knowledge of prescribing habits and intentions. Doubtful cases can be referred to prescribers for elucidation. How farcical this return of scripts three months after dispensing. Pharmacists object to marking scripts "pc" regardless of truth to secure payment for more than five days' supply. Rather than initial a lie, my "pc" serves for "person consulted," whether patient, physician, or "panjandrum" in charge of practice records.

The only palatable revision of FPN 114 would entail shifting responsibility for omissions to prescribers, where it assuredly belongs. Doctors must be urged to write prescriptions properly, just as pharmacists must dispense them properly. Where occasional accidental omissions occur the pharmacist should be trusted to carry out the prescribers' intentions. Whatever else, the principle must be firmly established that pharmacists cannot be held responsible and penalised for the shortcomings of another profession.

The unworkable provisions of FPN 114 represent the most disgraceful and vicious imposition upon our profession in my 48 years in pharmacy. This monstrous concept of cheating pharmacists must be challenged.

GUY C ROBINSON

Norwich

White coat

SIR,—My partners and I must be idiotic GPs according to Dr D J Vicary (6 November, p 1135). For the past eight years we have worn white coats in our surgery and, however our egos are affected, our pockets have benefited. Our annual expenditure on lounge suits has been reduced by 50%—a considerable achievement in these inflationary times.

R MACG AITKEN

Spalding, Lincs

SIR,—I have long been an admirer of Dr Julian Tudor Hart's work and philosophy (9 October, p 862) and I was therefore concerned to read Dr Vicary's letter (6 November, p 1135).

I have no idea what Dr Tudor Hart's motives are for wearing a white coat, but I very much doubt if it is to "separate" him from his patients or to satisfy his ego. Perhaps, however, some clues may be gained by comparing the environments of industrial South Wales and genteel rural Suffolk.

GORDON C HANCOCK

Birkenhead, Merseyside

Plasma propranolol levels in coeliac disease and Crohn's disease

SIR,—We were interested in the attempt of Dr B T Cooper and others (6 November, p 1135) to explain our findings of raised plasma propranolol levels in Crohn's disease (2 October, p 794) by enhanced absorption of the drug due to changes in the microclimate of the jejunal mucosa. As yet we do not know the mechanism involved and, contrary to their comment on our communication, never did claim to have shown "that propranolol was absorbed better in Crohn's disease." Indeed, we do not believe that this could be the case

since Patterson *et al*¹ showed that "there is virtually complete absorption" of propranolol in man after oral administration.

Propranolol is a drug that is extensively metabolised during its first passage through the liver; although enhanced overall absorption as such is unlikely to be the cause of the raised plasma levels in Crohn's disease, one might postulate that accelerated absorption, possibly by a change in the microclimate of the jejunal mucosa, might overload this system and allow more of the unmetabolised drug to reach the general circulation. However, if this were the case the same changes in the jejunal microclimate that Dr Cooper and his colleagues claim for Crohn's and coeliac disease should also occur in such non-intestinal diseases as rheumatoid arthritis and pneumonia, in which similarly raised plasma propranolol levels have been found by Babb *et al*.² We should be greatly interested to know whether Dr Cooper and his colleagues could supply us with such evidence. Contrary to their suggestion that the absorption of propranolol would be enhanced in untreated coeliacs we found in two such cases (unpublished) that the plasma levels were no higher than in the treated group.

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¹ Paterson, J W, *et al*, *Pharmacologica Clinica*, 1970, 2, 127.

² Babb, J, *et al*, *Lancet*, 1976, 1, 1413.

Treatment of cervical spondylosis

SIR,—I read with interest but with some concern your expert's answer to the question (23 October, p 1002) about the treatment of cervical spondylosis.

I would say that "cervical spondylosis" *per se* is not a clinical entity; the condition is a pathological-radiological abnormality present in the "normal" population radiologically in some 75% of people aged 50 or over.^{1,2} However, it may produce clinical symptoms and/or signs and these are very variable, ranging from neckache, with or without headache, to brachialgia, myelopathy, and vertebral basilar insufficiency; and indeed there may be various combinations and permutations of one or more of these in the individual patient.

Thus, as may be realised, the treatment required is varied, and may be medical, surgical, or both and in any event usually includes the treatment available from experts in the important remedial profession of physiotherapy. The treatment depends on many factors—the type and severity of the clinical syndrome, the number of attacks, the progression, the response to simpler rather than to more complex medical treatment, etc. Some of these patients do, sooner or later, require operative treatment, as I have now discovered in some 500 patients of a personal series operated on by an anterior decompression-fusion procedure during the past 15 years.

Finally, Sir, could I make a plea for the

discontinuance of the term "physiotherapy" to mean, in general, "exercises" and/or "traction." Both the questioner and the expert answerer appear to fail to appreciate that physiotherapy is a profession and that physiotherapists are experts with special knowledge of medical and surgical disorders and of their treatment by a wide variety of therapies—and not just "simple exercises"?

PHILLIP HARRIS

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Edinburgh

¹ Harris, P, in *Some Aspects of Neurology*, ed. R F Robertson, p 38. Edinburgh, Royal College of Physicians of Edinburgh, 1968.

² Kuhlendahl, H, and Kunert, W, *Medizinische*, 1954, 14, 499.

SIR,—Your expert's answer to the question on cervical spondylosis (23 October, p 1002) presents far too gloomy a picture.

If the questioner means osteophytosis and a diminished joint space, clearly all conservative treatment is useless. An osteophyte menacing the spinal cord or a foraminal osteophyte compressing a nerve root should be removed surgically.

Apart from these late cases described so thoroughly in Wilkinson's book,¹ there are the much more frequent cases described in mine.² In these cases the diagnosis of cervical spondylosis is mistaken; that is what the radiograph shows but not what the patient is suffering from. This history may make this plain in so far as the attacks of pain alternate with periods of complete freedom, though the radiological evidence of degeneration continues unchanged. Patients with root pain attributed to spondylosis recover after some months, retaining their osteophytes.

What these patients are really suffering from are attacks of internal derangement at an intervertebral joint. It is for this reason that lay manipulators are often able to relieve pains that doctors have pronounced intractable.

JAMES CYRIAX

London W1

¹ Wilkinson, M, *Cervical Spondylosis*, 2nd edn. London, Heinemann, 1971.

² Cyriax, J, *Cervical Spondylosis*. London, Butterworth, 1971.

Prostatic cancer

SIR,—Dr A Y Rostom (16 October, p 942) draws attention to the urgent need for controlled clinical trials to evaluate treatment policies in localised carcinoma of the prostate. Such trials are, indeed, long overdue, but he can be reassured that proposals have been discussed by urologists and radiotherapists in the United Kingdom on a number of occasions during the past year and it is hoped that an appropriate trial will soon be under way.

The limitations of conventional hormonal therapy and in particular the cardiovascular hazards of oestrogens have been demonstrated by the Veterans Administration Co-operative Urological Research Group.^{1,2} These findings have lent considerable weight to the view that hormonal therapy should be reserved for those patients with incapacitating symptoms or at least demonstrable metastatic disease. Yet prostatic carcinoma remains a major source of mortality and morbidity and is indeed the third leading site of malignant death

in males. It is for this reason that the wait-and-see policy referred to in your leading article (28 August, p 490) needs to be compared with radiotherapy in younger men with localised disease.

However, old habits are not easily discarded and a non-investigative approach to the management of these patients has become widespread. The TNM classification provides a good "shorthand" system of tumour characterisation but requires moderately sophisticated, and certainly expensive, techniques. We cannot share Dr Rostom's confidence in the accuracy of lymphography. Pedal lymphography does not opacify the obturator and internal iliac group of nodes, which are the most common site of nodal deposits. Moreover, in a recent study we have shown a 25% error rate, mainly false-negative, in the interpretation of opacified nodes. Thus a negative lymphogram has no value in staging, and pelvic lymphadenectomy must be considered for improving the accuracy of staging in selected younger patients. If the proposed clinical trials for localised prostatic carcinoma are to yield meaningful results, then detailed investigation to fulfil the TNM requirements must be accepted.

E P N O'DONOGHUE
G D CHISHOLM

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and Hammersmith Hospital,
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¹ Bailar, J C, III, and Byar, D C, *Cancer*, 1970, **26**, 257.
² Blackard, C E, *Cancer Chemotherapy Reports*, 1975, **59**, 225.

Student health

SIR,—I was interested to note in your leading article (13 November, p 1160) that the *BMJ* is to provide a short series of articles on student health. I hope that some attention will be paid to the health problems of the student nurse population. The case of such students is far from uniform, in spite of centres of excellence. Indeed, one might go farther and inquire about the vexed question of the care of the health of hospital staff in general.

Whatever became of the Tunbridge Report of 1968?¹

DAVID ILLINGWORTH

Edinburgh

¹ Ministry of Health, *The Care of the Health of Hospital Staff*, Report of the Joint Committee. London, HMSO, 1968.

Promotion of new drugs on television

SIR,—I was shocked at the blatant advertising of the new histamine H₂ receptor antagonist cimetidine (marketed by Smith, Kline, and French under the trade name of Tagamet). This occurred on the 9 pm news on BBC 1 on Thursday 18 November. The trade name of this no doubt excellent product was clearly visible to viewers in at least two shots.

In general practice we had received the literature (plus statutory data sheet) only on Wednesday 17 November; in my case it was the first I had heard about this new drug, now freely prescribable on an FP 10 (price not mentioned in the literature).

I understand that I am by no means alone in my concern over this trap into which the BBC reporters fell. By all means let us have authoritative information put over on or in

the media by the responsible medical authorities, but this occasion cannot be allowed to pass without protest. I understand that an official protest is to be made to the Association of British Pharmaceutical Industry over this matter.

H M WHITE

Bromsgrove, Worcs

Aortic incompetence in systemic lupus erythematosus

SIR,—With reference to my letter on this subject (20 November, p 1260) I should like to make it clear that this was a follow-up report of the patient originally described in more detail by Oh *et al*¹ and does not represent a new case.

A J ISAACS

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London SW1

¹ Oh, W M C, Taylor, R T, and Olsen, E G J, *British Heart Journal*, 1974, **36**, 413.

Appointments in community medicine

SIR,—I have waited with interest for some public response from the Faculty of Community Medicine to my earlier letter (28 August, p 523). An unexpectedly silent watchdog may be highly significant.¹ Some who were appropriately qualified, trained, and experienced to be appointed specialists at the time of reorganisation have been seriously and permanently affected by failure then to separate personal specialist grading from appointment to specific posts. They have resented the arbitrary and seemingly uncontrolled way in which the career grade continues to be conferred. It would be revealing to know the criteria (other than expediency) advised for adoption by faculty representatives on specialist appointment committees and to have confirmation that the Faculty, in refusing to recognise subspecialties, regards all specialists so far appointed as generalists within the broad specialty.

If community medicine is to be regarded as allied to clinical medicine and therefore to achieve the exemption not so far granted from the current review of management costs, it is essential for the faculty to demonstrate that standards for appointment to the permanent career grade have been, and continue to be, no less demanding than those for clinical consultants. The available evidence is largely anecdotal but not reassuring. Since much stress is laid on the need for evaluation in health services² and the specialty is that branch of medicine which deals with the health of populations or groups, it is particularly appropriate to inquire: (a) the proportion of founder fellows or members not meeting the full and specific criteria originally established under standing order 6; (b) the number of specialist community physicians already appointed who were not currently fellows or members of the faculty; and (c) the number of appointments made to the subspecialist grade as a proportion of all appointments made to specialist posts.

It may well be that the creation of the proposed new grade of hospital specialist (a permanent subconsultant grade) could provide a fortunate opportunity for a review of all existing specialists in community medicine on a personal basis, those with appropriate

qualifications and experience being regraded as consultants in community medicine. Meanwhile, the faculty board should carefully reconsider their continued silence on these matters, and reflect whether this furthers the consolidation and development of the emerging specialty.

R B ROBINSON

Hursley,
Nr Winchester

¹ Doyle, A C, *Silver Blaze*. London, Murray, 1890.

² Horner, J S, *British Medical Journal*, 1976, **2**, 827.

General practitioners and coronary care

SIR,—The implication that the general practitioner cannot play a useful role in the operation of prehospital coronary care schemes because calls from general practitioners for an ambulance in Nottingham are usually long delayed (Drs J D Hill and J R Hampton, 30 October, p 1035) cannot go unchallenged. Since its inception in 1966 the majority of calls for the Belfast mobile unit have come from general practitioners. The median delay between onset of symptoms and intensive care has been 100 min.¹ Over a quarter of the patients have been reached during the first 60 min.

In drawing their conclusions the authors assume, wrongly, that the response of an individual to the development of symptoms and the delay on the part of the general practitioner are innate and immutable. Adaptation is usually possible when necessary. As James Russell Lowell said in 1889, "New occasions teach new duties: time makes ancient good uncouth".

Activation of a mobile unit from whatever source at the earliest possible moment is, of course, to be encouraged. Nevertheless, exclusion of the general practitioner from this area of acute medicine is in the interests of neither the patients nor their doctors. Rumination over the obstacles does nothing to save lives. Drs Hill and Hampton will do a better service if they will now direct their energies toward bringing treatments of proved value to the maximum number of patients at the time of greatest risk, whether medical advice is sought through a general practitioner or the emergency ambulance service.

J S GEDDES

Cardiac Department,
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Belfast

¹ Pantridge, J F, *et al*, *The Acute Coronary Attack*. Tunbridge Wells, Pitman Medical, 1975.

The elderly in a coronary unit

SIR,—Dr F F Thompson (2 October, p 814) is indignant at the attitude of Dr B O Williams and his colleagues (21 August, p 451) concerning the admission of elderly patients, mainly over the age of 70, to a coronary care unit, and his sentiments are shared to some extent by Dr M S Pathy (18 September, p 696).

I must say that I find the comments of Dr Williams and his co-authors sensible and humane: "Keeping them at home when possible, at the expense of a few lives in the mild group not saved by immediate defibrillation, may often be kinder, sounder from the psychological point of view, and beneficial therapeutically"—that is quite apart from obvious practical and economical considera-