and confused parents the general practitioner really appreciates the most expert guidance.

M D COULTER
B M JONES

Potton,
Sandy, Beds

Commitment to oncology

SIR,—We have followed with interest the correspondence in your columns resulting from the leading article entitled "Commitment to oncology" (2 April, p 864), and now feel obliged to enter into the controversy stimulated by the comments made by Professor K D Bagshawe (18 June, p 1597), which, far from "settling the dust" on the issue as he hopes, are more likely to inflame the situation.

It is Professor Bagshawe's astonishing statement that "radiotherapy has already diminished in relative importance and it no longer provides a suitable foundation for training all future oncologists" which is the one most likely to upset the majority of radiotherapists, although it is not clear whether Professor Bagshawe considers radiotherapy to have diminished in importance purely in its role in the training of oncologists or whether he applies this statement to the position of radiotherapy in the management of malignancy as a whole. On either count we very strongly reject this generalisation as being inaccurate and misleading.

Considering, firstly, radiotherapy's position in training, other correspondents (Mr W H Bond, 7 May, p 1214; Dr K E Halnan, 14 May, p 1280) have already referred to the scope of training available under the auspices of the Royal College of Radiologists, which is intended to provide total training in all aspects of the investigation and management of patients with cancer. It is quite correct and proper to consider the product of this training to be a "radiotherapist and clinical oncologist," but it would be wrong to suggest that such radiotherapeutic oncologists should have a monopoly in the use of drugs in cancer treatment. Yet if we accept that cancer treatment is a multidisciplinary problem requiring the closest co-operation between the various participants the introduction into the team of a new member (that is, the medical oncologist or cancer chemotherapist) would be better achieved with the help and guidance of that team. The future medical oncologist will need to have as great a degree of knowledge of the application of radiotherapy in cancer as the radiotherapist currently has of the application of drugs if he is to be able to offer his patients a high standard of care. Therefore, to ensure that his training is sufficiently broad-based and comprehensive, part of it will need to be under the direction of the radiotherapists in specialist centres.

The statement that "radiotherapy has already diminished in relative importance" is likely to mislead a lot of people by suggesting that radiotherapy has achieved all that it is capable of in malignancy, yet this could not be further from the truth. Radiotherapy is gradually being released from the bonds of "radioresistance" (a word which defies any meaningful definition) and more and more tumours previously regarded as "resistant" are being successfully treated by radiotherapists. The studies on neutron beams and radiosensitisers, as well as in fractionation and in the optimisation of radiotherapy, promise

much for the future, and indeed in disseminated malignancy one should not discount the use of total-body or half-body irradiation as an alternative to chemotherapy when systemic treatment is required. To work actively in these matters will protect us from the criticism that we only follow behind the advances of others.

Most radiotherapists are well aware that there are many avenues to explore in the application of radiation in the treatment of malignancy, but while suspicions and misconceptions exist between the radiotherapists and medical oncologists the cause of a team approach in cancer is unlikely to be furthered and surely the message to both is that neither should try to "go it alone."

R G B EVANS
I C M PATERSON
J M BOZZINO

Regional Radiotherapy Centre,
Newcastle General Hospital,
Newcastle upon Tyne

Breath, alcohol, and the law

SIR,—The reply to the question posed by Professor J P Payne and Dr D W Hill (4 June, p 1468) is that the results given in our paper were obtained by Dr A W Jones, who was working at the time as a research student under Dr T P Jones, with technical and theoretical advice from myself. We could not give a reference to his thesis because it had not been published when we submitted our paper for publication.

The statement by Professor Payne and Mr Hill that our results "do not differ substantially" from theirs cannot be supported. Comparison of the precision with which the blood alcohol concentration was predicted shows that in our case the standard deviation (SD) was 3.4 mg/100 ml and in theirs 6.2 mg/100 ml; if readings taken before the peak and those from subject 1 are excluded the difference between the results can be accounted for mainly by the difference in the characteristics of the two breath instruments used. Theirs had a "precision of $\pm 3\%$ " while ours gave an SD of 0.5 mg/100 ml on a standard 100 mg/100 ml equivalent alcohol-air mixture. In addition, their instrument¹ analysed the last 100 ml of a 500-ml breath sample while ours used a 0.25-ml sample taken after at least 2 l of breath had been discarded to minimise the "dead space" effect. As I mentioned in my previous letter (7 May, p 1216), the dead space effect is the main reason why breath analysis cannot exactly reflect the blood concentration. This issue is fully discussed in our paper, which is also available in a shortened and more accessible version.² The importance of a large discard volume has been recognised by other workers.³⁻⁵

The instrument that we used, known as the "gas chromatograph intoximeter," has been available since 1969⁶ and has been used for police work in other countries.¹

In view of the legislation pending on the Blennerhassett Report it is unfortunate that Professor Payne and Mr Hill's paper, which is the most recent to appear in a British scientific journal, should condemn breath analysis on the results obtained with an out-of-date instrument, with an inferior analytical performance, which is not really suitable for breath analysis and is quite unsuitable for field use.

I can only repeat what I said in my last letter—that the time for laboratory studies has passed. A final judgment on the role of breath

analysis in medicolegal practice must await the outcome of operational studies with equipment suitable for police use.

B M WRIGHT

Clinical Research Centre,
Harrow, Middx

- ¹ Allobaidi, T A A, and Hill, D W, *Journal of Physics*, **E** 1975, **8**, 30.
- ² Wright, B M, Jones, T P, and Jones, A W, *Medicine, Science, and the Law*, 1975, **15**, 205.
- ³ Penton, J R, and Forrester, M R, *Proceedings of the 5th International Conference on Alcohol and Traffic Safety*, p 79. Freiburg, H F Schutz Verlag, 1969.
- ⁴ Harris, L S, Hodnett, C N, and Mullen, J B, *Proceedings of the 6th International Conference on Alcohol, Drugs and Traffic Safety*, p 561. Toronto, Addiction Research Foundation of Ontario, 1975.
- ⁵ Dubowski, K M, *Clinical Chemistry*, 1974, **20**, 294.
- ⁶ Noordzij, P C, *Proceedings of the 6th International Conference on Alcohol, Drugs and Traffic Safety*, p 553. Toronto, Addiction Research Foundation of Ontario, 1975.

*.*This correspondence is now closed.—Ed, BMJ.

MRC treatment trial for mild hypertension

SIR,—An important aspect of any anti-hypertensive drug trial is the amount of attention given to associated risk factors for coronary heart disease. The risk in severe hypertension is that of cerebral haemorrhage, cardiac failure, or renal failure, whereas in those with mild to moderate hypertension it is mainly that of accelerated atherosclerosis. It follows that in the second group just as important, or more important, as controlling the blood pressure is explicit advice on diet and persuasive advice against smoking.

In Japan it has been shown that owing to a "healthy" diet and low plasma cholesterol levels hypertension, unless severe, matters little even in smokers. In the Framingham study in the USA it has also been shown that moderate hypertension has no adverse effect if lipid levels are not raised.

Dietary advice in the UK has now been recommended for the population as a whole by two working parties and is particularly important for those at high risk, which must include all hypertensives. This creates a major additional problem for those engaged in trials because acceptance of advice depends not only on its content but by whom and in what manner it is given. Unavoidably, more variables are introduced. Presumably it would be thought unethical to omit these aspects from the control group as well as those receiving antihypertensive drugs.

RICHARD TURNER

University of Edinburgh

Severe thrombophlebitis with Praxilene

SIR,—I read with interest the paper by Mr C A J Woodhouse and Mr O G A Eadie (21 May, p 1320) on the incidence of thrombophlebitis after infusion of naftidrofuryl oxalate (Praxilene). We have been assessing this drug in patients with severe rest pain over the past two years and have so far given it to 35 patients. There has only been one incident of phlebitis and this occurred on the third day during intermittent infusion via a Venflon intravenous cannula, which was left in situ during the period of treatment.

The authors state that it is recommended that the drug should be infused over two hours with 200 ml of dextrose, dextrose saline, or low-molecular-weight dextran, but in the