

BRITISH MEDICAL JOURNAL

PROCEEDINGS OF THE
CURRENT CENSUS

SATURDAY 3 MARCH 1973

LEADING ARTICLES

- Constraints on Consultants page 501 Immunological Aspects of Osteosarcoma page 502
Tuberculous Peritonitis and Laparotomy page 502 Teachers and Patients page 503 Sudden
Whitening of Hair page 504 Postoperative Empyema and Survival in Lung Cancer page 504
Current Radiotherapy page 505 Latent Morbidity after Abortion page 506

PAPERS AND ORIGINALS

- Autoregulation of Brain Circulation in Severe Arterial Hypertension
S. STRANDGAARD, J. OLESEN, E. SKINHØJ, N. A. LASSEN 507
Use of 4% Chlorhexidine Detergent Solution (Hibiscrub) and Other Methods of Skin Disinfection
E. J. L. LOWBURY, H. A. LILLY 510
Postoperative Deep Vein Thrombosis in Sudanese Patients M. A. HASSAN, E. A. RAHMAN, I. A. RAHMAN 515
Deep Vein Thrombosis in a Queensland Hospital O. B. WILLIAMS, J. F. MCCAFFREY, O. J. LAU 517
Androgen Responses during Physical Exercise J. R. SUTTON, M. J. COLEMAN, J. CASEY, L. LAZARUS 520
Interaction between Clonidine and Desipramine in Man
ROBIN H. BRIANT, JOHN L. REID, COLIN T. DOLLERY 522
Direct Antiglobulin Reaction in ABO-Haemolytic Disease of the Newborn
E. L. ROMANO, N. C. HUGHES-JONES, P. L. MOLLISON 524
Concentration of Wear Products in Hair, Blood, and Urine after Total Hip Replacement
R. F. COLEMAN, J. HERRINGTON, JOHN T. SCALES 527
Mumps Pancreatitis without Parotitis K. NAFICY, R. NATEGH, H. GHADIMI 529

MEDICAL PRACTICE

- Use of Sequential Bayesian Model in Diagnosis of Jaundice by Computer
R. P. KNILL-JONES, R. B. STERN, D. H. GIRMES, J. D. MAXWELL, R. P. H. THOMPSON, ROGER WILLIAMS 530
Pitfalls in the Diagnosis of Jaundice due to Carcinoma of the Pancreas or Biliary Tree
R. B. STERN, R. P. KNILL-JONES, ROGER WILLIAMS 533
Patient Delay before Treatment of Myocardial Infarction IAIN C. GILCHRIST 535
A New Look at Infectious Diseases: Leptospirosis L. H. TURNER 537
Drug Taking among Medical Students at Glasgow University
A. J. MCKAY, V. M. HAWTHORNE, H. N. MCCARTNEY 540
Any Questions? 543
Personal View A. PATON 544

CORRESPONDENCE—List of Contents 545

BOOK REVIEWS 558

NEWS AND NOTES

- Epidemiology—An Outbreak of Food Poisoning 559
Medicolegal—Termination of Hospital Contract 559
Parliament—Questions 560
Medical News 561

OBITUARY NOTICES 555

SUPPLEMENT

- For Debate: G.M.C. . . . R.I.P. STANLEY ALLEN 61
General Medical Services Committee—Counter-inflation
Policy and Review Body; Decisions of Special Conference 67
G.P.s and V.A.T. 69
From the Committees: Welsh Council 69
Association Notices 70

CORRESPONDENCE

Correspondents are asked to be brief

Treatment of Malignant Melanoma A. W. Levene, F.R.C.S.	545	AHF-related Protein and Precipitation Reactions L. Holmberg, M.D., and Inga M. Nilsson, M.D.	549	Tubal Sterilization and its Reversal C. K. Vartan, F.R.C.O.G.; A. E. R. Buckle, F.R.C.O.G.	552
Central-Core Disease and Malignant Hyperpyrexia D. G. F. Harriman, F.R.C.P., and F. R. Ellis, PH.D., F.F.A. R.C.S.	545	Sympathomimetic Amines and Antidepressant Agents G. G. Wallis, M.D.	549	Afternoon Surgeries E. T. Griffiths, M.R.C.G.P.; R. N. Palmer, M.B.	552
Cost of Drugs J. D. P. Graham, F.R.C.P.ED.; D. K. Bose, M.R.C.G.P.	546	Classics and the Medical Student R. H. MacDougall, M.B., and D. W. Sinclair, M.B.	550	Vitamins in Illness Z. A. Leitner, F.R.C.P.GLASG.	552
Sarcoid Heart Disease L. Rossi, M.D.	546	Legalization of Cannabis C. E. Allen, M.D.	550	School Eye Clinics P. A. Gardiner, M.D.	552
Cutaneous Sarcoidosis in Venepuncture Sites A. Sakula, F.R.C.P.; R. F. Harvey, M.R.C.P., and others; I. A. Short, F.R.C.P.GLASG., and J. A. Milne, F.R.C.P.	547	Disseminated Intravascular Coagulation in Benign Tertian Malaria Barbara J. Bain, M.R.A.C.P.	550	Free Contraceptives R. D. Haigh, D.P.H.	553
Gastric Decompression after Abdominal Surgery D. M. Essenhigh, F.R.C.S.	547	Airgun Pellets and the Eye S. P. B. Percival, F.R.C.S.; B. R. Kesby, F.R.C.S.	550	Rigid Footwear A. W. Fowler, F.R.C.S.	553
Dangerous Patients A. I. Roith, M.R.C.PSYCH.	548	Radioimmunoassay Follow-up of Hydatidiform Mole Sir John Stallworthy, F.R.C.O.G.	550	Nitrazepam and the Elderly J. G. Evans, M.R.C.P., and E. H. Jarvis, M.R.C.P.	553
Working of the Mental Health Act S. J. G. Spencer, D.M., M.R.C.PSYCH.	548	Pathogenesis of Obesity B. N. Draznin, M.D., and Y. K. Marakhovskii, M.D.	550	Soaking Beds J. W. C. Leech, M.D.	553
Myocardial Infarction and Pulmonary Thromboembolism W. J. Windebank, M.R.C.P., and F. Moran, F.R.C.P.ED.	548	Cutaneous Polyarteritis T. Dyk, M.D.	551	Amoxycillin Rash in Infectious Mononucleosis R. Mulroy, M.R.C.G.P.	554
Fractured Lippen Loop and Pregnancy Z. Domány, M.D., and M. Hancsók, M.D.	549	Fluoride and Osteoporosis J. Dequeker, M.D., and A. Burssens, M.D.	551	Treatment of Dextropropoxyphene Poisoning Vanessa Hunt, D.A.	554
Childhood Leukaemia and Pregnancy Viraemia R. H. Lindenbaum, M.R.C.P.	549	Drugs in Infertility G. I. M. Swyer, F.R.C.P.	551	Chambers and the Periphery A. H. Holmes, F.R.C.S.ED.	554
		Potentialization of Neuroleptics by Catecholamine Inhibitors J. Walinder, M.D., and A. Carlsson, M.D.	551	Earnings of General Practitioners D. J. Anderson, M.B., and others.	554
				S.H.M.O.s and Medical Assistants I. M. Librach, M.B., D.P.H.	554

Treatment of Malignant Melanoma

SIR,—Your leading article (10 February, p. 306) presenting some aspects of contemporary thought on melanoma is, I believe, inadequate in certain respects.

It is misleading to state that cutaneous melanoma is unpredictable in its behaviour, the implication being that other malignant tumours are predictable in their behaviour or that it belongs to a group of tumours about which information is so scarce as to be inadequate for prognostic purposes. Neither is true. For example, there is a well-established relationship between prognosis and a large number of clinicopathological relationships—sex of the subject, anatomical location of the tumour, its size and histogenetic type, depth of invasion, clinical involvement of regional nodes, and radiosensitivity, to name the obvious ones.^{1,2} As in the case of the lymphomas there is an abundance of information of prognostic importance.

Again it is not "agreed that in the management of melanoma incisional biopsy must be avoided." On the contrary, I would suggest that it is a mandatory procedure to obtain a diagnosis on a large ulcerated cutaneous lesion of doubtful histogenesis before any treatment is given. Furthermore, informed opinion is that there are no known harmful effects from biopsy carried out on the ulcerated lesion.³ Where radiotherapy may claim to be the treatment of choice—that is, for the melanotic freckle and its conjunctival homologue—confirmatory biopsy should be an invariable preliminary. The final sentence

"External radiotherapy produces a poor response in most cases"—is misleading in its simplicity, which again has about it the suggestion that melanoma is one disease only, and an unpredictable one at that.

Finally, there is the statement that "the primary tumour must be excised with a very wide margin of skin at the earliest possible time and the defect covered with a skin graft." How wide? I have noticed that surgeons, the most frequent writers on the therapeutics of melanoma, either provide no guidance on dimensions, tailor it according to the anatomical site involved and the likely cosmetic problems presented, or resort to recommending one of the series of prime numbers 1, 2, 3, 5, 7, 11 cm as a suitable margin of clearance around the tumour, regardless of its size. So far as I am aware the choice of such numbers enjoys no pathological basis, nor sanction, but is an attempt to circumvent the subsequent appearance of satellite nodules. Since no method of surgical treatment guarantees freedom from this complication the recommended area of excision would still appear to be a debatable point, possibly to be determined by appropriate surgical research.—I am, etc.,

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- 1 Maillard, G. F., *Annales de Dermatologie et de Syphiligraphie*, 1971, 98, 5.
- 2 Clark, W. H., Jr., from, L., Bernardino, E., and Mihm, M., *Cancer Research*, 1969, 29, 705.
- 3 Epstein, E., Bragg, K., and Linden, G., *Journal of the American Medical Association*, 1969, 208, 1369.

Central-core Disease and Malignant Hyperpyrexia

SIR,—The report by Dr. M. A. Denborough and others (3 February, p. 272) of core-like areas in type 1 fibres in malignant hyperpyrexia myopathy is interesting, but they are not justified in referring to this myopathy as central-core disease as if it were a specific entity. Focal areas of absence of mitochondria in histochemically stained sections have already been reported by us in malignant hyperpyrexia myopathy,^{1,2} but we have preferred to use the term "moth-eaten fibres" to avoid any suggestion that the finding is specific. Our illustrations of the mitochondria-deficient areas, identical with those of Dr. Denborough and his colleagues, have been shown at international meetings and are shortly to be published.³ They are less numerous in our cases, possibly owing to a difference in the muscles examined.

Those with more than average experience of muscle biopsy realize that focal areas of mitochondrial absence, whether accompanied by preservation of myofibrils in electron micrographs (core-like fibres) or their disarray (target or targetoid fibres) are relatively common in neuromuscular disease in isolated fibres. To refer to all those with the former characteristics as central-core disease would clearly be ridiculous. Central-core disease is poorly defined, but the term should be reserved for cases which at least resemble the original descriptions.⁴ We believe that the patient described by Dr. Denborough and his colleagues suffered from malignant hyperpyrexia myopathy, and