Convulsions stopped (they had lasted for no more than 10 minutes), and subsequent blood glucose measurements were satisfactory. She was nauseated and complained of headache but had no neck stiffness, photophobia, or focal neurological signs. In a blood sample taken at 7 40 am the same morning the white cell count was $26 \cdot 2 \times 10^9$/l, 91% neutrophils. A medical senior registrar ordered blood cultures and a viral antibody screen to be performed. At 11 00 am her white cell count was $21 \cdot 4 \times 10^9$/l. Further investigations ordered included culture of nose, throat, rectal, and high vaginal swabs and a catheter specimen of urine. The following morning her white cell count was $12 \cdot 8 \times 10^9$/l. At no stage did she have fever or any symptoms not attributable to hypoglycaemia. All bacteriological and viral investigations yielded negative results. The patient remained well and at 38 weeks delivered a normal, healthy infant.

Given the combination of circumstances (late pregnancy, hypoglycaemia with concomitant adrenaline release, and a grand mal convulsion), the pronounced leucocytosis and its time course might reasonably have been predicted and the investigations, which were by no means trivial, either to the patient or to the laboratories, avoided.

JUDITH M STEEL

Department of Diabetes and Dietetics,
Royal Infirmary,
Edinburgh

C MICHAEL STEEL

Medical Research Council Clinical and
Population Cytogenetics Unit,
Western General Hospital,
Edinburgh

FRANK D JOHNSTONE

Simpson Memorial Maternity Pavilion,
Royal Infirmary,
Edinburgh

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District cancer physicians

SIR,—We were surprised at the opinions expressed by Dr L J Donaldson (19 September, p 682) in response to the Association of Cancer Physicians' report recommending the appointment of 63 cancer physicians in district general hospitals in England and Wales.[1]

We would be concerned if Dr Donaldson's views were widely held, but we have reason to believe that they are not. Everyone knows that cancer services need improvement; three recent reports[2-4] have emphasised this, and two have stressed the need for more cancer physicians in district general hospitals as well as in university centres, while the Bagshawe report on acute services for cancer[4] emphasises that "the treatment of cancer patients should be firmly based within the district hospital service." Clearly, the provision of more cancer physicians is only part of the solution. We fully support the view that more radiotherapists are also needed, as are surgeons, gynaecologists, paediatric oncologists, and community physicians with a special interest in cancer.

Dr Donaldson asserts that health authorities are wary of the increased costs that the appointment of cancer physicians would create. This is misinformed, since the appointment of a cancer physician reduces expenditure on cytotoxic drugs and results in their more efficient use (Royal College of Physicians, 1986 (comitia document 86/15)). Furthermore, when a delegation led by Sir Raymond Hoffenberg discussed this issue with the Chief Medical Officer these views were sympathetically received at the Department of Health and Social Security.

Cancer services need improving because patients need better overall care. There is more to care than chemotherapy; flippant remarks about magic bullets do not advance serious discussion about how the lot of the patient with cancer can be improved. More cancer physicians in the community would help to ameliorate what is currently a totally unacceptable situation.

T J MCELWAIN
J S MALPAS

Association of Cancer Physicians,
Royal Marsden Hospital,
Sutton SM2 5PT

1 McIllmurray MB. District cancer physicians: report of a working group of the Association of Cancer Physicians. *J R Coll Physicians Lond* 1987;21:117-21.
2 London Health Planning Consortium Study Group on Radiotherapy and Oncology. *Report*. London: Department of Health and Social Security, 1979.
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4 Standing Medical Advisory Committee. *Report of the working group on acute services for cancer*. London: Department of Health and Social Security, 1984.

SIR,—The proposals of the working party of the Association of Cancer Physicians for a network of cancer physicians, discussed by Dr L J Donaldson, appear to reflect the needs of the patients using our service.

BACUP (British Association of Cancer United Patients) was established two years ago to provide a national cancer information service for patients, their relatives, doctors, and other health professionals.[1] The service is offered by seven trained oncology nurses, who in the past two years have responded to over 30 000 inquiries, largely from patients and their relatives. In a large proportion of our inquiries we encourage and help patients and relatives to go back and speak to their doctors. Our experience shows that patients and their relatives do want in depth information about the disease and its treatment from a reliable and authoritative source. Patients are frustrated by the difficulty in getting such information from their doctors, who are often too busy to spend time dealing with this complex disease. This difficulty is compounded by the lack of cancer specialists, especially in the community. There is an ease in speaking to those who are familiar with the disease, are trained to communicate, and have the experience of the effects of cancer not only on the patients but on their families as well.

We would argue strongly that there is a great need for more cancer physicians, particularly in district general hospitals.

YVONNE TERRY

BACUP Cancer Information Service,
London EC1M 6AA

1 Clement-Jones V. Cancer and beyond: the formation of BACUP. *Br Med J* 1985;291:1021-3.

SIR,—In a well balanced article Dr L J Donaldson has drawn attention to the arguments for a district cancer physician. I would like to make some additional points.

Firstly, radiotherapists and clinical haematologists are specifically examined in their diplomas in the use of cytotoxic drugs. Secondly, I have found my surgical colleagues to be particularly safe in administering cytotoxic drugs, and my chest physician colleagues have lately aquired great skill in the use of cytotoxic drugs with the advent of real advances in treatment, particularly of small cell lung cancer. Thirdly, please remember that we are talking about only a score or so of really usable drugs. Finally, if we do have a district cancer physician I think he will need a diploma which includes a fair chunk of cancer in the examination paper. It would also need to have some statistics, radiation protection, and terminal care as part of its syllabus. Does, I wonder, such a diploma already exist?

P L C XAVIER

Regional Centre of Radiotherapy and Oncology
and Nuclear Medicine,
Oldchurch Hospital,
Romford RM7 0BE

How to take a teaching ward round

SIR,—Mr Alan R Berry (19 September, p 725) indicates the difficulties of teaching small numbers of medical students in hospital wards.

Perhaps it is time for the emphasis of medical student teaching in hospital to change. General practice is now attracting many able doctors and teachers, there are still enough patients in the community to allow teaching in very small groups, and in the community we are not constrained by ward routine.

Judging by the waiting times, there are still plenty of referrals to outpatients. Perhaps medical students should spend their time with these patients in their homes, before either the outpatient appointment or admission to hospital, and be allowed to present the history and examination in the usual way. This would have the additional advantage of providing the students with an understanding of the patients' home environment. It would be expensive in student time, but surely the benefits could be considerable.

I valued my teaching ward rounds as a medical student, but as society progresses so must medical education.

JACKY HAYDEN

Unsworth Medical Centre,
Bury BL9 8JR

Emergency phlebography service

SIR,—We wish to comment on the reply to our article (22 August, p 474) from Dr Ian Sykes and colleagues (19 September, p 724). As radiologists we perform those investigations required by the clinicians which are likely to help in their management of the patient. Patients referred for phlebography have a clinically suspected deep vein thrombosis; if the clinician suspects a ruptured Baker's cyst ultrasonography or arthrography is performed. If phlebography shows nothing abnormal it is up to the referring clinicians to determine whether or not further investigation is warranted.

We cannot agree with any of the statements in their last paragraph. Only those patients with a proved deep vein thrombosis will receive anticoagulation so the "unnecessary risk" in patients with the pseudothrombophlebitis syndrome does not occur. The urgent management decision is surely to determine the presence of a deep vein thrombosis, which carries the complications of pulmonary embolism and death.