will the abuse come from other surgeons, who may be fortunate in having a properly organized follow-up system, and who do not have to attend on Saturdays? Or is there a perfect solution to the problem?—I am, etc.,

Old Bursledon,
Hants.

T. ROWNTREE.

Spontaneous Elimination of Inhaled Inflorescence Presenting as Dorsal Tumour

SIR,—The article by Mr. A. Naylor under the above title (26 February, p. 524) leads me to report a similar case which once came to my notice. One day in 1944 or 1945 I was sitting on a bank covered with wild barley (*Hordeum fegalinum*) during an interval of a blood transfusion donor session somewhere north of London, when a local woman donor organizer then aged about 30 passed by, and I remarked that when I was a child we used to play with the heads of wild barley and put them up one another's sleeves. Owing to the barbs on the awns any movement of the arm would make the seed head move farther and farther up the sleeve. My companion then said:

"When I was a baby I swallowed one and it came out through my back." She said that it had been put into her mouth by a slightly older brother or sister. I was not entirely convinced by her story and circumstances did not permit me to verify the presence of a scar, but in view of Dr. Naylor's article I hereby withdraw any mental reservations I may then have had.—I am, etc.,

Serological Population
Genetics Laboratory,
London E.C.1.

A. E. MOURANT.

Treatment of Cardiac Arrest

SIR,—In the leading article of 13 November, p. 1135, in which the treatment of cardiac arrest in acute myocardial infarction was reviewed, the suggestion that "in the past doctors and nurses have been told to attempt resuscitation only in those persons whose score is less than 17" on the coronary prognostic index might lead one to accept this as a reasonable guide.

Recently in this hospital we have had two cases which have left us in doubt whether or not such a guide is possible.

The first case was a 58-year-old man with a massive myocardial infarction, who had a prognostic index of 28¹ and in fact was unconscious for two and a half hours, during which time he had the bizarre ventricular complexes ("Resuscitative attempts are unrewarding") on electrocardiogram and responded to resuscitation. He is now attending the outpatient clinic, is cheerful, well, and symptom-free.

The second case is a 60-year-old man who had a myocardial infarction followed by a cardiac arrest in asystole ("The outlook for those in asystole is practically zero . . .") and a prognostic index of 24. He is at present still an in-patient but shows no signs that he will differ in any way from those patients with a much lower index, now that he has recovered from the acute stage.

How can the mortality in hospital from myocardial infarction be reduced below the usual 30% unless those patients in the higher index group are saved, for it is in the above

17 group that the highest mortality occurs.—I am, etc.,

NORMAN P. HALLIDAY.

Queen Mary's Hospital,
Sidcup, Kent.

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- 3 Safar, P., Elam, J. O., Jude, J. R., Wilder, R. J., and Zoll, P. M., *Dis. Chest*, 1963, 43, 34.

Accidental Hypothermia

SIR,—The article by Dr. L. G. C. E. Pugh, "Accidental Hypothermia in Walkers, Climbers, and Campers" (15 January, p. 123), was both interesting and enlightening. It provides data to an area usually occupied by only conjecture or folklore. This should be read by anyone who ever takes walks in woodlands or mountains, and particularly by anyone responsible for taking youngsters on such expeditions.

The strong association of wetting, wind, and cold causing loss of the protective ability of the usual clothing makes me wonder whether some form of the insulating "wet suit" used by the Navy and civilian skin divers might not be worthy of consideration as a light, relatively compact emergency garment to be used in case of thorough wetting. Certainly such a garment has been proved effective in immersion wetting at very low temperatures and is perhaps as close as the thin man can come to acquiring quickly the equivalent of a good layer of subcutaneous fat.—I am, etc.,

W. B. GREENOUGH III.

Laboratory of Metabolism,
National Heart Institute,
National Institutes of Health,
Bethesda, Maryland, U.S.A.

Lithopaedion Formation after Silent Uterine Rupture

SIR,—I was interested in Squadron-Leader J. H. Binn's letter (15 January, p. 169) concerning lithopaedion formation after silent uterine rupture. An earlier stage of the above phenomenon was seen here recently.

The patient, a Nigerian woman aged 25–30, multipara, was admitted on 15 February 1966 complaining of abdominal pain and weakness. She was somewhat anaemic, but otherwise in fairly good shape. The abdomen was distended and tender, with an orange-sized mass in the hypogastrium and a larger mass with bony crepitus above it. Needling of the peritoneum cavity produced blood. The cervix was hard, admitted a finger, and was dry. Her obstetric history was as follows: *first*—premature, still-birth (7 months) at home; *second*—normal delivery at home, alive; *third*—premature delivery, child died after four days; *fourth*—normal delivery at home, child died one year later.

At laparotomy a moderate amount of mainly organized blood clots was present in the pelvis. An old macerated foetus had its head near the spleen. The lower tumour was the placenta attached by fibrous tissue to the fundus. The size of the uterus was that of a 2-month-old pregnancy. It had a clean tear from the internal os to the fundus, and the placenta was attached to its margins here.

The foetus and placenta were removed, and a subtotal hysterectomy done. Ovaries and Fallopian tubes were normal. One and a half

pints (850 ml.) of blood was given during the operation and the patient is to date doing fine. The foetus (female) weighed 2 lb. 12 oz. (1,150 g.) and was 16 in. (40½ cm.) long.

—I am, etc.,

Catholic Hospital,
P.O. Box 3305, Mapo,
Ibadan, Nigeria.

F. FERRARI.

Diet in Old Age

SIR,—Your article on diet and old age (5 February, p. 312) rightly stresses the dietary imbalance in the elderly. We have during the past 18 months investigated the ascorbic acid and thiamine blood levels in this class of patient, and have found that 41% were deficient in ascorbic acid and 59% deficient in thiamine on admission to hospital. In people living at home, and not ill or sufficiently ill for admission, 27% were deficient in ascorbic acid and 22% in thiamine.

Vitamin deficiency is therefore widespread among elderly people. We hope shortly to publish our results.—We are, etc.,

LOUIS L. GRIFFITHS.
J. C. BROCKLEHURST.
RONA MACLEAN.
JOHN FRY.

Farnborough, Kent.

Oral Contraceptives and Jaundice

SIR,—The report of Drs. K. E. Thulin and Jerker Nermark of cases of jaundice occurring in patients taking an oral contraceptive, Anovlar (5 March, p. 584), has encouraged us that the diagnosis made tentatively in a patient under our care at the present time is correct. We feel a short account of the case would interest others, since the long duration of generalized pruritus, without clinical jaundice, is a feature which differs from the cases described from Lund and other reported cases of hepatic dysfunction induced by oral contraceptives.

A 34-year-old housewife presented in December 1965, complaining of generalized pruritus. This had started in April 1965, and had gradually become more severe. She had never been jaundiced but her stools were paler than normal and her urine dark. She had been nauseated and had lost 8 lb. (3.6 kg.) in weight. During the last six weeks of her first pregnancy 12 years ago she suffered from pruritus of the feet and legs.

She was not jaundiced but looked ill and had multiple deep excoriations over the whole body. Her liver was palpable 1–2 fingers below the costal margin on deep inspiration, but was of normal texture and non-tender. Clinical examination was otherwise normal.

Laboratory investigations: stools, pale; urine contained bile but no excess of urobilinogen; serum bilirubin 1.6–2.4 mg./100 ml.; serum alkaline phosphatase 20–28 King units; plasma proteins were normal and transaminases were not done initially; plain x-ray of the abdomen showed no opaque calculi. At laparotomy the gall-bladder and biliary tract were normal but the liver was green in colour. Histological examination of the liver showed diffuse plugging of the bile canaliculi with bile granules in the parenchymal cells.

For two years prior to this hospital admission the patient had been taking oral contraceptives, using first Anovlar and then Orthonovum, both of which contain norethisterone. Post-operatively her pruritus dis-

appeared and her liver-function tests, including bromsulphalein excretion, have returned to normal a month after stopping Orthonovum.

There is, we believe, presumptive evidence that the pruritus, which lasted eight months before liver abnormalities were demonstrated, was due to the oral contraceptive. Drs. Thulin and Nermark commented on the occurrence of pruritus in pregnancy in two of their seven cases. Our patient suffered from pruritus in her first pregnancy.

We had intended to confirm that the oral contraceptive had been responsible for this patient's illness by giving her Orthonovum again, using bromsulphalein excretion as an index of liver dysfunction. Since the liver changes are completely reversible when due to norethisterone¹ this seemed to be a justifiable procedure, but in view of Drs. Thulin and Nermark's findings this hardly seems necessary.—We are, etc.,

I. R. CARD.
I. B. SNEDDON.
C. H. TALBOT.

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Sheffield 6.

REFERENCE

¹ Sherlock, S., *Proc. roy. Soc. Med.*, 1964, 57, 881.

One Year's Advertisements

SIR,—Instead of spending time complaining about drug advertisements some members of the medical profession might find it beneficial to read them.

Several months ago I issued a prescription for Beta-corlan, only to be told it had been withdrawn. I wrote to Glaxo inquiring about this and was informed it had been withdrawn because of "lack of demand" as compared to the older similar drug Corlan.

Beta-corlan (betamethasone disodium phosphate) is as active therapeutically as Corlan, but has the advantage of causing less gastric disturbance. It is also tasteless, whereas I find that Corlan tastes exceptionally foul, and it has the final advantage of costing the Health Service just half what Corlan costs.

I made some inquiries locally and afar among doctors I know, but only found one who had ever heard of Beta-corlan, so I am forced to assume that this drug was withdrawn only because most members of the medical profession are unaware of its existence. I know about it because I read every advertisement sent to me.

Upon my special plea, because I find this drug is so excellent for apthous ulcers, Glaxo have now reintroduced the drug and it is once again available. Because of the taste, few patients would persevere with plain Corlan, and for this reason alone Beta-corlan gives far better results.

As I am a nobody and Glaxo a very large firm I think it handsome of them to do as they have done, and I can only hope that this valuable drug will not be lost by default and be withdrawn again, and that other perhaps more valuable drugs suffer the same fate.

I keep up to date with my pharmacology by reading the advertisements in the *B.M.J.* and all the ones I receive by post, and I appear to be alone in being grateful for this material being delivered right to my armchair where it is most convenient to read it. I suppose everyone else goes on a course at least once a year.—I am, etc.,

Norwich.

C. A. PITT-STEELE.

Postgraduate Training Posts for Overseas Doctors

SIR,—The letter by Dr. W. M. C. Allen is extraordinary (26 February, p. 545). The main points appear to be:

(1) Facilities in England are being used by overseas graduates not only for postgraduate education but also for their own personal benefit. This is allegedly substantiated by the following.

(2) An Indian radiologist applying for a post of registrar in his own subject wrote: "A post in England would help me surmount the rigid foreign exchange restrictions imposed by the Reserve Bank of India."

(3) Training posts (conveniently vague—my comment) are intended to provide postgraduate education and should not be used by established foreign doctors as a source of income while in this country.

(4) The time has come to examine a little more closely our whole attitude towards postgraduate education of some of our overseas graduates if this is their aim and object.

For my part I can assure Dr. Allen (so as to end the slight doubt apparently remaining in his mind) that as an overseas graduate and trainee in surgery "personal benefits" are of great importance to me. I also suspect that as a trainee radiologist Dr. Allen was not entirely oblivious of this mundane aspect of life.

As to the Indian radiologist, I am quite sure all that he meant was that a post in England would help him obtain necessary foreign exchange (which otherwise would be difficult) from the Indian Government authorities.

The third point: I cannot for the life of me see why foreign doctors, established or otherwise, should take up a training post with the vow that he or she will not accept the income that goes with the post. There is considerable competition for a good training post, and the teaching and the income are both well earned.

The fourth point: If Dr. Allen were to examine this problem I do not know what conclusions he would arrive at.

Others more practical will find that, despite the sinister aim and object of the overseas graduates, the hospital authorities are obliged to employ them, because they have no British graduates to employ. Where there are, they are often taken in preference to better qualified (by British standards) overseas graduates. It is a simple question of supply and demand. When the supply of British graduates meets the demands of British hospitals it will require very little "examination" by Dr. Allen to stop our employment and training.—I am, etc.,

Wrexham.
North Wales.

P. K. CHAKRABARTY.

Examinations in English for Overseas Graduates

SIR,—I read with amazement and sorrow the decision taken by the British Medical Association Council (26 February, *Supplement*, p. 45) to recommend to the General Medical Council the recommendations of the General Medical Services Committee regarding an examination in English language for

overseas medical graduates before they began "independent medical practice" in Great Britain.

Would the Council be more precise in this respect? Would the graduates from Australia, Canada, and New Zealand be required to face such an examination, or would it be specifically directed to graduates from India and Pakistan (they form the bulk of overseas doctors in this country, and their medium of instruction is English)? Would I, for that matter, after working in British hospitals for nearly four years, have to qualify in such an examination if I did decide to enter into "independent medical practice"?

If our wise colleagues in the Council did decide to recommend such an examination for all the overseas graduates, would it not be better to hold it in their country of origin like the Americans do?—I am, etc.,

Hastings, Sussex.

L. R. M. KAMAL.

Review Body

SIR,—I refer to the recent statement about the Review Body's Report (12 March, *Supplement*, p. 61). In it the profession is advised of the delay in the Review Body's report, and that our representatives will continue to urge prompt and full implementation of the award.

I can see only one reason for the Government's refusal to consider the report until after the election. The Government anticipates that either the report or the Prices and Incomes Board's appraisal will so affront the profession as to produce an immediate crisis. I have little doubt that the profession is faced again with a head-on collision with political policies.

Our leaders can anticipate developments. Instead of the £45m. increase in pricing of the service there will be an offer of £10m. to approximate the 3½% national increase, plus perhaps another £5m. offset against sickness, seniority, and the destructive merit award plot. General practice in the National Health Service cannot survive another economic blight.

If the policy of pricing the new contract *ab initio* is dead, then the National Health Service is likely to be condemned with it.

Our leaders must have full backing for the alternative scheme. Divisions are being asked to discuss the matter again, but local medical committees must also pursue this. The left and right hands of the profession must work together. The profession must back its determination with its own money. Ten pounds from each doctor would give Ivor Jones more than £200,000 to get this scheme off the ground. The five thousand doctors who have loyally contributed so far are aware of all the difficulties. If the scheme won't work in their areas they hope it will work in others. If the scheme is not right in some respects they hope for later practical modifications. But they have paid up, and this is the fibre of loyal united action.—I am, etc.,

London E.5.

ALAN REZLER.

SIR,—The hour is almost at hand. Before we go into ecstasies about what the press forecast as a "substantial pay increase" let's