American surgeon and his family on three months' "holiday." Although he worked as hard as the rest of us, he thoroughly enjoyed the change of surroundings and the stimulus of new problems which he found, and he insisted that it was worth every dollar he had spent. When he worked out the cost, he discovered that it was equivalent to the price of a new Cadillac.

I doubt if it can always be done for that price, but if we can persuade some British doctors to do likewise their contribution towards meeting Africa's need would be worth incalculably more than the cost of a new Rolls.

Those of us working in Africa are constantly aware of the danger of our medicine becoming rusty. This has to be balanced against what we are actually achieving. It seems precious little at times in the chaos of trying to be all things to all patients. These things cannot be measured in academic terms, but short-term working visits by sympathetic doctors from "overdeveloped" countries would do a great deal to revive our drooping spirits and keep alight the flickering academic light. Just to have someone with whom to talk shop means more than will be appreciated by those plagued with a surfeit of medical meetings.—I am, etc.,

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IAN KENNEDY.

Laevadosin in Muscular Dystrophy

SIR,—It is probably correct to state that Dr. Walton and his group have never been enamoured with the possibilities of Laevadosin for the treatment of progressive muscular dystrophy. It is not surprising, therefore, to read (28 August, p. 533), "the trial has demonstrated beyond reasonable doubt that Laevadosin does not dramatically modify the natural history of the Duchenne type of muscular dystrophy when given over a one-year period." Such a statement would seem to be at variance with "Statistically . . . measures . . . are taken as objective evidence suggesting some amelioration of the dystrophic process."¹ What were the "statistics" of the latter and the "confidence limits" of the former measuring? In fact neither are writing of patients—both are using techniques of muscle-power testing (spring balance and M.R.C. grading), which soon show themselves to have the intrinsic problems of the method, the tester, and the tested and at best are poor approximations of muscle-power testing. The enzyme studies similarly present difficulties of interpretation rather than of accuracy.

One must ask the questions in terms of treatment of muscular dystrophy: (1) What are we looking for? and (2) How far have we got? To question (1) the answer must surely be—we are looking for a substance which will prevent or stop the dystrophic process in muscle and return the abnormal muscle to normal. Would it not be fair to say that we would be contented, for the time being, to be able to stop the dystrophic process? In answer to question (2) in terms of Laevadosin, surely we must give the verdict "not proven"—in either direction—to any of the studies so far reported. Our own testing of some 26 patients confirms that

"dramatic modifications" have not occurred. There are, however, too many "chance findings" in our cases (e.g., 6 out of a possible 13 patients lost their Gower signs) to make one want to throw away Laevadosin on the very flimsy evidence presented by the Newcastle group. As a scientific group, surely they must accept that they have looked at a very small number of patients. It is not enough to say that the "Thomson Group" were overenthusiastic and undercritical; the "Newcastle Group" are equally guilty in the opposite direction. It is possible that the Newcastle group are correct, but from their publications this is an intuitive evaluation, not a scientific one.

One's impressions are that one should perhaps ask the manufacturers to provide a more concentrated form of Laevadosin so that we can give bigger dosage more frequently (say, the equivalent of 10 ml. of the present material intramuscularly daily—despite the discomfort and remembering the problem of A.T.P. and shock), using "some objective method of measuring the efficiency of muscular activity (e.g., by means of voltage tension curves)."²

In addition, maybe it is possible to do another trial, using early cases of the disease in sufficient numbers to allow following up for some years, for we really have not established the natural history of the disease, nor has any group fully evaluated the use of Laevadosin in the early case.—I am, etc.,

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J. JACOBS.

REFERENCES

- ¹ Thomson, W. H. S., and Guest, K. E., *J. Neurol. Neurosurg. Psychiat.*, 1963, 26, 111.
- ² *Medical News*, 15 January, 1965.

Students' Mental Health

SIR,—I have read your leader "Students' Mental Health" (4 September, p. 547) with great interest. With regard to anxiety associated with the 2nd M.B. examination your readers may like to know of the results of a preliminary survey at my medical school relating this examination to smoking. In the students of one year, over 40% either started or increased their smoking "during 2nd M.B." Smoking ten or more cigarettes per day was significantly more common during this period than at periods eighteen months before and two months afterwards ($P=0.05$).—I am, etc.,

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R. F. HELLER,
Medical Student.

Quinidine-induced Syncope

SIR,—A recent publication in this journal presented six cases of quinidine syncope and drew attention to the toxic effects of this drug (Drs. Paget Davies, D. Leah, and S. Oram, 28 August, p. 517). We have recently encountered cardiovascular and respiratory collapse due to quinidine with fatal termination in a 45-year-old woman, following direct current conversion of atrial fibrillation.

This patient, with multi-valvular but not severe rheumatic heart disease, had atrial fibrillation of 14 months' duration. The ventricle rate was controlled with digoxin. Sinus rhythm

was established with a 400 watt-second direct-current shock. The patient was well afterwards and was started on quinidine 0.3 g. four times a day. Ten hours later, after having received a total dose of 0.6 g. of quinidine, she suddenly lost consciousness. There was complete and immediate cessation of circulatory and respiratory activity. Resuscitating measures were of no avail. Necropsy revealed no evidence of embolism or of myocardial damage. The atria were free of clots.

Only 0.6 g. of quinidine was administered to this patient. This supports the view that the usual test dose is of no help in indicating the patient in whom cardiac syncope is likely to occur. Moreover, in this patient all suggested predisposing factors—a digitalis toxicity, congestive heart failure, and ischaemic heart disease—were absent. Since the effectiveness of quinidine in preventing recurrence of atrial fibrillation once sinus rhythm is established is doubtful,¹ it is felt that its prophylactic use for this purpose should be strongly discouraged.—I am, etc.,

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P. B. HALMOS.

REFERENCE

- ¹ Halmos, P. B., *Brit. Heart J.*, in press.

General Practice—at Home, and Abroad

SIR,—I have just now ended surgery on a night in early September, three and a half hours after I began it. My partner and I have between us seen a total of 73 patients in that time. Earlier in the day we had dealt with a further 84 patients in surgery, by 'phone, in their homes, or in answer to notes, scrawls, or verbal requests, to our *two*, rotating, 24-hour-duty receptionists. Of all that, and two late calls to-night, approximately 80% was unnecessary.

I am now at home, too tired, frustrated, and tense to eat—and not willing to tackle the various letters, requests, etc., which can be done only at these hours. I am on call till 8 a.m. to-morrow morning single-handed, and on normal duty till surgery ends to-morrow night, whenever that will be.

Golf I cannot even consider, because of the time involved—tennis has become an impossibility—and watching football more and more a pipe-dream.

I look around at my fellow-man, and am astounded by the lunatic situation we occupy in general practice in England 1965. I read weighed arguments in the *B.M.J.* suggesting that more combined practices, better organization, more health centres, more receptionists, more health visitors, more nurses, more doctors are needed to give us a good Health Service. All very fine and noble sounding—most noble of all it must all be *free*. While the letters roll in each week fewer and fewer doctors and nurses remain to read their eloquent contents. Do we in fact believe the Charter will ever be fully implemented? Will the profession take an honest look at the situation? There just is not enough money available to the Government to pay the doctors a just wage and at the same time satisfy the imaginary needs of the patients. The demands of the patients must be reduced. The cost—actual cost of health—must be made quite clear to them. They must pay directly for it—to the doctor. They can then send their receipts (including drug costs and hospital costs)—if necessary their bills—