these during a 24-hour period, and her headache improved, but the same day severe pain began in both ankles and feet, and the next day she was unable to walk.

On admission she was normotensive, and febrile (99.5° F.; 37.5° C.). Apart from a soft pansystolic apical murmur, abnormal signs were confined to the legs. No pulses could be felt below the femorals, and there was a sudden temperature drop at both mid-calves. The distal parts of both feet were pale, ischaemic, and very painful.

The ischaemia was attributed to intolerance to ergotamine with presumed underlying obliterative arterial disease. The legs were exposed and kept cool, and tolazoline, 25 mg. thrice daily, given by mouth.

For two days there was little change, but on the third day both feet were warm, red, and oedematous, and later all pulses became readily palpable. The feet remained painful for several days, but there was no gangrene and the patient was eventually discharged home free from signs and symptoms in the legs.

There was no evidence of obliterative arterial disease or renal disease. The flocculation tests were weakly positive and the sedimentation rate 62 mm. at one hour falling to 32, but there was no increase of gammaglobulin on serum electrophoresis and no other evidence of an underlying collagen disease.

This case was considered to be a further example of prolonged arteriospasm after oral ergotamine tartrate for supposed migraine, in the absence of the recognized contraindications, but in this case due to intolerance to modest dosage (3 mg.) rather than to over-dosage with ergotamine.

I wish to thank Dr. Kenneth Harris for permission to report this case.—I am, etc.,

R. A. L. SUTTON.

University College Hospital,
London W.C.1.

Drug Rash After Triprolidine

SIR,—I was very interested in Dr. Suzanne L. Alexander's letter (22 August, p. 512). I have not seen the eruption she describes after using Proactidil but her letter strikes a chord. Grant Peterkin first described a lichenoid eruption occurring in troops in the Middle East who were given mepacrine to suppress malaria.¹ I came across it in troops in the Far Eastern theatre of war on the same therapy. It was then labelled "tropical lichenoid dermatitis". Since then I have seen the same eruption following the use of mercury (Guy's Pill), gold (Mycrysine) and even phenobarbitone. It is possible that many other drugs produce this reaction in certain individuals and perhaps triprolidine now adds its name to this list.—I am, etc.,

ALLAN BIGHAM.

Department of Dermatology,
Bradford Royal Infirmary,
Bradford, 9.

REFERENCE

- ¹ Peterkin, G., and Hair, H. C., *Brit. J. Derm.*, 1946, 58, 263.

Longer Training for Radiographers

SIR,—We, the undersigned radiographers, do not agree with Mr. R. F. Farr (18 July, p. 191) that lengthening the course from two years to three would encourage recruitment. Most women hope to be married early, and with this in mind the relatively short two-year training is attractive. If the training had

lasted three years we would not have been so attracted to radiography as to other three-year courses. Nor do we agree that a three-year training would be better than a two-year course followed by a hospital appointment for one year, or that women would be more likely to stay in radiography having done a three-year course. Few leave it now except for marriage or for the same work abroad.

The effect of lengthening the course would be serious in the transitional year: (1) at hospitals not recognized as suitable for third-year students, vacancies which under present conditions would be filled by newly qualified radiographers would not be filled at all; (2) at hospitals recognized as suitable the vacancies would be filled by third-year students not allowed to take full responsibility or to do unsupervised night duty, which would result in more night duty for the qualified radiographers. After the transitional year the effect is unpredictable. So many potential recruits may be deterred by the three-year course, as we would have been, that the radiographer shortage may become worse.

The present arrangements are working reasonably well. Why risk changing them? —We are, etc.,

JUDITH A. WOOD.

PAMELA J. WHELDON.

London N.W.3.

SIR,—I am constrained to comment on the inconsistent nature of Dr. G. Osborne's letter (5 September, p. 630) regarding the training of radiographers. He writes: "... the more advanced techniques tend to be left to the more senior radiographers ..." and, discussing the bulk wastage of females on marriage, "... this is a reason for letting students start at 17 and qualify at 19. ..."

How does one acquire senior staff under these circumstances? Or again, if one implements the author's theory that males be excluded from the profession because of an unattractive salary range, where else can one muster experienced assistance?

Two principal issues arise from this: (1) Wouldn't the profession be a more stable and enlightened body with the continuing addition of senior male members? (2) How does one form a cadre of experienced radiographers when recruiting stems only from the female population?

Surely it would be to everyone's advantage to discourage the "poor risk" element, and to increase the salary and the training period to encourage the "better risk" (and potentially senior) prospects.

For the interest of my colleagues this is no calumny on the good name of the senior and experienced female radiographer.—I am, etc.,

Welwyn Garden City,
Hertfordshire.

G. F. HURST.

T.A.B. for European Travel

SIR,—Your expert's reply on "T.A.B. for European Travel" is alarming (5 September, p. 621). Can he really mean that all travellers to all European countries, whether staying in cities or in the country, should be immunized against typhoid and paratyphoid? Already people are over-sensitive about typhoid after the recent outbreak in Aberdeen, and now your expert's reply, quoted in the

popular press (at least in *The Times* of 4 September), will worry them more than ever.

I can assure you, Sir, that the travelling public is not the healthily confident body it once was, but comes only too readily for medical advice before crossing the Channel. Each summer term brings me a bigger crop of students asking for advice or demanding immunization (which is quite often unnecessary) before travelling to other European countries. Some members of the academic staff are no better. Surely each case should be considered individually, and to recommend a universal measure, which in itself is not without risk and discomfort, is wrong. Need we have the national hypochondria on this aspect of travel boosted by those who should know better?—I am, etc.,

University College of Swansea, T. C. DANN.
Glamorgan.

Umbilical Cord

SIR,—Your leading article on the umbilical cord (1 August, p. 264) makes very interesting reading.

You rightly point out that "the cause of foetal death when the cord prolapses may be vascular spasm as well as direct pressure." I wish you had laid emphasis on the former factor more strongly. I have no doubt that vascular spasm in the cord is often the primary cause of foetal death in these cases,¹ apart from the fact that it can account for a misleading non-pulsatile cord when the foetus is still alive. Vascular spasm is elicited by cold and by handling; hence the correct management in prolapse of the cord is to replace it gently into the warm vagina. Further handling of the cord may be dangerous.

On the point of cord entanglements, one might draw attention to the fact that this finding in the case of twins is characteristic of a mono-amniotic set.² If the second twin is to be saved delivery must be immediate.—I am, etc.,

Medical School,
St. Luke's Hospital,
Malta.

A. P. CAMILLERI.

REFERENCES

- ¹ Rhodes, P., *Proc. roy. Soc. Med.*, 1956, 49, 937.
² Bender, S., and Prebble, S. E., *Brit. med. J.*, 1961, 1, 1810.
³ Raphael, S. I., *Amer. J. Obstet. Gynec.*, 1961, 81, 323.

Hierarchies in Mental Hospitals

SIR,—Most psychiatrist will have sympathy for Dr. C. Entwistle's wish (5 September, p. 631) to do away with hierarchism in mental hospitals. Some will find his solution—abolition of the office of medical superintendent or director—naïve. He apparently hopes that by abolishing an office he can abolish abuse of power. Reflection on human nature suggests he may be over-optimistic. Consultant rulers of small empires can be as authoritarian as superintendent rulers of large.

Dr. Entwistle has not followed the golden rule of diagnosis before prescription. He neglects to ask—if there are, as he states, authoritarian medical superintendents—why, since the Mental Hospitals Act of 1959, do consultants acquiesce in this state of affairs? Could it be that such consultants are as hierarchy minded as their "ruler" and wish for themselves authority which they resent in