zine), with which she was being treated, the oedema recurred at irregular intervals. The fourth case was a girl aged 21 under the care of St. Thomas's Hospital, who was on Tofranil (imipramine), Marsilid (iproniazid), and Largactil (chlorpromazine). Her mother had charge of the tablets. She was admitted to hospital in coma. Blood and urine samples showed no evidence of drug overdosage. When she recovered she denied to hospital staff that she had taken anything other than the normal dose. The mother confirmed this. Yet, after discharge from hospital, the girl told us that for weeks she had been palming the nightly chlorpromazine tablet, and had taken 40 tablets before lapsing into coma.

We have at this time over 50 patients on various antidepressants, and though some of them can hardly stand up because of hypotensive effects they are all finding life worth living.

It is the family doctor who should be prescribing these drugs, certainly singly, and it is hoped, as we gain more experience, in combination. It is the writing of physicians, pathologists, toxicologists, and committees with little clinical experience of handling the antidepressants that is making it difficult for us to accept the much more authoritative statements of those who think, teach, and practise as Dr. Sargent does.

Our patients do not die from antidepressant drugs, either singly, in combination, or in massive overdosage. They sometimes die by their own hands without them.—I am, etc.,

London S.W.11.

B. HYNES.

Anti-folic-acid Drugs

SIR,—In "To-day's Drugs" (30 January, p. 302) your expert says, with respect to antifolics, "The effect these substances have on the germinal chromosomes is unknown, but may be harmful, and they certainly should not be given to women in the child-bearing age."

Are we to deduce from the above that antifolics can safely be given to men in their procreative years?—I am, etc.,

CELIA LUTWAK-MANN.

Molteno Institute of
Biology and Parasitology,
Cambridge.

** We have shown Dr. Lutwak-Mann's letter to our expert contributor, who replies: "Methotrexate may well be harmful to both men and women, and it was not implied that antifolics could safely be given to men. The whole comment on their use was meant to be critical."—ED., *B.M.J.*

Doctors' Dilemma

SIR,—During a meeting of the Medical Disciplinary Committee of the General Medical Council held on 25 and 26 November 1964 it was reported that a charge of infamous conduct in a professional respect was being heard in the case of a doctor who held the degree of M.B. from an Indian university. The charge alleged that he used the designation M.D. on his printed notepaper or appended it to his signature in communications to persons in the United Kingdom and pretended that he possessed a degree of Doctor of Medicine granted to him by the

University of the State of New York or by some other university, whereas he had, in fact, obtained no such degree.

To my mind this raises a rather tricky problem which may concern itself more with a question of semantics than of false pretence. In Canada and the United States the general public assumes that any person licensed to practise medicine is in possession of an M.D. degree. Most correspondence from lay as well as professional bodies addressed to us appends the initials M.D. after our names. Indeed, such official bodies as the American College of Surgeons, which is fully aware of my academic qualifications, made out my certificate of Fellowship describing me as ———, M.D. I think the appellation M.D. is considered to mean as much Medical Doctor as the possession of a university degree of that nature.

Personally, I take pains in using my correct degrees when signing official documents and letters to other doctors. This is probably of particular importance when making out narcotic prescriptions and when signing official documents. However, when writing letters to employers, school principals, or other lay bodies, the initials M.B., B.S. may often be meaningless on the local scene. This difficulty is of course overcome by calling myself Doctor ——— on my stationery, and I know that most practitioners in the United Kingdom use a similar title on their letterheads and on their prescription forms. Since, however, very few graduates of British medical schools are, in fact, in possession of the degree of doctor in any faculty of any university, this description is equally false as

using the appendage M.D. to designate my status in this country.

Surely the time has come for British universities and universities of other Commonwealth countries to adopt the otherwise worldwide system of awarding the degree of Doctor of Medicine to their medical graduates. The description of Bachelor of Medicine and Bachelor of Surgery perhaps with the additional information of physician and surgeon that many United Kingdom practitioners display on their stationery must be highly misleading and confusing to the general public.—I am, etc.,

Oakville Medical Centre,
Oakville, Ontario.

J. A. LOEB.

Arcus Senilis

SIR,—I read with great interest the study of arcus senilis by Dr. G. M. McAndrew and Dr. D. Ogston (13 February, p. 425). I would like to point out that the occurrence of this corneal deposit is much influenced by exposure of the cornea to changes in temperature and perhaps to trauma from dust, etc. I have noted that a marked arcus (grade 4) is sometimes to be seen in a young man who has led an outdoor existence or who has worked in front of a furnace. Lastly, and perhaps most conclusively, I have on a number of occasions seen a unilateral arcus in a patient with a residual Bell's palsy. I have felt that failure of closure of the eye was in this case somehow responsible.—I am, etc.,

London W.1.

L. P. E. LAURENT.

Portable Anaesthetic Apparatus

SIR,—It has probably occurred to many anaesthetists that the Boyle circle Mark III would form an admirable self-contained portable anaesthetic apparatus if it were connected to a supply of oxygen and fitted with a simple vaporizer.

When I was giving closed-circuit Fluothane (halothane) anaesthesia in Malaysia recently the Malaysian Oxygen Company was also

impressed with the suitability of this device and produced a stand for a Mark III circle system to which was attached a small oxygen cylinder, reducing valve and flow meter, and Goldman vaporizer. This equipment is illustrated in the accompanying illustration. I have now used it for most types of surgery where spontaneous breathing is appropriate, and it appears to be a cheap, simple, and safe

portable anaesthetic apparatus. I am sure the Malaysian Oxygen Company's parent company in London would be prepared to make a similar stand for their equipment if requested.—I am, etc.,

T. H. S. BURNS.

Department of Anaesthetics,
St. Thomas's Hospital,
London S.E.1.

Perfusion Treatment of Cancer

SIR,—Recently while carrying out perfusion on a case of inoperable carcinoma of the mandible the following observation was made. A male patient aged 82 was admitted with an extensive growth of the left mandible, cheek, tongue, and floor of the mouth, which had previously been treated with telecobalt therapy. The histology revealed a squamous-cell carcinoma. It was decided to infuse the affected area with 5-fluorouracil through a catheter inserted into the left superficial temporal artery. During the procedure the catheter was advanced downwards and 1 ml. of Disulphine blue injected to outline the area of distribution. In order to confirm that the catheter was not in the common carotid artery the fundus on that side was examined. However, it was found that the vessels of the left fundus were stained blue. The catheter was then withdrawn by 2.5 cm.

From this observation we feel that a simple clinical method would be to observe the fundus on the same side, as the catheter is advanced and the dye introduced. The point at which the vessels of the fundus stained blue would denote that the end of the catheter was sited at or just below the level of the carotid bifurcation. Withdrawing the catheter by approximately 2 cm. would then ensure that the catheter was not in the common carotid artery.—I am, etc.,

E.N.T. Department,
Dudley Road Hospital,
Birmingham 18.

PILLOO HAKIM.

Treatment of Obesity

SIR,—In your recent leading article on obesity (19 December, p. 1543) and in many other papers and letters on this all-important subject scant attention seems to have been paid to the essential factor of calorie output or metabolic rate in coming to grips with the problem.

On rare occasions I have come across instances where a stone or more has been lost over a period of two to three months without discomfort by simple expedients such as abandoning a waistcoat, a vest, a regular hot-water bottle, the additional blanket on the bed, or spending less time in sleep.

Calculation of the energy outputs of physical exercise from gymnasium activities to mountain climbing are depressingly small, and in any event such infrequent feats of endurance are quite beyond the average obese subject. But the regular daily and nightly measures listed above cost nothing and can be regarded as practical politics.

Most of us would be glad to hear of the results of any course of work directed towards stepping up metabolism and consequent loss of weight without resorting either to drugs or unduly irksome diets. Such research should prove relatively simple to carry out,

requiring little apparatus, and at the same time amply rewarding.—I am, etc.,

J. G. C. SPENCER BERNARD.

Aylesbury, Bucks.

Work for Married Women Doctors

SIR,—At a time when the shortage of doctors is approaching crisis proportions the problems facing married women doctors in finding part-time work have received no publicity at all in your columns. The wastage of graduates among women in the same position as myself (through no fault of our own) must be considerable.

During the past two years I have made intensive and unremitting efforts to find suitable work, but have not succeeded. However, during this time I have reviewed the various problems and feel that they are worthy of note. My conclusion is that at the present time I see no possibility of my practising medicine again. In common with many graduates, I find being a full-time housewife exceedingly boring and I can only hope to find other work in which my very specialized medical training may be of use. Preliminary inquiries reveal that this will be difficult.

The results of my inquiries are as follows. The part-time posts available are:

(a) Regular work

Local authority work (Health Clinics etc.)

Hospital posts (clinical assistantships and part-time casualty officers)

Family Planning Association Clinics

General-practitioner assistantships

(b) Irregular work

Local authority work

Locums—general practitioner or hospital.

The main problem is that there are extremely few regular posts available. Local health authorities *where possible* prefer to employ full-time doctors. The vast majority of hospital posts are offered to general practitioners almost exclusively. Of equal importance is the fact that, unless one regards two hours' travelling time for a one-hour surgery "locum" as worthwhile, it is necessary to have a car. It is quite impossible to earn enough to buy and run a car oneself, working part-time, and so the few posts there are available only to those women who have a car for their own use. Irregular work can be done only by those women who—(1) have resident domestic help (or the equivalent—i.e., a relation); or (2) have few family commitments; or (3) have a husband free and willing to take over domestic chores at short notice.

Very few people to whom I have spoken realize that domestic help can be employed only on a regular basis, and therefore, unless one has regular work, one cannot have extra domestic help.

I have given a great deal of thought to these problems, but have thought of only one solution. Many specialties could be very well served by two (or more) part-time S.H.O.s replacing an existing S.H.O. (full-time). Such specialties I suggest are—geriatrics; casualty; long-stay orthopaedic, medical, and general surgical cases; E.N.T.; and possibly some others. For such posts a car would not be necessary, and so many more women

would be eligible to apply. This would help to ease the shortage of junior hospital doctors.

I should be glad to hear from anyone who is interested in this problem.—I am, etc.,

Richmond, Surrey.

VALERIE Y. MUIR.

Hazards in Hospital for Ex-smokers

SIR,—A friend of mine who gave up smoking six months ago is at present in hospital for a minor operation. Since his operation he has started to smoke again. Ex-smokers who are admitted to hospital are probably exposed to greater temptation to resume the habit than at any other time because of pain, sleeplessness, boredom, or simply because they have to lie all day and watch others smoke. As the medical profession is the champion of the anti-smoking campaign, it is ironical that a relapse should be associated with a stay in hospital. As ex-smokers are probably bored more easily than smokers, and this boredom is most likely to lead to resumption of the habit, particular attention should be paid to them in hospital, if only to ensure that they are adequately occupied, encouraged to persevere, and not given beds next to heavy smokers.—I am, etc.,

Norwich.

SYLVIA T. LAND.

Gregor Mendel

SIR,—The excellent reproduction of the facsimiles of Mendel's classical paper in your recent admirable "Festschrift" on the occasion of the Mendel centenary was particularly welcome. Alas, for a very sad reason. Early this century Professor Hugo Ilits, Mendel's main biographer, found the beautifully written manuscript "in a box full of papers destined for the flames." He remained the faithful custodian of this unique document until 1939, when, being a Jew and active Social Democrat, he had to leave Czechoslovakia at the