(24) Recurrent carcinoma of colon, with incipient carcinomatosis; burnt-out schizophrenia.
(25) Senile osteoporosis; hiatus hernia; diverticulitis (? Saint's triad, as she had a cholecystectomy).

It is evident from these two lists that, in this part of the country at any rate, "important" illness is as common in general practice as it is in hospital, if not commoner. It should be noted that the general-practice list is drawn from a population less than a tenth of the size of that producing the "hospital" list of "medical" patients. Can one escape the conclusion that, in this area at any rate, the bulk of important "medical" illness is treated by the family doctor at home? Admittedly general practitioners near large district general hospitals may send more of their cases to hospital, but this is partly counterbalanced by the fact that country doctors tend perforce to "tackle" more cases on their own than we town doctors do.

Surely, Sir, if the role of general practitioner is being discussed, we need objective evidence rather than preconceived ideas. To describe the treatment of important illness as "more or less exclusively a hospital responsibility" is sheer mumpsimus.—I am, etc.,

Lowestoft, Suffolk. M. P. CARTER.

W.C.s in Hospitals

SIR,—As a patient in hospital at the present time I wish to voice a complaint which I have often heard, as a G.P., from patients who have been in hospital. This concerns the sanitary arrangements for both bed- and up-patients. The plumbing in most hospitals is woefully inadequate and old-fashioned in design and there is nothing the nursing staff can do about it. After food and drink the two most important things in nature are the emptying of the bowels and bladder. People just do not like sitting on what are virtually communal lavatory seats, particularly in this germ-conscious age, and so they stand instead of sitting. Lavatory pans and seats and the floors of toilets are often flooded with urine and dirtied by faeces. Despite cleaning, the lavatories are often unpleasant, for this is a non-stop business in most large wards. Patients do not like using commodes. There is no more distressing a sight than young nurses awkwardly lifting ill or elderly people through narrow doors of tiny lavatories and trying to sit them on the pan.

Much money is wasted in hospitals which might well be diverted for improvement of toilet facilities. The bottle-necks in some departments are reaching alarming proportions, and hold-ups in special investigations often cause patients to occupy beds which should be available for really ill people, thereby easing the load of the G.P. The advice of experts is required here. The day of the "amateur" administrator is passing. Perhaps a Dr. Beeching could fit the bill.—I am, etc.,

Musselburgh, Midlothian. C. C. LUTTON.

Bedside Hazard

SIR,—A middle-aged female patient of mine recently recovering from pneumonia was awakened one evening by a very loud explosion in the bedroom ("like a war-time explosion"). It was discovered that a tumbler on her bedside table had exploded into many thousands of slivers, the largest being only one or two mm. long. Only the base remained. Had not the patient been lying down facing away from the explosion she would no doubt have received many nasty cuts.

The cause?—a small transistor radio also on the bedside table a few inches away from the tumbler. The set was on, but the volume turned right down. Presumably the frequency of the sound waves emitted caused the glass to vibrate in its fundamental mode, and hence explode, as in the case of the soprano shattering a wine-glass with a high note.

As this apposition of tumbler and transistor radio must occur tens of thousands of times every day all over the country, it would be interesting to know if such accidents occur frequently.—I am, etc.,

Ashby-de-la-Zouch, Leicestershire. P. M. CORKEY.

Perinatal Mortality

SIR,—The recent report by the National Birthday Trust Fund[1] has been used in support of increased hospital confinement as a means of reducing the perinatal mortality. An examination of Table A on page 4 shows that, while the perinatal mortality rate for England and Wales in 1960 is high in relation to several other countries, by far the greatest proportion of this excess is in the stillbirth figure, and it is doubtful whether hospital confinement (rather than domiciliary confinement) will make much reduction in this figure. One would then think that better antenatal care should be a more important factor in reducing the perinatal death rate, and Bradford is commended on page 6 for bringing its perinatal death rate down to 31.8 in 1962 as a result of "an intensive effort arising out of the closest co-operation between the hospital, the local authority, and the family doctor."

This figure of 31.8 is slightly higher than the national average of 30.8 for 1962, so it would seem that there is no simple answer.—I am, etc.,

Kirkintilloch, Glasgow. DAVID A. PRIMROSE.

REFERENCE

1 Report of the Maternity Services Emergency Informal Committee, National Birthday Trust Fund, 1963. London.

Tetracycline in Tuberculosis

SIR,—I was perturbed to read that Dr. J. C. Chatterji (4 January, p. 62) advocates tetracycline with isoniazid in his patients, even though this is only during the six weeks while they are being desensitized to streptomycin and P.A.S. In 1954, when this combination was advocated,[1] there was little else to combine with isoniazid when streptomycin and P.A.S. could not be used. In 25 patients whom I reviewed in 1960[2] the sputum became negative in 60%, but in 40% the sputum continued to be positive and resistance to isoniazid rapidly emerged. These patients were given 4–5 g. daily of tetracycline or oxytetracycline and in only two divided doses. With the 2 g. a day that Dr. Chatterji uses resistance to isoniazid rapidly emerged in nearly every case.[1 2] It is difficult to imagine that the smaller mean weight of Indian patients would counterbalance this. Certainly thiacetazone and probably ethionamide or pyrazinamide, or, even better, two of these drugs together, would provide a far more effective combination with isoniazid.

Tetracycline has very little place in the treatment of tuberculosis to-day, except when there is secondary infection. In ten patients given streptomycin as well, eight continued to have positive sputum and resistance to streptomycin emerged.[2] With pyrazinamide, in only one out of eight patients did the sputum become negative.[2 3] Another eight patients given cycloserine and tetracycline continued to have positive sputum.[2] Results with ethionamide[4] and with kanamycin[5] are also very poor. Tetracycline, 2 g. twice daily, together with viomycin, 2 g. twice weekly, is probably the most adequate of these regimes, though still weak. It provides fair operative cover.[2 6 7] By itself it only cures a small proportion of patients,[2 7] and resistance to viomycin often emerges after a few months.[2]—I am, etc.,

Ware Park Hospital, Ware Herts. A. PINES.

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Stein-Leventhal Syndrome

SIR,—I am pleased to see further published work (11 January, p. 96) on this important syndrome and I congratulate the authors on the report of the investigations carried out. I must, however, correct a wrong impression which might be conveyed to readers in the reference to my own work on this subject. The authors state that my operative technique of ovarian eversion[1] is unnecessary and undesirable because of possible bleeding and adhesions. This dogmatic statement may convey the impression that I have discontinued this technique myself—which, of course, is not the case. My conviction, which has been appreciated by Stein himself, is that by this method ovulation is facilitated in these patients with gonadotrophic imbalance. Oozing from the cut ovarian surface is easily controlled by light everting mattress sutures of 00 catgut, and adhesions are prevented by the Gilliam suspension, which completes the operation. The proof of the efficacy of this technique (which Stein and others in the U.S.A. have themselves carried out) is shown in the excellent pregnancy results which follow it—a point which the authors of this article have not reported upon in their series.

In a long experience with many cases I have yet to observe or re-operate upon a case of post-operative adhesions. In the American technique of closure of the wedge resection, which is used by Chamberlain and Wood, it is more than probable that adhesions will follow unless the Gilliam suspension completes the operation because it is impossible to be