diagnosis and several more had raised blood pressure on admission to hospital.[1] In our series a low blood pressure or low pulse pressure was unusual, even in cases of severe aortic stenosis, although the pulse waveform was almost always abnormal. We believe that the coexistence of aortic stenosis and hypertension is more than chance and it may be that raised systemic pressure accelerates wear of the aortic valve, especially if it is congenitally bicuspid.

[1] Wren C, Petch MC. Calcific aortic stenosis. *J R Coll Physicians Lond* 1983;**17**:192.

Should general practitioners use dithranol?

Dr R H SEVILLE (Lancaster LA2 6DT) writes: Dr Judith Donaldson and Dr W J Cunliffe (18 June, p 1938) are entirely correct in their conclusion that short contact treatment with dithranol is successful in the home management of quiescent psoriasis. Of 51 patients with psoriasis whom we treated, 11 cleared themselves completely at home, 23 showed pronounced improvement, 10 showed some improvement, and seven more severely affected patients were referred for hospital admission. The treatments used at home in increasing potency were either dithranol cream 0·25%, Stie-Lasan ointment (0·4%), or Dithrolan (0·5%), all being commercially available. Patients increased the time of application by following a detailed instruction sheet.[1] It must be emphasised, however, that full written instruction or careful supervision, or both, is necessary to avoid patients burning themselves with this most useful drug.

[1] Seville RH, Martin E. *Dermatological nursing and therapy*. Oxford: Blackwell Scientific Publications, 1981:20-6.

Spinal disease presenting as acute abdominal pain

Dr D V MORGAN JONES (Ruislip, Middlesex HA4 7DE) writes: The lesson of the week (9 July, p 117) reminded me of an occasion more than 40 years ago when Sir James Walton entered the lecture theatre at the London Hospital somewhat breathless and informed us inexperienced medical students that he had just failed 12 graduates for the MS(London)—there had been only 13 candidates. He had asked them the differential diagnosis of acute abdominal pain and only one candidate had mentioned disease of the spine as well as the numerous other causes.

Pruritus ani

Professor BRYAN N BROOKE (St James's Hospital, Balham, London SW12 8HW) writes: Mr John Alexander-Williams's review of pruritus ani (16 July, p 159) was all that a leading article should be—informative and entertaining with much good sense. But could that "notorious" in relation to Rabelais have been a lapsus manu for "notable"? There was nothing notorious about the man who, it could be argued, was the greatest writer medicine has yet produced and whose intent it was to pillory the abuses and tyrannies of his time. There may still be some ignorant prudes who recoil from Rabelais because they do not know that the rumbustiousness they object to was a veneer added by Urquhart in his translation. That Mr John Alexander-Williams is no prude I know; but it is not the first time I have had my doubts about my old friend's sense of history.

Adverse reactions during treatment with amiodarone hydrochloride

Dr A SAMANTA, Dr G R JONES, and Dr A C BURDEN (Department of Medicine, Leicester General Hospital, Leicester LE5 4PW) write: Dr Brian McGovern and others (16 July, p 175) report hair loss in two patients treated with amiodarone. We report a case of total hair loss in a patient receiving this drug.

A 62 year old woman was admitted in September 1981 with Stokes-Adams attacks due to the "tachy-brady" syndrome. A permanent cardiac pacemaker was inserted and tachyarrhythmias controlled by a combination of digoxin and amiodarone. At that time insulin dependent diabetes mellitus and autoimmune hypothyroidism were also diagnosed. She was given a combination of short and intermediate acting insulin twice daily, and full replacement with thyroxine. Ten months after starting treatment with amiodarone she complained of considerable scalp hair loss. Thyroxine concentration at this time was 179 nmol/l (14 μg/100 ml) (normal range 54-142 nmol/l (4-11 μg/100 ml) and thyroid stimulating hormone concentration 5·3 mU/l (normal <6·0 mU/l). Over the next three months the hair loss progressed to complete alopecia; amiodarone was withdrawn and digoxin continued. Within two months of this she noted a pronounced improvement in the quantity of scalp hair, and after eight months of stopping amiodarone she had regained all her hair. Thyroid functions were within the normal range.

Although drug induced alopecia is relatively common,[1] to our knowledge alopecia totalis has not been documented with amiodarone.[2] Our patient was on a constant dose of thyroxine, with no clinical or biochemical evidence of thyroid dysfunction. The strong temporal relation of alopecia totalis to amiodarone treatment leads us to believe that this is yet another adverse reaction of amiodarone.

[1] Davies DM, ed. *Textbook of adverse drug reactions*. 2nd ed. Oxford: Oxford University Press, 1981:427.
[2] Reynolds JEF, ed. *Martindale, The Extra Pharmacopoeia*. 28th ed. London: The Pharmaceutical Press, 1982:1374.

No smoking on planes

Dr IRENE A KREIS (The Hague, The Netherlands) writes: Minerva's campaign against smoking, especially during flights on commercial planes, has my support. Does she realise, however, that the air during flights only circulates? So one has to inhale polluted air anyway. The only sensible solution would be no smoking on planes.

Blood counts and economics

Dr GRAHAM J HARRIS (Oldchurch Hospital, Romford, Essex RM7 0BE) writes: I should like to make the following observations on Dr T J Hamblin's leading article (18 June, p 1918). Firstly, the red cell distribution width cannot be discarded as "apparently meaningless" when it is such a useful tool for assessing the quality of the reporting of red cell morphology. Secondly, blood film examination is a must, with or without clinical reason or an abnormal count. Unsuspected abnormalities such as microspherocytes, blood parasites, myelomas, and even the odd leukaemia are found all too often in apparently normal patients. The actual differential count is not so easy to justify, although the difference in time taken to look for abnormalities and to carry out a hundred cell differential is very small. At this hospital the cost of a blood film and differential is approximately 10p, a small price to pay for the information compared to the cost effectiveness, for example, of radioimmunoassay for α-fetoprotein or B_{12} totals.

Learning medicine

Mr C B SPURGIN (Finchfield, Wolverhampton WV3 8BP) writes: Professor Peter Richards (30 July, p 339) pointed out that those who select entrants to medical school do not generally show a preference between A level mathematics and A level biology, although more applicants offer the latter. Another aspect to be considered is the fate of unsuccessful applicants to medical schools. This was very relevant to me, before retirement, as senior science master and careers master at a grammar school. Only a few applicants succeed in securing places at medical and dental school—fewer than 25% 10 years ago, and I do not suppose things are very different now. All but the very able need to consider safety nets and other courses they can apply for. There is no doubt that A level mathematics provides a bigger and better safety net than A level biology. There are good reasons why many intending doctors and dentists should choose mathematics, if they are up to it, rather than biology as a sixth form subject. I discussed the matter in two papers in 1975,[1 2] and gave statistical data in 1976,[3] all of which remain relevant today.

[1] Spurgin CB. Entry to medical schools with 'A' level in mathematics rather than biology. *British Journal of Medical Education* 1975;**9**:140-4.
[2] Spurgin CB. Entry to dental schools with 'A' level in mathematics rather than biology. *Br Dent J* 1975; **138**:229-31.
[3] Spurgin CB. (Letter): Sixth-form subject choices for would-be doctors and dentists. *School Science Review* 1976;**57**:786.

Beveridge report

Dr G NINANE (Tohogne, Belgium) writes: In the obituary notice of Dr Hugh A Clegg (16 July, p 220) it is stated: "The Beveridge report was published in 1943." This statement is not correct. Beveridge sent his report to the minister, Sir William Jowitt, with a letter of introduction dated 20 November 1942.[1] And, according to John E Pater's book *The Making of the National Health Service*, "On 1 December 1942 the Beveridge report on social insurance and allied services was published" (p 43); it "rapidly became a best-seller" (p 45) and "came to be debated in the House of Commons during three days in February 1943" (p 45).[2]

I thought that it was important to recall to your readers this date of publication—1 December 1942—because of the historical importance of this report and the deep admiration many people have for the work of Sir William Henry Beveridge.

[1] *Social insurance and allied services*. (Beveridge report.) London: HMSO, 1978.
[2] Pater JE. *The making of the National Health Service*. London: King's Fund, 1981.