by two of the following three tests: standard agglutination, anti-human globulin, and complement fixation. Thirteen of the 19 patients were diagnosed during 1971-2 compared with five in 1973-4 and one in 1975.

These findings indicate that the brucellosis eradication campaign has had considerable effect in Ayrshire. Moreover, it should convince clinicians that brucellosis is now unlikely in this area, and that they should rarely request laboratory tests for brucellosis.

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Compensation for congenital defects

SIR,—While supporting the basic idea of extending the protection of the law to the possible liability to a child born disabled (leading article, 28 February, p 482), a number of Members of Parliament are most concerned about the weaknesses in the Bill on scientific grounds.

Already several consultants and medical practitioners concerned with obstetrics and paediatrics have voiced their concern too, but no amendments were made during the committee stage in the Commons. If the misgivings which have so far been expressed by Lord Pearson, Mr Ian Kennedy and Dr R G Edwards have support, MPs would welcome the comments of the medical profession as to what amendments might be made to improve or change this Bill.

The primary concern of the Congenital Disabilities (Civil Liability) Bill must be for the wellbeing of victims of congenital disabilities. As the Bill stands at present a baby must live for 48 hours before compensation for loss of expectation of life may be recovered. The Bill also contains different liabilities in terms of negligence concerning the causation of fetal damage.

After all the problems that arose over the thalidomide disaster it is natural that the law should seek to resolve the problems of congenital liability. If there are further comments in addition to the Law Commissioners' report and the Law Society working paper on this subject, Members of Parliament and their Lordships would welcome them.

LYNDA CHALKER
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Health and Social Services Committee

House of Commons,
London SW1

Rib pain

SIR,—In your leading article (14 February, p 358) on rib pain, an exhaustive list is published of the more and less frequent causes of non-visceral thoracic pain. However, the most common lesion of all in civilian practice—a lower thoracic disc protrusion—is omitted. Just as displacement of a fragment of cervical disc may result in root pain in the upper limb and a lower lumbar disc protrusion can impinge against the nerve root causing sciatica, so is intercostal root pressure common at the sixth to twelfth thoracic levels.

The difference is that cervical and lumbar disc herniations often draw attention to the diagnosis by provoking a clear root palsy. This is not to be expected in thoracic root pain: a palsy or pressure on the spinal cord is seldom encountered. The signs are thus less obvious and a diagnosis of muscle strain, intercostal neuritis, or (since a deep breath hurts) "pleurodynia" may be made. Indeed, protrusions of primary posterolateral onset, in which root pain is present without any posterior component, may be thought of as gastritis, cholecystitis, chronic appendicitis, or a renal disorder.

It is important that these lesions should be recognised by doctors; for, quite apart from patients' relief, they afford apparent confirmation of lay manipulators' mistaken ideas that visceral disease can be put right by spinal manipulation that they suppose alters sympathetic tone. If a doctor has diagnosed a visceral disorder and, after many months of negative investigation and fruitless treatment, the patient finds himself well after a few simple twists who can blame the laymen for advancing so advantageous a notion?

For the sake of the good name of our profession and the advancement of scientific concepts I hope thoracic disc lesions will receive the attention they deserve.

J H CYRIAX

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SIR,—I was surprised to find in your leading article on this subject (14 February, p 358) that the impression was given that most primary rib tumours were benign. After listing a number of benign rib tumours, including chondroma, solitary myeloma, and fibrous dysplasia, the article went on to say that primary malignant tumours are rare. This is not in accord with the literature, where, in most series, the malignant cases outnumber the benign ones.

In the chest cage generally (and often it is difficult to determine if a tumour has originated in the rib or in adjacent tissue) my own series of primary tumours includes 21 definitely malignant tumours, three plasmacytomas, which may or may not be considered benign, and only 12 tumours which were definitely benign. These included four haemangiomas, one subperiostial lipoma, one eosinophilic granuloma, and four cases of fibrous dysplasia.

The malignant tumours are usually locally malignant, and the results of surgery, if it is bold and radical, are good. The results of procrastination or ineffective surgery are very bad, for the tumour will extend inexorably and is usually radioresistant. It seems to me, therefore, very important that there should be a broad understanding that chest wall tumours should be taken seriously, and, although the article mentions that chondromas should be removed, I do not think it stresses enough the frequency of malignancy.

JOHN DARK

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SIR,—Hitherto few of your leading articles have been of much positive help to clinical general practice. "Rib pain" (14 February, p 358) is a notable exception because it views the problem of an undiagnosed symptom—which is exactly what patients present to their GPs. Perhaps, following your example, the organisers of postgraduate lectures for GPs will structure their courses in similar manner rather than give us the standard rehash of revision notes for the MRCP examination.

On the specific topic of rib pain I wonder if I might add to your list two causes commonly found in general practice: Bornholm disease and pulled or torn fibres of the diaphragm. These conditions themselves give further illustration of the gulf that sometimes appears between the academic and the practising clinician. The academic might argue that neither condition has anything to do with pain specifically in the ribs. The clinician, however, starts with the words of the patient and not those of the textbook. Secondly, both diagnoses are virtually unprovable within the practical framework of clinical practice. This might upset the academic who has little insight into the fact that his own treasured factual proofs and demonstrations are themselves little more than inspired guesses that may well look a bit silly in as little as 10 years from now, let alone in a hundred. The evolution of the "Medical Practice" section of the *BMJ* has been a notable acknowledgement of your own acceptance that not all problems can be discussed, let alone resolved, within the rigid framework of research papers. But even you, sir, do not yet go far enough. Perhaps your train of thought would have led you further into the exciting world of clinical general practice if you had begun your leading article with, "When a patient says he has rib pain what does he mean?"

ROBERT LEFEVER

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SIR,—In your leading article (14 February, p 358) solitary myeloma was described as a benign tumour affecting the rib. Few clinicians would agree that myeloma can be solitary and certainly it is never benign. Being primarily a disease of bone marrow, the overt presentation in one site is invariably associated with clinically occult lesions elsewhere, and the majority of patients die from multiple myelomatosis.

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SI units

SIR,—The recent introduction at this hospital, under protest, of SI units has been difficult and expensive and has brought, as was predicted, no advantage but instead danger and confusion. No doubt danger and confusion will abate as we become accustomed to these units, but neither the scientists nor the clinicians who work here expect that any benefit will accrue from the change. The arguments in its favour are flimsy and pedantic and an appeal to international conformity comes ill from those who have put us out of line with the United States of America in this regard.

It is not hoped that we can revert to former practice, and the damage which has been done will perhaps be minimised by not trying to do so. We are concerned rather to prevent a repetition of this unnecessary misfortune, for it is not to be supposed that SI units are the last word of the theoretical reformers. There may be some who will advocate the replacement of decimal counting by binary notation