Correspondence

Correspondents are asked to be brief.

Undergraduate Medical Education J. S. Ross, M.B. 479	Perioral Dermatitis D. S. Wilkinson, F.R.C.P., and A. J. Rook, F.R.C.P. 481	Extra Duty Allowances J. S. Elkington, F.R.C.S.; P. J. Heath, M.B. 484
Coronary Occlusion in Rheumatoid Arthritis M. McC. Reid, M.R.C.P. GLASG., and T. F. Fannin, F.R.C.S. 479	Chemotherapy of Bronchitis K. Zinnemann, F.R.C.PATH., and Joyce Frazer, B.Sc.; A. A. B. Mitchell, B.Sc. 481	Financing the N.H.S. R. R. Wilson, M.D.; P. G. Konstam, F.R.C.S.ED.; Nancy M. Tweedie-Stodart, D.P.M. 484
Hyperarousal in Space Flights R. C. B. Aitken, M.D. 480	Another Paraquat Fatality J. G. Masterson, M.R.C.PATH., and W. J. Roche, M.B. 482	Constitution of B.M.A. F. R. Ryle, M.B., and J. L. D. Roberts. 485
Drugs for Dysentery J. F. Warin, D.P.H. 480	Drugs in Depressive Illness Z. Hussain, D.P.M. 482	Junior Staff in Regional Hospitals J. J. Shipman, F.R.C.S.; J. B. Ryder, F.R.C.P.I. 485
Unhopeful Signs in Lung Cancer Eileen C. Crofton, B.M. 480	Blue Light and Jaundice J. F. Lucey, F.A.C.P. 482	G.M.C. Annual Retention Fee S. S. Barker, F.F.A.R.C.S., and others 485
Poisoning with PCP J. B. Chapman, M.B. 480	Amblyopic Eyes G. V. Catford, F.R.C.S. 483	Second Green Paper R. C. Bell, F.R.C.S., and K. S. Cameron, F.F.A.R.C.S. 485
Hypothalamic Dysfunction and Antidepressant Drugs W. R. McLeod, M.B., and others. 480	Entonox as a Psychotherapeutic Aid I. J. MacDonald, D.P.M. 483	Review Body's Report W. H. Hayes, M.R.C.S.; M. Stein, D.C.H. 485
	Colour in Rhodesia M. J. Clay, M.B. 483	

Undergraduate Medical Education

SIR,—It is a pity that there was little opportunity to discuss undergraduate medical education at the recent Special Representative Meeting.

I believe the basic trouble with the Todd Report¹ is in its underlying concept for undergraduate teaching. If you accept its ideas then most of our objections to its postgraduate programme, such as its length in time, the restrictions imposed, and vocational registration become almost inevitable. While it is important that doctors should be well educated men, I deplore the obsessive emphasis on general teaching that permeates the chapters on undergraduate training.

Para. 225 says: "The recommendations we have made in Chapter 3 for postgraduate education and training should, if accepted, release medical schools from any remaining thought that they need to produce a graduate fit to practise medicine independently; the undergraduate clinical years can then be regarded solely as part of a basic university education in medicine."

The Todd Report rightly points out that much time is spent at present in an unrealistic way. The course is stuffed full of more and more subjects in an attempt to cover everything. Much that is taught is of marginal use to potential doctors, and in this respect the report serves a useful purpose if these are eliminated.

While we must not hide our faces to new influences, I am alarmed at what is proposed be put in place of the redundant subjects. I believe that the proposals for undergraduate education give a deliberate emphasis and undue influence to sociological subjects. This creates an alarming imbalance in the proposed first degree course in medical science. It is a course that could well be undertaken without any intention to practise medicine, producing a medically qualified social worker rather than a budding doctor.

I am convinced that sound clinical education in medicine at an early stage of the undergraduate career is essential. Young minds will quickly mop up knowledge when the imagination is stimulated. The student sees what medicine is all about when he begins to meet patients, and I believe this cannot start too soon. If the public are to continue to be well served, let us see to it that they are looked after by kindly understanding doctors who have been thoroughly taught from an early stage that the patient is the person who matters.—I am, etc.,

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Coronary Occlusion in Rheumatoid Arthritis

SIR,—We were interested to read the leading article on coronary occlusion in rheumatoid arthritis (21 March, p. 707). We recently presented the clinical and necropsy findings¹ in the case of a boy aged 8½ years, suffering from juvenile rheumatoid arthritis, complicated by amyloidosis, vascular calcification, and arteritis, with arterial narrowing and occlusions within the coronary system.

His illness commenced at the age of 2½ years and required several courses of prednisone, with cessation of this therapy from the age of 5 years until his terminal illness. During this illness he complained of retrosternal and epigastric pain, thought at the time to be due to oesophageal varices and hepatomegaly.

At necropsy there were several striking features, including widespread subendocar-

dial plaques of calcified material within the atria and extending back into the pulmonary veins; extensive medial calcification of the medium and small arteries with sub-intimal fibrosis amounting to occlusions within the coronary system, including the anterior descending and left circumflex arteries; and within the myocardium there were numerous small areas of fibrosis of differing ages and quite extensive subendocardial fibrosis. It is noteworthy that this child complained of central chest and epigastric pain, which in retrospect was probably the result of myocardial ischaemia and infarction.

C. C. Forsyth^{2,3} described a case of Still's disease with marked vascular calcification which improved radiologically on treatment with corticosteroids. Like our own patient, her case was complicated by amyloidosis which also responded to steroids. Any possible relationship between amyloidosis, vascular calcification, and arteritis progressing to occlusion can only be guessed at. It is conceivable that a cause and effect relationship does, in fact, exist.

You did not mention amyloidosis, though this is a common complication in adult rheumatoid arthritis, of the order of 15%⁴ to 60%.⁵ This added complication, affecting as it does the small vessels, might well play some part in the initiation of vascular narrowing.—We are, etc.,

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- 5 Teilmann, G., and Lindahl, A., *Acta Medica Scandinavica*, 1954, **149**, 449.