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Correspondence

Correspondents are asked to be brief.

Recruits for Venereology

SIR,—In his discussion on the failure to control venereal disease, Mr. Ambrose King (21 February, p. 451) mentions that the most gifted of young graduates have seldom entered venereology. In fact, in the past 10 years few practitioners have been willing to train as venereologists. Already it is becoming difficult to find suitably qualified people to fill consultant vacancies, and unless this is remedied the future efficiency of the venereal disease service will be in jeopardy.

There are two main reasons for this lack of recruitment. One is the poor opinion of the specialty held by the profession generally and with which undergraduates are inculcated very early in the clinical years. The other is the poor financial return given to the consultant venereologist who has little private practice, few, if any, domiciliary visits, and much less opportunity of obtaining a merit award than in any other specialty.

The poor image the specialty has in the eyes of the profession generally is, as Mr. King points out, based mainly on ignorance and the obvious way to improve the image is to make the type of work carried out in the clinics much more widely known. Your suggestion (21 February, p. 448) that V.D. clinics might more properly be named departments of genito-urinary medicine and the consultants, genito-urinary physicians, might help to do this.

To my mind the only way a sufficient number of practitioners for the future well-being of the V.D. service can be induced to offer themselves for training now is financial—namely, by a special allowance attached to the registrar, senior registrar, and consultant grades. This allowance might vary according to the area in which the clinic is situated.

The efficiency of the V.D. service is threatened also by inability to obtain male technicians. These men, part nurse, part laboratory technician, are essential in the larger clinics. The salary scale is so low that it is impossible to obtain men willing to undergo training or to recruit men trained in the Services—formerly the main source of V.D. technicians.

Incidentally, a similar suggestion to yours regarding the names of V.D. clinics and consultants was made by me in a paper given to the Medical Society for the Study of Venereal Diseases 12 years ago.—I am, etc.,

W. FOWLER.

Venereal Diseases Department,
General Hospital,
Birmingham.

Primary Cancer of the Breast

SIR,—I was sorry to see in your leading article on primary carcinoma of the breast (7 March, p. 579) that there is still a belief in the old idea that the lymphatic drainage from the medial side of the breast goes to the retrosternal glands chiefly, and that from the lateral side of the breast goes to the axilla chiefly. It can easily be shown that the lymphatic drainage from any site in the breast goes to both these major drainage areas. I would advise any surgeon who doubts this to try a simple procedure to which I was introduced by Professor Kinmonth of St. Thomas's Hospital.

Inject 3 ml. of vital blue into any site in the breast preoperatively. The vital blue is taken up by the lymphatics, which one then sees as blue lines. Whatever site is chosen for the injection of the vital blue in the breast a very similar lymphatic distribution is seen, both to the axilla and the retrosternal glands, though few run to the abdomen. I was first interested in tracing the lymphatics because to me the great contraindication to radical mastectomy is the subsequent oedema of the arm, which occurs, as we all know, chiefly in the fat patient. I thought I would be able to trace the lymphatics and so avoid damaging those from the hand. If one injects the vital blue into the hand one can see there is no definite path of lymphatics through the axilla separate from those draining the breast. The only contraindication to using vital blue is the damage to the nerves of the anaesthetist, but the blue colour does not last for very long.—I am, etc.,

CHARLES HEANLEY.

Hassocks,
Sussex.

SIR,—Your leading article on primary cancer of the breast (7 March, p. 579) draws attention to the importance of selection of the treatment most likely to benefit an individual patient with this disease. You quite rightly indicate the futility of radical local treatment in the presence of distant spread, and stress the need for more sophisticated techniques for the diagnosis of occult metastases. This is only a part of the problem. Surely the crucial difficulty in making a judgement on the right treatment for an individual patient is still the lack of evidence on the factors which significantly affect prognosis? Your leading article suggests that if the lymph nodes in the axilla are involved some form of radical treatment should be employed, be it surgical or radiotherapeutic. We suggest that there is no good basis at the present time upon which to determine the treatment of the regional lymph nodes.

The trials mentioned in your leading article, for the most part, are each comparing two forms of radical treatment to the