chial and bronchiolar musculature, and whereas the usual bronchodilators act through various neurogenic mechanisms, ether is one of the few drugs to act directly on and relax these muscles. Ether can be administered safely intravenously as a 5% "mixture" in normal saline, and it would seem that this little-known treatment is worthy of a controlled clinical assessment. I have seen it produce completely relaxed respiration in a matter of minutes in a patient in severe status asthmaticus in whom the usual drugs had failed to produce any worthwhile response.

The second point. The advice to give 0·5 g of aminophylline intravenously before the ambulance arrives should be tempered with the word "slowly," for this can be a lethal drug in this dosage if administered rapidly, especially in the presence of hypoxia.—I am, etc.,

L. O. MOUNTFORD

Elstree, Herts

SIR,—The leading article (9 December, p. 563) on status asthmaticus reviewed well the present state of knowledge of this frightening condition. We would like, however, to question a statement with reference to oxygen therapy which may be misleading. You say: ". . . but unless the level of $Paco_2$ is known it may be safer to compromise with 35% oxygen. . . ." No reference is quoted for this view, but we believe it is generally accepted that the patient in acute status asthmaticus (except when he is in the final stages of chronic lung damage from his disease) has a normal ventilatory response to carbon dioxide.[1] There is therefore no reason to suppose that the relief of what may be severe hypoxia will appreciably affect the ventilatory drive.

The inexperienced reader of this editorial could be discouraged from giving high concentrations of oxygen to a patient in desperate need of it, simply because the blood gas measurements were not available. The treatment of severe hypoxia, a rapidly fatal condition, is surely the first priority in this situation, and if the $Paco_2$ does rise quickly as a result, it is likely that further measures would have been necessary in any case. Teaching in the past has caused far too many junior doctors to withhold potentially life-saving oxygen for fear that their patient is relying on the hypoxic drive for maintenance of ventilation. This certainly does not apply in previously fit patients with lobar pneumonia or status asthmaticus.—We are, etc.,

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1 Pontoppidan, H., Geffing B., and Lowenstein, E., *New England Journal of Medicine*, 1972, **287**, 743.

Infertility after the Pill

SIR,—In your leading article (14 October, p. 59) there is no reference to the fact that permanent infertility was described as a complication of an oestrogen summation disease in sheep as far back as 1946 by Bennetts *et al.*[1] Correspondence on this subject from me was published in 1961[2 3] and 1962[4] and a subsequent article by me[5] also emphasized the permanency of any sterility that might arise following this summation disease.

Since there seems to be a close resemblance between human infertility following the ingestion of an oestrogenic pill and that occurring in sheep which have grazed for a period on oestrogenic pasture, may I suggest that a determined effort be made by our profession to assist our veterinary colleagues to elucidate the precise mechanism of this infertility. Their need is not as great as ours. A practical solution of the sheep infertility problem is being provided by plant breeding, which has greatly reduced the oestrogen content of subterranean clover, and by the periodic buying-in of breeding ewes from properties where the disease does not occur. Neither of these methods appears feasible in medical practice.

I trust that some medical research unit may take advantage of the opportunities offering in this sphere while the animal problem still exists.—I am, etc.,

T. LOVEGROVE

Dianella,
Western Australia

1 Bennetts, H. W., Underwood, E. J., and Shier, F. L., *Australian Veterinary Journal*, 1946, **22**, 2.
2 Lovegrove, T., *British Medical Journal*, 1961, **1**, 1830.
3 Lovegrove, T., *British Medical Journal*, 1961, **2**, 713.
4 Lovegrove, T., *Medical Journal of Australia*, 1962, **2**, 106.
5 Lovegrove, T., *Medical Journal of Australia*, 1970, **1**, 213.

Management of Early Breast Cancer

SIR,—I believe it was Sir Hedley Atkins who remarked, "We are at last beginning to make some progress; we now know that we do *not* know how we should treat early breast cancer."

The trial organized and reported by Mr. M. Baum and others (25 November, p. 476), is most praiseworthy in its aim to collect sufficient patients so that even small differences between therapeutic regimens may be demonstrated with certainty. When such a large co-operative effort is being made it seems a pity, however, that the trial has not been better designed and that the regimens chosen for comparison are not more representative of current practice. Their protocol seems to me to be open to serious criticism on the following grounds:

(1) *Simple Mastectomy.*—In the protocol it is laid down that "simple mastectomy is performed in all patients *without surgical attention to the axillary lymph nodes*" (my italics). But surely the commonest form of radical therapy practised today is extended simple mastectomy, in which nodes at least as high as the pectoralis minor are removed, or even Patey's mastectomy. Since clinical assessment of axillary nodes is notoriously unreliable, histological evidence concerning their invasion is surely highly desirable, if only to permit accurate staging. Without this, statistical analysis will be much more difficult.

(2) *Postoperative Radiotherapy.*—The protocol for the radiotherapy group lays down irradiation of skin flaps, regional node areas, and chest wall in all cases. This is quite contrary to usual practice in stage 1 and 2 cases. As the authors themselves mention, Paterson and Russell[1] demonstrated a worsening of prognosis in stage 1 cases who had irradiation of the chest wall. There appeared to be a significant increase in the incidence of liver metastases in these cases. There must, therefore, already be a suspicion that radiotherapy depresses host resistance to the development of metastases in stage 1 cases.

In many centres no irradiation is given if the axillary lymph nodes are not invaded, or at most only a parasternal field is treated if the tumour is in the centre or medial part of the breast.

(3) *Radiotherapy Dosage.*—The range of values given in the protocol seems to be on the low side (nominal skin dose value according to Ellis's formula is less than 1,400 rads). If radiotherapy is to be given at all, it must be to an effective dosage, otherwise it may well do more harm than good.—I am, etc.,

D. K. SAMBROOK

Singleton Hospital,
Swansea

1 Patterson, R., and Russell, M. H., *Journal of the Faculty of Radiologists*, 1959, **10**, 174.

Tragic Dilemma

SIR,—I was interested and concerned to read your leading article entitled "Tragic Dilemma" (9 December, p. 567).

This case illustrated, as you so rightly say, some of the very deep anxieties which face us as doctors. The close relationship between the doctor and the patient and his family is now greatly threatened by those who set themselves up as intermediaries who, as far as I know, have no set standard of ethics. I refer of course to the social service departments. There has always been the temptation to play a divine role in decision-making, and this particularly relates to decisions such as termination of pregnancy and has dominated the euthanasia debate. In the final analysis I am sure that we must recognize our limitations and, having respect for the individual and his family, allow parents to decide, after the best possible medical advice, what decision they will take in relation to their children.

We must surely acknowledge that in our society we still regard the parents as standing in loco Dei as far as ultimate responsibility is concerned and that anyone else can act in loco parentis only where the mental or emotional state of the parents is so impaired as to render their decision-making detrimental to their children.—I am, etc.,

D. E. FORD

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SIR,—We realize that it is often unfair to comment without being in possession of all the facts about a situation, but we were horrified to read in your leading article (9 December, p. 567) about what seems to us to be a glaring example of short-sighted surgery. What is the hoped-for goal to be attained by interfering in the natural course of events here? What opportunity will this little chap have of any sort of fulfilment in life, physically, mentally, or emotionally? Surely our task as doctors is to relieve suffering—not to cause it.

The irony is that this is supposed to be for "the welfare of the child in its widest