Arabic and English, outlining the current teaching on fasting for Ramadan during pregnancy; the midwives copied this and use it when seeing women who are fasting.

Clearly, interpretation of the teachings on exemption from fasting differs greatly, and staff may not always appreciate that a woman is fasting. The issue of whether a woman is eating enough may arise only if she fails to gain weight. This study showed that a substantial number of pregnant women do fast, and this will not be known unless they are specifically asked.

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1 Rashed AH. The fast of Ramadan. *BMJ* 1992;304:521-2. (29 February.)

Corticosteroids and male infertility with an immunological basis

SIR,—Carolyn E Grundy and colleagues are premature in dismissing corticosteroids as being of doubtful efficiency in male infertility with an immunological basis and as having "unacceptable side effects"—particularly as they report on only three patients, in whom two clinical pregnancies were established.¹

In their references the authors fail to include an excellent paper by Hendry *et al.*² This reported a double blind, placebo controlled crossover trial in which 48 patients participated, with 18 months of follow up. This was a well designed study and showed a significant improvement in the pregnancy rate during steroid treatment compared with placebo treatment (31% *v* 10%).

We are conducting a similar trial of cyclical steroids. Until we have identified the different prognostic groups we are offering the treatment to men with antibody titres greater than 10%, regardless of the other semen variables, as long as investigation of the female partner shows no abnormality. A preliminary analysis of our results in this relatively unselected group of patients (30 patients and 105 cycles of treatment) suggests a cumulative pregnancy rate of 20% at four months of treatment. From previous work in this department these patients would be expected to have a cumulative pregnancy rate of only 4% at four months without treatment.

We think that although in vitro fertilisation with specially prepared semen will undoubtedly have a role in the management of these patients, particularly when there are other abnormal semen variables or female factors to be considered, cyclical steroid treatment will continue to be important, especially for those who do not have access to in vitro fertilisation.

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1 Grundy CE, Robinson J, Guthrie KA, Gordon AG, Hay DM. Establishment of pregnancy after removal of sperm antibodies in vitro. *BMJ* 1992;304:292-3. (1 February.)

2 Hendry WF, Hughes L, Scammell G, Pryor JP, Hargreave TB. Comparison of prednisolone and placebo in subfertile men with antibodies to spermatozoa. *Lancet* 1990;335:85-8.

The Bevan factor

SIR,—Those who believe that Nye Bevan would have had any truck with the NHS reforms do him a great disservice.¹ *In Place of Fear* sets out his

aspirations.² In the 1930s many lived in fear without hope. He wanted to create a system in which there was hope. It was not a vision of safety nets for the poor but of services all could use confidently.

"Society becomes more wholesome . . . healthier . . . if [citizens know that] not only themselves, but all their fellows have access . . . to the best that medical skill can provide." He believed that the service should not be influenced by self interest. "Economic man" and medicine, he believed, did not mix. The new system is propelled by self interest and financial incentives. General practitioners, he considered, "should be able to earn a reasonable living without having . . . a register . . . too large to allow good doctoring."

He saw the NHS as a triumphant example of collective action applied to "a segment of society where commercial principles are seen at their worst." Danger arose "at the point where private commercialism impinges on the service." So he would have not had sympathy with internal markets, which like insurance systems might be expensive, create anomalies, and cause "chaos of little or big projects." Extracontractual referrals would have been seen to create "frontier problems," destroying the "essential unity of the Service," and no system that delayed care until it was clear "that money would follow the patient" could have met with his agreement. Charity funding ("warm gushes of self-indulgent emotions") and the use of the voluntary sector would have been resisted lest they gave rise to "a patch-work quilt of local paternalism."

His enthusiasm for preventive medicine was tempered by his sympathy for the individual. "Not even the apparently enlightened principle of the 'greatest good for the greatest number' can excuse indifference to individual suffering," he said after quoting Dylan Thomas, "After the first death. . ."

He would have found the current tax debate familiar: "There being nothing in the public exchequer which was not wrung from the reluctant taxpayer, communal need and private greed were in constant war with each other." He felt he had created an institution protected from attack, and prophesied, "No political party would survive that tried to destroy it," unless it was destroyed "stealthily and in such a fashion that they appear to have no responsibility" for its destruction. Is stealth succeeding?

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1 Warden J. The Bevan factor. *BMJ* 1992;304:338. (8 February.)
2 Bevin A. *In Place of Fear*. London: Heinemann, 1952.

Goya's living skeleton

SIR,—Geoffrey Hooper offers an alternative diagnosis of fibrodysplasia ossificans progressiva (formerly known as myositis ossificans progressiva)^{1,2} to explain the physical abnormalities of Claude Seurat, the "living skeleton."³ Unfortunately, the contemporary descriptions of Claude Seurat do not fulfil the triad of clinical features associated with this disorder: hard swellings usually over the shoulder girdle and trunk; deformities (scoliosis and torticollis) secondary to the developing swellings; and a short great toe or deformity of the thumb.² Contemporary accounts record Seurat's hands as "semi-flexed" and his feet as "well formed; a trifling overlapping of the toes is probably accidental."⁴

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1 Hooper G. Goya's living skeleton. *BMJ* 1992;304:509. (22 February.)

2 Wynne-Davies R, Hall CM, Apley AG. *Atlas of skeletal dysplasias*. Edinburgh: Churchill Livingstone, 1985:547.

3 Park RHR, Park MP. Goya's living skeleton. *BMJ* 1991;303:1594-6. (21-28 December.)

4 Hone W. *Every-day book*. Vol 1. London: Hunt and Clarke, 1826:1017-34.

Restricted entry to the tamoxifen trial

SIR,—Following the Medical Research Council's decision to restrict the tamoxifen breast cancer prevention trial to women at very high risk of developing the disease, the two major cancer charities have decided to do without the council's support. In view of the public interest in this matter I thought it might be helpful to the clinical community if I set out the council's reasons for its decision.

After comprehensive peer review members of the council continued to be worried by aspects of the toxicology of tamoxifen and by the proposed patient information leaflet.

The concerns about toxicology centre on the fact that tamoxifen induces liver tumours in rats at doses that, because of bioaccumulation in humans, can be considered to be similar to those to be used in the trial; there is therefore no dose or safety margin. The rat tumours are unusual in that they do not follow the normal pattern of hepatocarcinogenesis induced by steroids and are highly malignant.

An additional factor was that tamoxifen has recently been shown to form DNA adducts in rodents. This work has been published in the United States¹ and confirmed at the Medical Research Council's toxicology unit. There are still uncertainties concerning the suitability of the rat as a model, and so the toxicology unit is carrying out urgent studies of the metabolic pathways of tamoxifen in rats, mice, and humans.

Few women have received tamoxifen for longer than five to seven years, whereas the maximum incidence of liver tumours induced by known carcinogens occurs at eight to 10 years.

In view of these concerns the council emphasised that the issues should be set out clearly and explicitly in the patient information leaflet so that women could make a fully informed choice about entering the trial, and that the trial should go ahead only in women aged 40 and over who were at very high risk. This group would include women with a fourfold and greater risk of developing breast cancer. The charities have decided that the Medical Research Council will not now have a role in the study; the toxicology unit's studies are, however, continuing.

The council has no wish to spread alarm among women taking tamoxifen for proved breast cancer, for which it is a well tried and effective treatment. The council has taken the view, however, that until more evidence is obtained to inform better risk-benefit calculations for using tamoxifen in prevention the best course is to proceed with caution.

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1 Han X, Liehr JG. Induction of covalent DNA adducts in rodents by tamoxifen. *Cancer Res* 1992;52:1360-3.

Acute medical beds could be cut

SIR,—P J Toghill's fears¹ about the implications of the Audit Commission's report on the management of acute beds² are based on misunderstandings. A 30% cut could not be made in the number of medical beds in isolation, nor is it suggested that wards are standing empty. Paragraph 58 of the report states:

If all districts could achieve lengths of stay and turnover intervals at least as low as the current best 25 per cent of districts (even after allowing for the