Correspondence

Letters to the Editor should not exceed 500 words.

Teach-in on the Hospital Service

SIR,—I was amazed to see the statements attributed to Mr. Gordon Forsyth (Lecturer in Department of Social Administration, University of Manchester) in the report of the "Teach-in on the Hospital Service" (5 March, p. 606) relative to the functions of the Royal Colleges.

I can assure him, from a detailed and intimate knowledge of the work of one of them and from more than a nodding acquaintance with the others, that his remarks—"What do the corporations do in return for the money they take in examination fees?" or "Why could not the universities rather than the colleges offer postgraduate qualifications?" or, again, "The B.M.A. should be able to negotiate alone on pay without pressure of splinter groups and the consultant colleges"—show at the best a woeful lack of such basic knowledge as one might have expected from a leading participant in a teach-in or, at the worst, an almost libellous slur on those institutions which guard the standards of medical work in the country—the very standards on which he, as a layman, may have or has had to depend.

The Royal Colleges are responsible (through their examinations) for the overall competence and/or excellence (according to the diploma granted) of their diplomates. They are national bodies incorporating in a modern and up-to-date environment all the history and tradition of British medicine. In comparison with this, a university is relatively parochial—and rightly so. Its standards of teaching and of qualification vary from university to university, and, in any one, between discipline and discipline. The universities *do* offer postgraduate qualifications, but the basic qualifications for consultant status in the consultant service of the National Health Service are the diplomas of the Royal Colleges.

The colleges have set standards—and kept them under constant review—in the ethical, clinical, and scientific practice of British medicine and have willingly advised the Minister and Ministry of Health on these matters whenever required to do so. For this very reason they have studiously avoided involvement in the financial concerns of the consultant profession and so maintained an independent opinion which, over the years, has proved of the greatest value to all concerned—Ministry and profession alike. Through their membership of the Joint Consultants Committee they have nevertheless kept themselves actively cognizant of existing conditions in the hospital service.

For Mr. Forsyth's benefit, may I point out that, apart from the foregoing responsibilities, the college with which I have the honour to be most closely associated organizes throughout the year courses of postgraduate lectures attended (voluntarily) by an average of more than 1,000 students a year; administers an institute of basic medical sciences unique in

the country; contains no less than eight professorial scientific research departments; accommodates in residence 100 overseas postgraduates; maintains active links with the corresponding leading institutes in Commonwealth and foreign countries; conducts examinations overseas and so spreads the knowledge and prestige of British medicine throughout the world; houses the administration of almost all the allied specialist associations; publishes a monthly journal of its own; serves as a base for many and varied national and international conferences, and through its museums and library offers facilities for postgraduate education unrivalled in the world.

If Mr. Forsyth still does not feel such comprehensive functions justify a separate and corporate existence, I trust he will at least have the courtesy to come and see for himself.—I am, etc.,

London W.1.

ARTHUR PORRITT.

SIR,—In the past few months the Manchester Regional Hospital Junior Staff Group have tried to educate the general public with regard to the problems of junior hospital staff which have to be faced now if the hospitals are to provide an adequate service. Two of the ways in which the Group has sought such publicity were the "Panorama" programme which appeared on 21 February 1966 and the "Teach-in on the Hospital Service" recently held in Manchester.

Unfortunately the "Panorama" programme was too abbreviated to have much influence. It was a pity that the final and "off the cuff" comment by Robin Day gave the impression that the Review Body Report would provide a complete answer, since the improvements required are not only financial. The report of the teach-in (5 March, p. 606), though factually accurate, did not convey the sense of urgency which was apparent at the meeting. What is more, your leading article (5 March, p. 557) gave only brief reference to the teach-in and did not make absolutely clear a short-term measure which can be taken now to help solve the ever-growing problem of lack of doctors in Great Britain. This is so to improve the terms and conditions of service that junior hospital doctors no longer have the desire to emigrate. As far as the hospital service is concerned, to increase the pre-registration period to two or three years would be another short-term but also a short-sighted measure which would fan the flames of resentment already existing among junior hospital staff.

The continuance of the hospital service depends on the education of junior medical staff to enable them to replace their senior colleagues. The Royal Colleges must begin to show adequate interest in this postgraduate education. Traditionally this has been their responsibility, and as was commented by Mr.

Gordon Forsyth at the teach-in, except for relieving examinees at regular intervals of high examination fees, for the majority of junior staff they have failed miserably. (Perhaps the present pass rate of these examinations would be higher if examinees paid after passing instead of before!) Postgraduate education does not mean simply organizing "courses" for the few, but includes setting down a definite syllabus and actively providing for all junior staff a regularly organized educational programme at local levels. In addition, there must be encouragement to postgraduates, both those *without* as well as with higher degrees, to take an interest in research with adequate provision of both time and facilities. The only proper postgraduate education is one in which the individual generates his own ideas for research as his education and experience progress, and accordingly the pattern of the "higher degrees" must alter.

Finally, it is essential the general public appreciate the precarious state of the hospital service, which will soon collapse from lack of doctors as well as lack of funds. Taking the longer view, to provide an adequate number of doctors by the earliest possible date requires an increase in the intake of the present medical schools. To wait until new medical schools are available in sufficient numbers will be too late, since it takes seven to eight years to train an individual up to the level of a hospital registrar.—I am, etc.,

BRIAN LIVESLEY,

Chairman,
Manchester Regional Hospital
Junior Staff Group, B.M.A.

Manchester 23.

SIR,—I was very interested to read your report on the "Teach-in on the Hospital Service" organized in Manchester on 25 February (5 March, p. 606).

This is the first time I have seen the use of the expression "teach-in" used in connexion with a medical meeting in the United Kingdom. Perhaps someone can tell me how it differs from a seminar, a symposium, a group discussion, a conference, etc. I am sure that there will be many like myself who will be wanting to know what this "new" method of discussion entails.

I think one should be very careful about the introduction of such terms unless there is a real justification for their use, particularly in this case since it sounds so horrible.—I am, etc.,

W. HOBSON,

World Health Organization,
Copenhagen.

Salicylic Acid in Aspirin Mixture B.N.F.

SIR,—The irritant effect on the gastric mucosa of salicylates and in particular of salicylic acid has been known for many years.¹⁻³ Nowadays the oral use of salicylic acid for therapeutic purposes is, to our know-

ledge, non-existent, and its use as a preservative in foodstuffs has been forbidden by law since 1925. Moreover, the *British Pharmacopoeia* lays down a stringent limit (0.15%) as the maximum permissible amount of salicylic acid in aspirin tablets.

In the presence of moisture aspirin hydrolyses to form salicylic and acetic acids. Aspirin Mixture and Aspirin Mixture for Children (*B.P.C.* and *B.N.F.*) are essentially aqueous suspensions of aspirin, and as might be expected hydrolysis occurs rapidly. However, the *British Pharmaceutical Codex* states no limits for salicylic acid in either mixture, and indeed the official assay procedure involves complete hydrolysis and determination of aspirin in terms of salicylic acid by acid/base titration.

We have used a method of assay for aspirin mixture by ultra-violet spectrophotometry, which gives the amounts of both aspirin and salicylic acid present, and have studied the deterioration of Aspirin Mixture *B.N.F.* at room temperature for periods of up to six months. Salicylic acid was detectable within half an hour of making a fresh mixture, and within a few hours the level was above the maximum concentration allowed by the *British Pharmacopoeia* for aspirin tablets. After a week the mixture contained about 20 mg. of salicylic acid per 15 ml. dose, and after 10 to 14 days the mixture contained less than the minimum amount of aspirin permitted by the *B.P.C.* and more than 30 mg./dose of salicylic acid. By the end of two months each dose of mixture contained about 100 mg. of salicylic acid, though at this time the mixture still gave a satisfactory result when assayed by the official (*B.P.C.*) method. After six months' storage at room temperature the mixture was found to consist predominantly of salicylic acid. At higher temperatures the hydrolysis of the aspirin in the mixture occurred much more rapidly, being virtually complete in four weeks at 37° C.

The *B.P.C.* monographs for Aspirin Mixture and Aspirin Mixture for Children both state: "The mixture deteriorates rapidly and must be freshly prepared." Our results show that even when this requirement is satisfied considerable deterioration will occur during the normal period of use, and in addition there is the possibility that mixtures prescribed and dispensed weeks or months previously might be reused by the patient. Furthermore, in our own experience the mixture is sometimes not freshly prepared in retail pharmaceutical practice but is made batchwise and stored as either normal or double-strength "stock" mixtures. For this reason we examined six samples of each of the adult's and child's mixtures prepared in this way and obtained from retail pharmaceutical practices in the Brighton area. The six adult's mixtures contained an average of 54.5 mg. of salicylic acid per 15 ml. dose and the child's mixture an average of 9.6 mg. per 4 ml. dose.

Our results show, we think, that aqueous suspensions of aspirin are unsuitable for internal use, since they may contain considerable quantities of salicylic acid. Furthermore, the official assay procedures for both mixtures are clearly unsatisfactory. In view of the fact that solubilized, buffered, and inexpensive aspirin tablets are available on the market we would suggest that Aspirin Mixture and Aspirin Mixture for Children are

now obsolete preparations and represent an unnecessary therapeutic hazard, especially for infants.

Finally we note that it is not proposed to delete either preparation from the new *B.P.C.* now in preparation.—We are, etc.,

M. D. DAY.
J. F. HARPER.
C. J. OLLIFF.

Pharmacy Department,
College of Technology,
Brighton 7, Sussex.

REFERENCES

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- ² Roch, M., *Bull. gén. Thé.* (Paris), 1912, **163**, 218.
- ³ Douthwaite, A. H., and Lintott, G. A., *Lancet*, 1938, **235**, 1222.

Popliteal Aneurysms

SIR,—Your leading article (12 March, p. 625) contained much useful information but less sense of proportion than enthusiasm for surgical treatment. If we accept as evidence of aneurysm the physical sign of widening of the popliteal artery behind the knee, the finger-tips of the two hands being unmistakably separated by one inch or more of pulsating swelling, then popliteal aneurysms are so common that a vascular surgeon will see several cases each month. Arteriography, as your leading article rightly points out, gives little idea of the size of the sac, most of which is filled with thrombus. Yet here I must disagree with the gloomy forebodings on the subject of complete thrombosis—an event which, except in connexion with other events (such as the more widespread acute ischaemia during aortic clamping), may pass quite unnoticed, or later become recognizable as a cause of intermittent claudication from the fact that the opposite patent popliteal is palpably aneurysmal. Embolization it is true is an important complication, though not so much as a cause of intermittent claudication as of severe localized ischaemia of the terminal small arteries of the extremity, for example, the plantar arch or posterior tibial, producing digital gangrene with the unusual feature that either or both of the ankle pulses may still be present. Massive gangrene is the result of leakage or rupture with compression of the popliteal and its collaterals around the knee-joint. This complication is quite rare; there should be good warning that it may be about to happen when aching and swelling of the calf and ankle give evidence of compression of the more yielding accompanying deep veins.

Yet the occasional large tender or painful aneurysm does require surgery, though unhappily local morbidity following removal is much commoner than the leading article suggests. Popliteal vein thrombosis is a regular and troublesome complication for the reasons stated, but much worse and also quite common is a painful neuritis of the medial popliteal nerve, due no doubt to necessary retraction during the reconstruction. Numbness and burning paraesthesiae of the medial toes and forefoot may give the patient no peace for many weeks. Such distress seems a high price to pay for academic perfection in the treatment of a symptomless, often bilateral, moderate, or small-sized aneurysm, whose natural history without any treatment usually shows it to be harmless if one can resist the temptation to operate. I,

too, greatly enjoy reconstructing the popliteal artery for aneurysm, but not so much as to claim all early cases for this opportunity to practise surgical craftsmanship.

Finally, a word on technique. Dacron grafting it is true does well in these cases, especially in the early or uncomplicated larger ones. A small aneurysm in a lengthened and tortuous popliteal may be resected so as to permit an end-to-end anastomosis, an alternative to grafting which is often forgotten today, and which I have found possible even in cases of abdominal aortic aneurysm. Simpler still, and very often far better suited to the elderly subject, is Hunterian ligation, not even mentioned in the article. It is nearly two hundred years since this advance was made, and nothing in the brilliance of vascular surgery today can diminish the outstanding value of this safe, certain cure.—I am, etc.,

London W.1.

H. H. G. EASTCOTT.

SIR,—Your leader on popliteal aneurysms (12 March, p. 625) prompts me to make a few observations.

(1) It was said that in the past syphilis was an important cause. I believe this statement to be apocryphal. Syphilis mainly affects the arch of the aorta, and the postillions and other horse riders in the classical days of popliteal aneurysms of the seventeenth and eighteenth century got their disease from repeated trauma of the popliteal fossa from their riding boots. Trauma is a definite cause of these aneurysms in relatively young people without severe atherosclerosis. One patient I had was digging in the garden when he was given a sharp blow behind his knee by his exuberant Alsatian dog. Aneurysms caused by sharp blows are frequently saccular in character, rather than the fusiform type that occurs in the atherosclerotic.

(2) Intermittent claudication in these patients does not necessarily mean that embolization of the distal arteries has occurred as a result of the detachment of grumous material and clot from the aneurysm. Claudication will also be caused by a thrombosed and consolidated aneurysm with a poor collateral circulation. As the ostia of the collaterals become narrow, so the circulation fails.

(3) The operative treatment of popliteal aneurysms need not always be excision of the aneurysm and the insertion of an arterial graft (whether vein or Dacron). For the large fusiform aneurysms this is certainly the treatment, and I well remember demonstrating this operation as the first colour television operation shown at a B.M.A. meeting in Birmingham. Alas, in this case, I used an artery homograft, and as this type of graft is liable to become aneurysmal after a few years my patient was given back his old disease. However, for the small saccular aneurysms I can recommend a return to the Matas disobliterative endaneurysmorrhaphy. I have used this method with lasting success in three cases. Essentially the procedure is to open the aneurysm, to remove all the clot and grumous atheromatous material from within, and then to reconstruct the artery either by using the tougher part of the wall of the aneurysm or by the attachment of a vein patch.