I wonder whether anybody has been fortunate to find this service available. I doubt whether it exists. Personal application to two laboratories produced negative responses and indirect information that the Secretary of State for Scotland was considering a scheme. The information given by the local executive council was that no such scheme had been initiated and it was thought doubtful if it would be. A letter of inquiry to the Scottish Western Regional Hospital Board received a courteous but basically uninformative reply about the difficulties of such a scheme but that it was under consideration. Two letters (16 January and 10 February) to the Minister have not had the courtesy of acknowledgment, let alone reply to date.

I realize that this is a small matter compared to the other issues at stake at this time. However, I, and others to whom I have spoken, find it a real source of irritation taken along with the other grievances being aired just now. It is just this sort of thing, minor though it is, which makes the rank and file feel that successive Ministers and our top committees are out of touch.

The Minister says this service exists; let him make sure it does in fact exist—now.—I am, etc.,

Hamilton,
Lanarkshire.

A. N. DOWIE.

Phenacetin Abused

SIR,—The report in the *B.M.J.* (1 February, p. 288) describing "Chronic Phenacetin Nephropathy" is possibly guilty of perpetuating a "terminological inexactitude." Can a condition subsequent to chronic ingestion of "a commercial preparation containing phenacetin" be attributed to phenacetin? Surely it may result from the chronic dosage of the other constituents of the mixture, or from some effect of their combination?

Similarly the case reports of the nephrotoxicity of phenacetin in the literature which I have examined appear to relate to the effects of mixtures of phenacetin and other drugs.

Let there be precision in the collection of evidence before phenacetin and its derivatives can be fairly condemned, and let us meanwhile by all means banish abuse of and by phenacetin.—I am, etc.,

New York.

ROBERT JOHN.

Rashes with Amiphenazole

SIR,—The letter of Drs. H. Baker and J. S. Pegum (7 December, p. 1473) has just come to our notice. They refer to a lichenoid eruption following the ingestion of 200–800 mg. per day (orally) of amiphenazole ("daptazole"). There was an incidence of two out of ten cases in one study.

We have had experience of the use of amiphenazole extending over six years, and with perhaps some 700 cases the dose has been on the average 50 mg. thrice daily, either orally or parenterally. In a smaller series (100 cases) 100–200 mg. thrice daily has been given by mouth. Not once has such a phenomenon as described above been noticed. In both series the period of administration was often as long as two years, with at least one-quarter of the cases continuing for six months.

We cannot suggest a reason for the above side-action, but would at least like to inquire if there were any other medication given with the amiphenazole, not to explain away the results but to ascertain whether the presence of another specific drug with amiphenazole were the cause.

Finally we would like to state that the unreliable results obtained by Professor Scadding (16 November, p. 1269) in the management of the ambulant bronchitic might be due to the unreliability of amiphenazole. Tacrine ("T.H.A.") is a far more definite respiratory stimulant, but must be given by injection.—We are, etc.,

W. MOON.

F. H. SHAW.

Department of Pharmacology,
University of Melbourne.

D. W. BRUCE.

Prostatic Carcinoma

SIR,—The treatment of carcinoma of the prostate described in "To-day's Drugs" (8 February, p. 358) calls for comment. Not all authorities do believe in high stilboestrol dosage. Professor Charles Huggins himself advised 1 mg. b.d., but always undertook a bilateral orchidectomy as well. He believes this operation is an absolute essential in the treatment. It is easily possible in every case—under local, if need be.

As it is unfortunate that fluoxymesterone should be mentioned in such close context as the succeeding paragraph, I hope I may be forgiven for restating the obvious—that this relates to breast cancer and not to the prostate.—I am, etc.,

Briercliffe,
Nr. Burnley, Lancs.

A. F. ROBINSON.

Bacteraemic Shock

SIR,—I read with interest your leading article on bacteraemic shock (1 February, p. 254). I can recall a case presenting with this condition some five years ago. The patient, a man in his early forties, had attended one afternoon for a "routine" dilatation of his urethral stricture. Later that evening he collapsed in the recovery room and by the time I was called to see him he had received three bottles of blood and two of "dextran" with no improvement in the level of his blood-pressure. The patient was relatively cheerful, pink in colour, and warm to the touch. His pulse was barely perceptible and his blood-pressure almost unrecordable. It was apparent to us that there must be a generalized loss of tone in the smaller blood vessels and capillary bed with pooling of blood in the periphery. It was suggested that this was due to some bacterial toxin introduced as a result of dilatation of the urethra. As transfusion into this vast capillary bed was of no avail, treatment was directed towards the bacteraemia and restoration of the peripheral vascular tone. Intravenous broad-spectrum antibiotics together with "mephine" (mephentermine) and hydrocortisone were administered. The patient recovered with no untoward effects.

One cannot help feeling there must be considerable risk of producing an overloaded circulation in the patient who recovers if transfusion is advocated in the treatment. Particularly when one is most likely to

encounter this syndrome in an age-group which is so susceptible to changes in blood volume. Fortunately the condition appears to be remarkably rare. The case mentioned above is the only one I can recall during three years on a busy urological unit.

I also wonder how the syndrome of "bacteraemic shock" can be related to the syndrome of "catheter fever." Both conditions appear to be of similar aetiology, the one presenting as a hypotension and the other as a hyperpyrexia with no lowering of the blood-pressure.—I am, etc.,

Military Wing,
Musgrave Park Hospital,
Belfast 9.

I. S. LISTER.

F.R.C.S. in the Specialties

SIR,—We have been very interested in the correspondence about the Primary Fellowship examination in the specialties initiated by Mr. O. Gayer Morgan (21 September, p. 743).

As many young ophthalmologists have considerable difficulty with the primary examination they spend several years studying general anatomy, physiology, and pathology. Little exception can be taken to the last two, but the study of the first in such detail puts considerable strain on the candidates and they spend valuable time studying a subject which they confess they gratefully forget in a very short time. It is all very well to talk about laying a good foundation in general subjects, but this has already been done in the second professional examination and one cannot continue to go back and do it all over again; and the task of the ophthalmologist in training would seem to us to be the study of his specialty in more detail. To spend valuable time studying a subject which is not applicable to this specialty seems to us to be a waste of valuable time, and far from making better ophthalmologists would seem to delay them unnecessarily in assimilating essential knowledge of their specialty.

The position in London seems to be that there is a sufficiency of successful candidates, but in the Glasgow area several very promising young men have abandoned the examination altogether, and in the last two years particularly there has been a real dearth of applicants with the Fellowship for consultant posts. This debars them from consultant posts in teaching hospitals.

According to the Wright Report just issued more consultants are now needed in the Scottish Hospital Service, including ophthalmology, but it may prove very difficult to supply them so long as the Primary Fellowship is retained in its present form.—We are, etc.,

J. N. TENNENT.

Glasgow W.2. A. M. WRIGHT THOMSON.

SIR,—With reference to the current correspondence "F.R.C.S. and the Specialties" it may come as a surprise to hear that in this country the F.R.C.S. has no standing as a higher surgical qualification. In Canada too it is not accepted as evidence that a man with the F.R.C.S. is a well-trained surgeon; he must have a background of well-supervised graduated training over many years, followed by success in his specialty board examination before he is so recognized.—I am, etc.,

New York.

M. J. SMYTH.