munity, partly to keep in touch with their power and partly to test out themselves and the adults around them. They select one member or a group of the staff and create in them a feeling that they are either better or worse than some other member of staff, slightly distorting what one of them has said. If staff are not wary they will find themselves victims of this kind of "splitting" manoeuvre (see part IV of this series), collude with it, and become angry with each other. They must therefore be open, discuss their feelings honestly with each other, and be seen by the adolescents to be getting on well with each other. The adolescents must know that everything that happens is known and shared by all the staff—and also that staff can have differing views and disagreements that do not create conflicts such as to make working together impossible. They must, moreover, know that their own interests are the common concern of all the staff.

The pressure-cooker phenomenon and the role of staff on the floor minimising acting out create other problems and dangers. Containing acting-out behaviour can be done in various ways. Staff who have the task of containing acting-out behaviour and, as it were, pushing it back into the patient may well be inclined to use this as a legitimate opportunity of unleashing their own aggressive and sadistic feelings on the patient. Patients who are experiencing severe persecutory anxiety may be pushed into psychotic behaviour if their verbal and behavioural acting out is not handled sensitively and with sympathy. There is the danger that staff will become the victims of projective identification and unknowingly persecute the patients.

Staff on the floor must be constantly aware that they have a responsibility and role. They must attempt a sympathetic and realistic interaction with the patients and at the same time constantly examine their own feelings and behaviour. Genuine concern, non-possessive warmth, and empathy, the staff attitudes advocated by Carl Roger, are essential for this type of work.

The fifth of six weekly articles.

References

1 Strachey, J, *International Journal of Psycho-Analysis*, 1934, **15**, 127.
2 Ezriel, H, *British Journal for the Philosophy of Science*, 1956-7, **7**, 29.
3 Ezriel, H, *British Journal for the Philosophy of Science*, 1956-7, **7**, 342.
4 Freud, S, *Complete Psychological Works*, vol XXIII, p 177. London, Hogarth Press, 1964.
5 Bion, W K, *Learning from Experience*. London, Heinemann, 1962.
6 Klein, M, in *Contributions to Psycho-Analysis 1921-45*, p 282. London, Hogarth Press, 1948.
7 Klein, M, *et al*, in *Developments in Psycho-Analysis*, p 198. London, Hogarth Press, 1952.

Is the vertebrobasilar syndrome a common cause of a "drop fall" in the middle-aged? How can the diagnosis be established, and is there any treatment? Is there an association with Menière's disease?

Almost all middle-aged sufferers from drop attacks are women. The victim falls forward on to her hands and knees but remains conscious. In the absence of injury she recovers immediately. Some patients say they are not aware of falling, but all can feel the impact on striking the ground. Such attacks are quite common, and 12 out of 200 consecutive women attending a gynaecological clinic gave a history of such a fall.[1] In most patients no cause is apparent, and the tendency to drop attacks may disappear after a year or two. They have been called cryptogenic drop attacks.[1]

Drop attacks associated with vertebrobasilar insufficiency may occur in middle age but are much commoner in the elderly. They are associated with other features of brain stem dysfunction—transient or permanent. Vertigo, ataxia, or weakness may precede or follow the attack, and there may be precipitating factors such as rising from a chair, turning the head, or extending the neck. Such attacks are often attributed to compression of the vertebral artery by osteophytes in the neck. Since most of the attacks have no obvious cause investigation is largely a process of careful history taking and the elimination of other possibilities. These include weakness of the muscles around the hips; spastic weakness of the legs associated with cervical spondylosis; Parkinsonism; and, very rarely, akinetic epilepsy, which is usually associated with petit mal and myoclonus. Falls caused by postural hypotension or Stokes-Adams attacks are usually associated with faintness rather than simple falling. To undertake vertebral angiography to establish a diagnosis of vertebrobasilar insufficiency would be like using a dangerous sledge hammer to crack a nut.

In cryptogenic cases there is no treatment. In others the underlying cause is treated. In drop attacks associated with cervical spondylosis and vertebrobasilar insufficiency it is always worth trying a collar. There is no association with Menière's disease, as in this condition there is deafness, tinnitus, and severe attacks of vertigo, which is quite another story.

1 Stevens, D L, and Matthews, W B, *British Medical Journal*, 1973, **1**, 439.

What is the treatment for persistent tennis elbow?

Tennis elbow is a musculotendinous enthesiopathy of the lateral epicondylic attachment of the extensor muscles of the forearm. It is usually an "over use" injury but may arise spontaneously. It is characterised by (*a*) pain in the elbow on resisted extension of wrist or forearm muscles (this may be limited to the extension of only one finger); (*b*) pain on lifting heavy objects; and (*c*) a sharply localised, severe tenderness strictly limited to the lateral epicondyle but occasionally producing a radiated pain down the forearm or up to the mid-arm. Tennis elbow may be associated with cervical spondylosis and carpal tunnel syndrome, which may be the cause when treatment is not immediately effective.

The most effective and quickest method of treating tennis elbow is an accurately placed 50-mg dose of hydrocortisone acetate injected with a wide-bore needle, accompanied by 1 ml of 2% lignocaine, into the point of maximum tenderness; the injection should preferably be as deep as possible. This will relieve pain in most patients within a few days. A firm bandage applied immediately after the injection is often also effective and worth while. In cervical spondylosis the pain is sometimes referred to the outside of the forearm from structures in the neck, but if the above physical signs are present this should not cause confusion in diagnosis. If the diagnosis is certain, and there is only a temporary response to local steroid infiltration, avoiding activities that exacerbate the pain, such as tennis, squash, badminton, or clothes wringing, for a month or so is often effective. The patient should also be reassured that the condition is essentially self-limiting and if untreated generally resolves spontaneously in one or two years. Surgical release of the attachment is effective but rarely needed or advised. Other local forms of treatment that have their proponents are deep transverse frictions, as advised by Cyriax,[1] and the local application of ultrasonics, which may sometimes help. Manipulative treatment (either of the elbow or of the cervical spine) is also used at times but requires knowledge of specialised techniques.

1 Cyriax, J, *Text Book of Orthopaedic Medicine*, vol 1, 6th edn, 1975; vol 2, 9th edn, 1977. London, Baillière and Tindall.

Do antiperspirants cause lumps in the breasts?

The most widely used topical antiperspirants contain aluminium salts, in particular, chlorides, sulphates, and phenyl sulphonates; the most effective, however, is aluminium chloride hexahydrate, 20% in ethyl alcohol. Practically no absorption of aluminium occurs even after swallowing these soluble salts. Although milk is apocrine sweat, topically applied antiperspirants have never been shown to affect its secretion, nor have they been shown to cause lumps of any type in the breasts.

RAWP and the Oxford Region

We regret that the third part of Mr Michael Jeffries's article, "Closures, economies, and cuts," must be held over until next week.

Thursday, 9 March

INGREBOURNE CENTRE, OLDCHURCH HOSPITAL—8 for 8.15 pm, Mr Francis Huxley: The Couvade and similar ritualised modes of dealing with psychological infection.

MEDICOLEGAL SOCIETY—At Royal Society of Medicine, 8.15 pm, the Rt Hon Sir A Melford S Stevenson: The privilege of silence.

ROYAL COLLEGE OF SURGEONS OF ENGLAND—5 pm, Arris and Gale lecture by Mr G Brocklehurst: The significance of the evolution of the cerebrospinal fluid system.

UNIVERSITY OF CAMBRIDGE—At Department of Genetics, 4.30 pm, Dr E Thompson: Probabilities on pedigrees and genotypes of ancestors.

Friday, 10 March

INSTITUTE OF LARYNGOLOGY AND OTOLOGY—5.30 pm, Mr P McKelvie: Hypophysectomy.

Saturday, 11 March

BIRMINGHAM MEDICAL INSTITUTE MIDLAND THORACIC SOCIETY—12.30 for 1 pm, lunch,* 2 pm, agm, 2.15 pm, presidential address by Mr S F Stephenson. (Guests are invited.)

BMA NOTICES

Conference of Medical Academic Representatives 1978

Nominations are invited for election to fill the following vacancies at the Conference of Medical Academic Representatives on Monday, 26 June 1978:

Constituency	Clinical	Preclinical
Hospital medical schools:	(Vacancies)	(Vacancies)
London		
Charing Cross Hospital	1	—
Guy's Hospital	1	—
London Hospital	1	1
Royal Free Hospital	1	1
St Bartholomew's Hospital	1	—
St George's Hospital	1	1
St Mary's Hospital	1	1
St Thomas's Hospital	—	1
University College Hospital	1	—
Universities with medical schools:		
England		
Birmingham	1	—
Bristol	—	1
Cambridge	1	—
Leeds	—	1
Leicester	1	1
Liverpool	1	—
Newcastle upon Tyne	1	1
Nottingham	1	—
Oxford	—	1
Sheffield	—	1
Southampton	1	1
Northern Ireland		
Queen's University, Belfast	1	—
Scotland		
Aberdeen	1	1
Dundee	1	—
Edinburgh	1	1
St Andrews	—	1
Wales		
Welsh National School of Medicine	1	—
Research establishments		
MRC Clinical Research Centre, Northwich Park	1	—
MRC National Institute for Medical Research	—	1
Postgraduate institutes		
British Postgraduate Medical Federation institutes (excluding the clinical institutes at Hammersmith)	2	1

The above list does not include those constituencies where nominations have been received following the notice in the medical academic staff handbill of December 1977 which was issued to the current MASC representative.

Nominees, and their proposers, must be medically qualified and hold a full-time contract of employment with one or more of the following: a university, the Medical Research Council, or an institution engaged in medical research. The electorate will consist of those academic staff in the above category in the appropriate constituency.

The conference will elect eight clinical and eight preclinical representatives to the Medical Academic Staff Committee for the 1978-9 session.

Nomination forms may be obtained from the Secretary, British Medical Association, BMA House, Tavistock Square, London WC1H 9JP, and should be returned *not later than Tuesday, 28 March 1978.*

E GREY-TURNER
Secretary

Central Meetings

MARCH

8 Wed BMA Council Executive, 10 am.
9 Thurs Organisation Committee, 10 am.
10 Fri Diseases of the Chest Group Committee, 2 pm.
15 Wed General Purposes Subcommittee (CCHMS), 2 pm.
16 Thurs General Medical Services Committee, 10 am.
16 Thurs Journal Committee, 2.15 p.m.
17 Fri Executive Subcommittee (CCCM), 10.30 am.
17 Fri Board of Science and Education, 10.30 am.
17 Fri Rheumatology and Rehabilitation Group Committee, 3 pm.
22 Wed Consulting Pathologists Group Committee, 10 am.
22 Wed Consulting Pathologists Group, 2 pm.
23 Thurs Negotiating Subcommittee (CCHMS), 10 am.
28 Tues Manpower Subcommittee (CCHMS), 2 pm.
29 Wed **Council**, 10 am.

Division Meetings

*Members proposing to attend meetings marked * are asked to notify in advance the honorary secretary concerned.*

Blackburn—At Blackburn Royal Infirmary, Tuesday, 7 March, 8 pm, Dr Francis Pigott: "The white coat worker—professionalism and trades unionism."

Brighton and Cuckfield—At Hove Town Hall, Saturday, 11 March, 7.15 for 8 pm, BMA ball.* (Guests are invited.)

Eastbourne—At Lamb Inn, Tuesday, 7 March, 7.30 for 8 pm, joint meeting with Pharmaceutical Society.*

East Yorkshire—At Hull Royal Infirmary, Friday, 10 March, 7.30 pm, open meeting, speaker Professor P H A Sneath: "Life on another planet," followed by buffet supper.*

Gloucestershire—At Parliament Room, College Green, Thursday, 9 March, 7.15 pm, Mr Denis Fredjohn: "Five years to span ten centuries."* (Followed by supper, guests are invited.)

Halifax—At Marmaville Country Club, Mirfield, Friday, 10 March, 7.30 for 8 pm, annual dinner dance.*

Liverpool—At Liverpool Medical Institution, Wednesday, 8 March, 6.30 pm, buffet, 8 pm, Dr Francis Pigott: "The current medicopolitical situation—a personal view."*

Manchester—At Boyd House, Tuesday, 7 March, 8 for 8.30 pm, scientific meeting, speaker Dr I W Dymock: "Peptic ulcer disease and treatment."* (Cold platter supper provided.)

Mersey Regional Committee for Hospital Services—At Liverpool Medical Institution, Wednesday, 8 March, 5 pm.

Northallerton—At Friarage Hospital, Monday, 6 March, 9 pm, agm.

North Tyneside—At Preston Hospital, North Shields, Monday, 6 March, 8 pm, agm. At Europa Lodge Hotel, Wallsend, Saturday, 11 March, 7.30 for 8 pm, dinner dance.*

North-west Essex—At Princess Alexandra Hospital, Harlow, Tuesday, 7 March, 7.30 pm, evening of orthopaedic films.

Rotherham—At Brecon Hotel, Monday, 6 March, 7.30 for 8 pm, dinner, 9.15 pm, Dr Alan Usher: "Quick cases and odd ends."*

Wakefield—At Saville Colliery, Saturday, 11 March, 8.30 am, trip down mine.*

Waltham Forest—At Chasneys, Thursday, 9 March, 7.30 for 8 pm, annual BMA dinner.*

West Berkshire—At Royal Berkshire Hospital, Wednesday, 8 March, 8.30 pm, annual BMA lecture by Wing Commander Tony Nicholson: "A funny thing called sleep." (Preceded by supper, 7.30 pm. Members' wives welcome.)

UNIVERSITIES AND COLLEGES

LONDON

MD—F Afshar, P D Fairclough, S Franks, I F Moseley, G M Roberts, R B Stern.

ABERDEEN

Appointment—Dr J G Simpson (senior lecturer in pathology). MS—D T Caridis.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

At a meeting of the Executive Committee of the College held on 9 February, with the sanction of the Council, a Diploma of Fellowship was granted to P J Gore.

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

At a quarterly meeting of the College on Thursday, 2 February, with the president, Dr R F Robertson, in the chair, Dr A J S Gardiner was elected Member of the College.

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

At meetings of the Council of the College held on 3 and 4 February with the president, Sir John Dewhurst, in the chair, the following were admitted to Membership of the College: H A Alchalabi, R N Al-Dahwi, I Alexander, G S Anthony, D Y Araf, P Arora, W G Atchison, A N Azan, H S Al Azzawi, A K Basu, Susan G Bateman, J L Beynon, A D Bhadri, R K Bhuyan, R Bickerstaffe, A H W Boyle, D R Bromham, A S Burney, A C Burton, J P Calvert, Indira Chandran, Rosemary K-K Cheung, K Cietak, L N Das, A T Dempsey, J J L De Souza, O Djahanbakhch, P W Docherty, J W Dowdell, R R Draper, D K Edmonds, R McA Ellice, A M El-Shafei, M M El-Sheikh, A D Falconer, Nancy L-L Fok, M K Foo, M Fourcares, Janette G Ghattas, B P Giorgio, H Goonetilleke, J V P Ralalale, S W Hammersley, M N Haque, Margaret A Harper, J N Harrild, N A Harrison, M Z J Hashash, M G Hoffman, Valerie D Hood, B A Idris, T C McN Inglis, Makram F Ishaq, R A Ismail, Grace Jacob, N G Jaffar, A L M Jameel, N S Jayawickrama, D B Johnson, J M E Jones, M J Joseph, K Kamala, S R Kambaran, R Kanapathippillai, S Kar, J H Kennedy, J A Khouri, Suraiya S Khwaja, P C L Knight, K T Koh, S Kolbhandari, S A Kulkarni, C E Kymisis, S I Laguda, I R Lange, A A S Latib, T A Lavin, Sheila R Lawson, Y C Low (alias Loo), T K R Luk, Ellen M (Elaine) Lynch, J M McDonnell, P F McMullan, A B Maclean, W P Mason, K B L Mendis, Angela M Mills, F D Mistry, S P Mitra, S A S Moghraby, J M Morsman, A Mowla, A K Mukerjee (Mukopadhyay), R D Murphy, S R Nag-Chaudhury, N I Nushaiwat, C O'Herlihy, J A P Pal, S K Pal, S S Parhar, I S R Parson, A D Parsons, Elizabeth H E Pease, C K W Pugh, D H A Redford, I R Roberts, D N Roychoudhuri, M A-E H M Sabry, A K S K I Saleh, S Saminathan, J W Scott, M G Sedgley, G L Sellars, S S J Sharma, *J H Shepherd, D K Shetty, N Shroff, L J P Silva, J Singh, K Siripurapu, G Sittampalam, K K Siu, S K Sreevalsan, K Sultana, *R S Sungkur, P D Sutherland, T H Tai, H Y Tan, K J Tan, K K Tan, T-K Tan, K-L Tay, Margaret H Thom, I A L Treharne, M M A Van de Klee, Valli S Vinayakom, J Webster, R M Williams, Y K Wong, J Woolfson.

*Awarded Regional Councils' Gold Medal.

APPOINTMENTS

BIRMINGHAM AREA HEALTH AUTHORITY (TEACHING)—The following consultants have been appointed—Dr M H Arif, Dr J Hurdley (anaesthetists); Dr A J L Cole (radiologist).

GREATER GLASGOW HEALTH BOARD—The following consultants have been appointed—Dr J McGavigan (bacteriologist); Mr E G Anderson (orthopaedic surgeon).

HAMPSHIRE AREA HEALTH AUTHORITY (TEACHING)—Mr A P Camilleri (consultant obstetrician and gynaecologist); Dr E E Gulland (consultant psychiatrist).

NORTH-EAST THAMES RHA—Mr B C Sommerlad (consultant in plastic surgery).

NORTHERN RHA—The following consultants have been appointed—Dr P J B Tilley (neurology); Dr Marjory Lothian, Dr Joan M Waterfall (anaesthetics); Dr V M Joglekar (geriatric and general medicine); Mr J M Lennox (general surgery); Dr P I Silverstone (obstetrics and gynaecology); Dr T L Pilkington (mental handicap); Dr F S Pagan (medical microbiology); Dr A Prabhakar (mental illness).

SOUTH GLAMORGAN HEALTH AUTHORITY—The following consultants have been appointed—Dr J Sibert (paediatrician); Dr D Krishnamurti (psychiatrist in mental handicap); Dr P Smith (physician).

Notice to authors

When original articles and letters for publication are not submitted exclusively to the *British Medical Journal* this must be stated. For detailed instructions to authors see page 6 of the issue dated 7 January 1978.

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