC on forehead diagnosed in 1961. Second twin had BCC on face in 1968.

Male pair of unknown zygosity, born 1931. First twin had BCC on shoulder in 1970. Second twin had a mid-back BCC in 1974.

In addition 65 discordant pairs were identified whose zygosity distribution (17 identical, 39 fraternal, and 9 unknown) corresponds to that of the whole twin series. The crude proband concordance rate in identical twins (2/19) is certainly much greater than the risk in the general population, but the common familial environment is a confounding factor which should be considered. Family studies should prove useful in clarifying its role.

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LYLY TEPPÖ

Finnish Cancer Registry

¹ Sarna, S, *et al*, *Human Heredity*, 1978, **28**, 241.

Lord Mayor Treloar Hospital, Alton

SIR,—We, the undersigned consultant orthopaedic surgeons of the Wessex Region, wish to make public our total opposition to the decision of the Hampshire Area Health Authority to close the Lord Mayor Treloar Hospital at Alton.

This decision, which we are told is irrevocable, was announced to a meeting of the surgical staff on 16 June 1978 but had apparently actually been taken by the authority as long ago as last July, without consultation with or notification to any orthopaedic surgeons on the staff of the hospital or region.

Alternative arrangements are being offered to the districts in the form of additional beds and operating theatres in the mistaken belief that this will suffice to replace the comprehensive facilities of the Regional Orthopaedic Centre. It is evident that these proffered schemes will do nothing to lessen the waiting lists in any district, while a successful regional orthopaedic centre which is working well with a dedicated staff and happy atmosphere, a school of orthopaedic nurse training, and magnificent rehabilitation facilities, and which has enjoyed complete freedom from industrial strife, is to be shut down.

It is our considered opinion that a wrong decision has been made. Taken in haste to meet the present financial crisis, its consequences will be incalculable and this area authority will stand condemned for being the only one in the country to shut down a large and successful regional orthopaedic centre. This hospital has served a large area of southern England since 1907. It has a national reputation and has earned the devotion of its patients. It has also maintained an international reputation since Sir Henry Gauvain's pioneer work on bone tuberculosis in the earlier decades of this century. Over the years the hospital has adapted successfully to the changing scene, and it is our wish that the Lord Mayor Treloar Hospital be allowed to continue as an active regional orthopaedic centre.

We deplore this ill-judged decision and ask the Hampshire Area Authority to think again. We appeal to the Wessex Region and to the Minister of Health to re-examine this issue. We hold the ultimate clinical responsibility for providing the orthopaedic needs of our patients.

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EDWARD SMYTH
JOHN WILKINSON
ROBERT JACKSON
J W FITZGERALD
J A ROBERTSON

MICHAEL HUNTER
ROBIN DENHAM
M ELIZABETH SHELSWELL
JOHN ALLISON
W E G GRIFFITHS

Negotiating rights for junior hospital doctors

SIR,—Mr Tom McFarlane's charges (22 July, p 282) of preplanned filibustering to prevent debate on Motion 104 at the Hospital Junior Staff Conference are unjust.

Motion 104 was the third resolution in the section on "Representation of Hospital Junior Staff," to which a time limit of 30 minutes had been allocated under the guillotine arrangement. The first two resolutions in this section dealt with very important matters—representation of junior doctors on Council and BMA facilities for Regional HJSCs—and used up all the time allocated. An average of 15 minutes per debate is hardly filibustering.

Mr McFarlane might more appropriately have asked, however, why the conference Agenda Committee had not placed Motion 104 at the beginning of the section, thus ensuring that it would be debated, if it was indeed of the importance suggested by the representatives of MPU/ASTMS. He might have gone further and asked why the members of MPU/ASTMS present at the conference did not oppose the report of the Agenda Committee at the appropriate time.

While I am not in a position to answer the latter question, I can perhaps give an explanation on behalf of the Agenda Committee. The Junior Staff Conference exists to formu-

late broad outlines of policy for the Hospital Junior Staff Committee to pursue during the following year. It has no powers to alter either the constitution or the composition of the HJSC itself, which is an autonomous standing committee of the BMA. As far as the Hospital Junior Staff Conference is concerned, therefore, Motion 104 was not one which fell directly within the remit of the conference and the Agenda Committee could not therefore give it precedence over motions which did so fall. This year 126 motions appeared for debate on the conference agenda and of these time allowed for only 32 to be dealt with. The Agenda Committee endeavours to perform the difficult task of ensuring that full consideration is given to the maximum number of resolutions which fall within the remit of the conference and cannot, now or in the future, give priority to resolutions which fall outside this remit.

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Hospital Junior Staff
Conference

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Private day cases and outpatient diagnostic services

SIR,—You kindly published (1 July, p 60) a letter from me stressing the importance of consultants informing the Health Services Board if they have evidence of the use of diagnostic services for private patients in the hospitals listed in the Health Services Board circular of 6 June 1978. In that circular the board asked health authorities to provide written confirmation of the accuracy of the SH3 nil returns for 1976 and 1977. It has been pointed out to the board that there is, in fact, no space on form SH3 on which information may be given about the use of diagnostic facilities for private patients, and in view of this the board has agreed that whenever a health authority submits a nil return the board will ask for further specific confirmation that there has been no use, under the authorisation as distinct from under "open access" arrangements, of these services for private non-resident patients. No proposals will be made without such confirmation, although this may mean the board having to delay their submission to the Secretary of State.

It is still important, however, for any evidence of the use of such facilities to be brought to the notice of the board.

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New consultant contract

SIR,—Since it became plain that rather fewer than half of those eligible to vote in the recent ballot had actually approved the new contract in principle I supposed that such a radical change in our terms of service would not be enacted without further consultation. Unfortunately, such a course of events is now far from certain.

If the new contract proposals should be implemented despite the inadequacy of the mandate, the effect on the significant minority who favour an "open" contract, largely on the lines of the present one, would be oppres-