this way one rapidly adjusts to headlight glare and drives without danger. The streets of Britain are much better lit in general than the streets of my own country, but I feel much safer driving at night here. It is not the annoying glare from oncoming lights on a wet night that is the problem, it is the multitude of sudden poorly lit sections that turn up unexpectedly in any city. This is a real danger if one drives with sidelights on instead of headlights at low beam.

Interestingly enough, I found that the further north one went in Britain the worse lit were the roads and the less likely were the drivers to use their headlights. Your drivers used them for signalling, for overtaking, as a token of thanks, in fact for everything but the reason they were put there—in order to see when driving at night.—I am, etc.,

Goulburn, New South Wales. DAVID C. WALLACE.

Diet and Diverticulitis

SIR,—I was very interested in Dr. E. H. Goulston's letter (11 November 1967, p. 359) drawing attention to the presence of diverticulosis in Ethiopia. I have recently edited a book[1] in which I go so far as to say this disease is un-African, in fact rare. In preparing this book I travelled widely in Africa in search of information and to confirm facts.

I feel the truth is probably tied up with the connotation of the word African, which really has no scientific meaning. But it would seem from the evidence available that diverticulosis is rare or at least uncommon in Africans of negroid origin, whereas it is found in countries where most of the inhabitants are of Arab stock. This sort of finding is well known in other conditions—e.g., renal calculi are very uncommon in Africans (negroid), but in Sudanese of Arab stock they are common.

The high prevalence of sigmoid volvulus in Ethiopia is also mentioned by Dr. Goulston. This condition is common in parts of Ghana, the Ivory Coast, Sudan, Uganda, Tanzania, and Rhodesia and is uncommon in many other African countries; yet the diet in these two groups is substantially the same.

Work from Uganda will shortly be published which attributes the cause to a lesion in the extramural nerve tissues of the pelvic colon; in other words it is not unlike Chagas's disease. If this work is confirmed it seems at last that diet may be exonerated.—I am, etc.,

London N.10. W. W. DAVEY.

REFERENCE

1 Davey, W. W., *Companion to Surgery in Africa*, 1968. Edinburgh.

Hospital Medical Records

SIR,—The Tunbridge Committee on the Standardization of Hospital Medical Records[1] suggested the setting up of a committee to carry on its work. The Minister accepted this recommendation and set up the Advisory Committee on Hospital Medical Records with the following terms of reference:

In the light of progress in the use of information derived from medical records to keep under continuous review methods of meeting the rapidly changing needs of the modern hospital service including the extension and improvement of standardized forms.

During its first year this new committee has begun work on forms which were either not covered or only partly dealt with in the original Tunbridge report—for example, discharge summaries, pathology and *x*-ray reports, obstetric forms, and, shortly, a drug prescription documentation. Small subcommittees have been formed as appropriate and advice and views have been sought from many quarters, and we shall continue to welcome the ideas and experience of those who have been taking a special interest in any aspect of hospital medical records. We hope to finish up with forms which will meet most needs of the clinicians and also take into account such important considerations as information retrieval and relationships to other health services.

One of our national characteristics is to resist uniformity, but those who are aware of the untidy, unwieldy notes so commonly found in many hospitals are equally aware of the waste of time and greater liability for errors which can arise from badly arranged notes. A basic framework for hospital records seems elementary common sense; it is clear that such a framework will be an essential prerequisite for the computerized systems of the future; those who wish to elaborate can always do so.

At the present time about a million forms a month designed by the Tunbridge Committee are now being used in hospitals in England and Wales.—I am, etc.,

F. AVERY JONES,
Chairman,
Advisory Committee on Hospital Medical Records.

Central Middlesex Hospital, London N.W.10.

REFERENCE

1 *The Standardization of Hospital Medical Records*, 1965. H.M.S.O., London.

Traveller's Diarrhoea

SIR,—The article by Dr. A. C. Turner on prophylaxis of traveller's diarrhoea (16 December, p. 653) does not present the basic data. We are told that the incidence of diarrhoea was significantly less in patients treated with Streptotriad than in controls, but we are not told what the actual reduction in frequency was. A significant difference is not always of practical importance. Nor are we told whether the distribution of territories to which the subject travelled was the same in the different treatment groups. Since the incidence of diarrhoea in the different territories was so different variation in the distribution of territories could have had an important effect on the results. Furthermore, it is important to know whether the incidence of diarrhoea in North America (7.7%) is as much affected by Streptotriad as the incidence of diarrhoea in Africa (25.9%). Could Dr. Turner complete his paper by publishing the essential results of his study?—I am, etc.,

London S.W.10. C. M. FLETCHER.

*** In response to our request for shortening of Dr. Turner's paper two tables giving this information were unfortunately omitted. We much regret this. The tables read as follows:

Incidence of Diarrhoea and Duration of Bowel Disturbance

Incidence	Inert Control (385 Patients)	Neomycin/ Trisulphonamide (355 Patients)	Streptotriad (364 Patients)	Total All Groups (1,104 Patients)
Upset during trip ..	61	67	43	171
Within 72 hours of return	6	6	3	15
Totals ..	67 = 17·4%	73 = 20·6%	46 = 12·6%	186 = 16·8%
Duration of bowel upset				
1 day	17	21	15	53
2 days	11	18	6	35
3 „	12	12	6	30
4 „	5	3	4	12
5 „	4	1	5	10
>5 „	4	9	4	17
Not recorded	14	9	6	29
Three or more stools on 3rd day	14	14	9	37

Regions Visited and Duration of Trips Correlated with Total Incidence of Diarrhoea in all Groups

Region	2–4 Days	5–9 Days	10–18 Days	19–24 Days	25–35 Days	More than 6 Weeks	Total	Incidence of Diarrhoea %
North and Central Europe ..	8	20	40	0	0	0	68	15·6
South Europe	7	57	315	11	0	0	390	16·9
Middle East	2	34	42	4	2	1	85	23·5
Asia (including India and Pakistan)	5	12	48	12	13	5	95	15·1
Africa	8	15	46	32	19	1	121	25·9
Australia/New Zealand	0	1	2	12	6	0	21	11·3
S. America/Caribbean	1	9	121	13	0	0	144	12·6
Other (Canada, U.S.A., etc.) ..	1	6	4	1	0	1	13	7·7
More than one region	0	8	70	55	32	2	167	
Totals	32	162	688	140	72	10	1,104	

We have asked Dr. Turner about the point concerning the incidence of diarrhoea in different countries, and he writes:

"With regard to the incidence of diarrhoea in the different territories where the variation was so different, one can only say that symptomatically the attacks were similar, but we did not carry out a comparative survey of all the territories because the incidence of diarrhoea was so small in North America we did not feel the figures would have stood up statistically."—ED., *B.M.J.*