knowledge of prescribing habits and intentions. Doubtful cases can be referred to prescribers for elucidation. How farcical this return of scripts three months after dispensing. Pharmacists object to marking scripts "pc" regardless of truth to secure payment for more than five days' supply. Rather than initial a lie, my "pc" serves for "person consulted," whether patient, physician, or "panjandrum" in charge of practice records.

The only palatable revision of FPN 114 would entail shifting responsibility for omissions to prescribers, where it assuredly belongs. Doctors must be urged to write prescriptions properly, just as pharmacists must dispense them properly. Where occasional accidental omissions occur the pharmacist should be trusted to carry out the prescribers' intentions. Whatever else, the principle must be firmly established that pharmacists cannot be held responsible and penalised for the shortcomings of another profession.

The unworkable provisions of FPN 114 represent the most disgraceful and vicious imposition upon our profession in my 48 years in pharmacy. This monstrous concept of cheating pharmacists must be challenged.

GUY C ROBINSON

Norwich

White coat

SIR,—My partners and I must be idiotic GPs according to Dr D J Vicary (6 November, p 1135). For the past eight years we have worn white coats in our surgery and, however our egos are affected, our pockets have benefited. Our annual expenditure on lounge suits has been reduced by 50%—a considerable achievement in these inflationary times.

R MACG AITKEN

Spalding, Lincs

SIR,—I have long been an admirer of Dr Julian Tudor Hart's work and philosophy (9 October, p 862) and I was therefore concerned to read Dr Vicary's letter (6 November, p 1135).

I have no idea what Dr Tudor Hart's motives are for wearing a white coat, but I very much doubt if it is to "separate" him from his patients or to satisfy his ego. Perhaps, however, some clues may be gained by comparing the environments of industrial South Wales and genteel rural Suffolk.

GORDON C HANCOCK

Birkenhead, Merseyside

Plasma propranolol levels in coeliac disease and Crohn's disease

SIR,—We were interested in the attempt of Dr B T Cooper and others (6 November, p 1135) to explain our findings of raised plasma propranolol levels in Crohn's disease (2 October, p 794) by enhanced absorption of the drug due to changes in the microclimate of the jejunal mucosa. As yet we do not know the mechanism involved and, contrary to their comment on our communication, never did claim to have shown "that propranolol was absorbed better in Crohn's disease." Indeed, we do not believe that this could be the case since Patterson *et al*[1] showed that "there is virtually complete absorption" of propranolol in man after oral administration.

Propranolol is a drug that is extensively metabolised during its first passage through the liver; although enhanced overall absorption as such is unlikely to be the cause of the raised plasma levels in Crohn's disease, one might postulate that accelerated absorption, possibly by a change in the microclimate of the jejunal mucosa, might overload this system and allow more of the unmetabolised drug to reach the general circulation. However, if this were the case the same changes in the jejunal microclimate that Dr Cooper and his colleagues claim for Crohn's and coeliac disease should also occur in such non-intestinal diseases as rheumatoid arthritis and pneumonia, in which similarly raised plasma propranolol levels have been found by Babb *et al*.[2] We should be greatly interested to know whether Dr Cooper and his colleagues could supply us with such evidence. Contrary to their suggestion that the absorption of propranolol would be enhanced in untreated coeliacs we found in two such cases (unpublished) that the plasma levels were no higher than in the treated group.

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[1] Paterson, J W, *et al*, *Pharmacologica Clinica*, 1970, **2**, 127.
[2] Babb, J, *et al*, *Lancet*, 1976, **1**, 1413.

Treatment of cervical spondylosis

SIR,—I read with interest but with some concern your expert's answer to the question (23 October, p 1002) about the treatment of cervical spondylosis.

I would say that "cervical spondylosis" per se is not a clinical entity; the condition is a pathological-radiological abnormality present in the "normal" population radiologically in some 75% of people aged 50 or over.[1 2] However, it may produce clinical symptoms and/or signs and these are very variable, ranging from neckache, with or without headache, to brachialgia, myelopathy, and vertebral basilar insufficiency; and indeed there may be various combinations and permutations of one or more of these in the individual patient.

Thus, as may be realised, the treatment required is varied, and may be medical, surgical, or both and in any event usually includes the treatment available from experts in the important remedial profession of physiotherapy. The treatment depends on many factors—the type and severity of the clinical syndrome, the number of attacks, the progression, the response to simpler rather than to more complex medical treatment, etc. Some of these patients do, sooner or later, require operative treatment, as I have now discovered in some 500 patients of a personal series operated on by an anterior decompression-fusion procedure during the past 15 years.

Finally, Sir, could I make a plea for the discontinuance of the term "physiotherapy" to mean, in general, "exercises" and/or "traction." Both the questioner and the expert answerer appear to fail to appreciate that physiotherapy is a profession and that physiotherapists are experts with special knowledge of medical and surgical disorders and of their treatment by a wide variety of therapies—and not just "simple exercises"?

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[1] Harris, P, in *Some Aspects of Neurology*, ed. R F Robertson, p 38. Edinburgh, Royal College of Physicians of Edinburgh, 1968.
[2] Kuhlendahl, H, and Kunert, W, *Medizinische*, 1954, **14**, 499.

SIR,—Your expert's answer to the question on cervical spondylosis (23 October, p 1002) presents far too gloomy a picture.

If the questioner means osteophytosis and a diminished joint space, clearly all conservative treatment is useless. An osteophyte menacing the spinal cord or a foraminal osteophyte compressing a nerve root should be removed surgically.

Apart from these late cases described so thoroughly in Wilkinson's book,[1] there are the much more frequent cases described in mine.[2] In these cases the diagnosis of cervical spondylosis is mistaken; that is what the radiograph shows but not what the patient is suffering from. This history may make this plain in so far as the attacks of pain alternate with periods of complete freedom, though the radiological evidence of degeneration continues unchanged. Patients with root pain attributed to spondylosis recover after some months, retaining their osteophytes.

What these patients are really suffering from are attacks of internal derangement at an intervertebral joint. It is for this reason that lay manipulators are often able to relieve pains that doctors have pronounced intractable.

JAMES CYRIAX

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[1] Wilkinson, M, *Cervical Spondylosis*, 2nd edn. London, Heinemann, 1971.
[2] Cyriax, J, *Cervical Spondylosis*. London, Butterworth, 1971.

Prostatic cancer

SIR,—Dr A Y Rostom (16 October, p 942) draws attention to the urgent need for controlled clinical trials to evaluate treatment policies in localised carcinoma of the prostate. Such trials are, indeed, long overdue, but he can be reassured that proposals have been discussed by urologists and radiotherapists in the United Kingdom on a number of occasions during the past year and it is hoped that an appropriate trial will soon be under way.

The limitations of conventional hormonal therapy and in particular the cardiovascular hazards of oestrogens have been demonstrated by the Veterans Administration Co-operative Urological Research Group.[1 2] These findings have lent considerable weight to the view that hormonal therapy should be reserved for those patients with incapacitating symptoms or at least demonstrable metastatic disease. Yet prostatic carcinoma remains a major source of mortality and morbidity and is indeed the third leading site of malignant death