The Table shows two groups of patients: (1) Those with mesenteric adenitis who have evidence of recent appendicitis—that is, are iron-positive—in whom appendicectomy coincides with cure in 24 of 25 cases (96%). This approximates closely to the cure rate of 98% which I have described for removal of acutely inflamed appendices.[4] (2) Those who have no evidence of recent appendicitis—that is, are iron-negative—in whom appendicectomy coincides with cure in only 9 of 15 cases (60%). This is well below the cure rate of 86% normally associated with emergency removal of a normal appendix.[4]

There thus appear to be two distinct groups of patients with mesenteric adenitis, one in whom the appendix is involved (whether as cause and effect or sharing a common aetiology), and the other in which the appendix is not involved—or at least has not yet become involved. Until the two can be separated clinically the surgeon making the diagnosis of mesenteric adenitis must weigh the risks of unnecessary operation against those of missing appendicitis. The findings described above would appear to make a diagnosis of mesenteric adenitis a less attractive justification for non-operative treatment than it is at present, at least for the adult patient.

Were my findings applicable to the problem of the acute abdomen of childhood, I feel Mr. Jones would have won his point. However, until they are confirmed or refuted for the patients in the younger age groups the criticisms of 1965 must unfortunately remain valid.—I am, etc.,

J. G. R. HOWIE.

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Holmes-Adie Syndrome

SIR,—As your leading article (1 February, p. 267) shows, the pathological report of Harriman and Garland[1] has confirmed previous hypothetical postulates as regards the site of the pupillary lesion in Adie's syndrome. Your leader does not, however, cover two interesting aspects of this disorder.

The complete Adie's syndrome has been reported in association with other neurovegetative phenomena—for example, delayed gastric emptying. Secondly, and of more interest in explaining the pupillary phenomena, are various reports[2–5] which show that sympathetic (stellate ganglion) block can relieve the pupillary changes. This ties in with the pathological changes.

Six patients with unilateral Adie's syndrome were treated as follows: Two with guanethidine eye-drops 5·0%, and four with thymoxamine 0·5%. The two guanethidine-treated patients had a spontaneous recovery of light reflexes. Three out of four of the thymoxamine-treated patients had a recovery of pupillary reflexes to light and all four had a change in the pupillary response to dark adaptation.

From pupillographic studies, the pathology, previous reports of pharmacological responses, and the changes with sympathetic blockade, surgical and therapeutic, it is reasonable to assume that the pupillary changes arise from incomplete parasympathetic interruption. Further, that there is an intact peripheral neurone and that the size and shape of the pupil would depend on the volume of sympathetic activity.—I am, etc.,

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Strokes and the Pill

SIR,—The arrival of the *B.M.J.* on 22 March with your leading article (p. 733) coincided with the admission to this hospital of a 26-year-old Indian woman with benign intracranial hypertension. She complained of headaches and blurred vision for two weeks. There was bilateral papilloedema but no sign of focal neurological disease or other systemic disorder. Carotid angiography was normal.

She had been using an oral contraceptive (5 mg. lynoestrenol and 0·15 mg. mestranol) for two years. This was discontinued on admission to hospital. Thereafter there was steady improvement in her symptoms and the papilloedema had almost completely disappeared in three weeks. No specific treatment was given.

This appears to be a further example of pseudotumor cerebri developing in association with the use of oral contraceptives.—I am, etc.,

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Pietermaritzburg,
Natal, South Africa.

Trichomoniasis and Gonorrhoea

SIR,—I have read with interest the comments raised by Dr. D. F. Hawkins (12 April, p. 116) and Dr. N. Rosedale (3 May, p. 315) in connexion with my letter (8 March, p. 642).

At present, methods available for the detection of Neisserian infection are far from satisfactory, especially in women and in respect to tests for cure. Frequently, repeated tests are necessary after treatment of trichomoniasis before gonorrhoea is detectable. Trichomoniasis is usually a more acute infection in the females, particularly when associated with gonorrhoea. I have repeatedly seen patients who were almost in tears with distress from being reinfected as their asymptomatic male contacts have not been treated at other clinics because of negative findings. In each case cure has only resulted after proper treatment of the patient and the contact. It is always more difficult to cure the infections than to clear the patients of their symptoms. Unfortunately, the disappearance of symptoms is too often regarded by both patients and doctors as a sign of cure, which is not always the case.

In the present state of affairs, perhaps these infections should now not be regarded as venereal and non-venereal with the implication, insinuation, and conclusion that can be drawn from them, but as sexually transmissible infections, when the management and treatment of the patients with these infections will be more successful. I await positive proof to the contrary.—I am, etc.,

W. TSAO.

Wembley, Middx.

Doctors and the Practice of Nursing

SIR,—I share the sentiments of Mr. M. C. T. Morrison (19 April, p. 191) that the special relationship which used to exist between doctors and nurses is in danger of disintegrating.

Fortunately this is not the case between doctors and midwives. The Central Midwives Board will only approve hospitals as training schools for midwives if the consultant staff participate, with the midwife teacher, in the instruction and examination of pupil midwives. Hence since the formation of the C.M.B. by Act of Parliament in 1902 a happy relationship has existed between doctors and midwives. Every year eight examinations are held and hundreds of obstetricians each paired with a midwife teacher correct scripts and conduct clinical and oral examinations for about 9,000 pupil midwives. In several centres in Britain doctors of many specialties play an important part in the instruction of future midwife teachers.

The C.M.B. are deeply appreciative of the willing co-operation of the medical profession in the training of midwives, and they believe it is of mutual benefit to both professions and thus to the public we both serve.—I am, etc.,

MARGARET I. FARRER,
Midwife and Deputy Chairman of the Central Midwives Board.

London S.W.7.

Cyclator Ventilator

SIR,—I would be grateful if the attention of your readers could be brought to two faults which may occur in the Cyclator ventilator.

On several occasions it has proved impossible to ventilate a patient by hand using the Cyclator circuit although the ventilator has been apparently switched off. On squeezing the reservoir bag gas was vented at low pressure inside the machine, and inflation of the patient did not take place. To restore the situation a separate circuit had to be connected, and the time lapse might have endangered the patient. It was found that two minor faults could give rise to this situation and both happened to be present simultaneously.

Some rotation of the on/off switch while in the "off" position was possible on this particular machine. In certain positions this allowed a small leak through the switch permitting the driving chamber to pressurize, thus activating the bypass valve and preventing manual ventilation. This fault was rectified by replacing the valve seating.

The expiratory pause control on this machine allowed a pause in excess of the theoretical maximum (30 sec.), and, in fact, over the last half-turn of its travel the variable

leak from the bellows was totally occluded, so that once pressurized the bellows had no means of emptying and allowing the valve to open. Obviously, when using the machine to ventilate a patient no one would adjust the expiratory pause to this length; however, the machine may be disconnected from the driving gas supply with the Cyclator still switched on. If the expiratory pause control is then screwed up to its "longest" setting, on reconnection, although the Cyclator is switched off immediately, the valve bellows have pressurized and manual ventilation remains impossible until the expiratory pause control is unscrewed.

These faults emphasize the necessity of having constantly available a circuit which is completely independent of any automatic ventilator fitted to the anaesthetic machine. As far as I am aware, these particular faults have not been noted before.—I am, etc.,

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Asthma in Malta

SIR,—In your report (19 April, p. 179) on the short paper "A Study of Bronchial Asthma in Malta," it was stated that I advocated skin tests and that in a series of 419 patients desensitization was effective in just over half. I did not recommend skin testing; as a matter of fact, skin testing was carried out in only 98 patients. I only claimed that when correlated with the clinical history skin tests were frequently informative.

Desensitization treatment, which was carried out on 56 patients, resulted in marked improvement in only 12 of the cases (2·8% of the whole series); indeed, this is very different from the figure reported. However, I did suggest that desensitization, especially in children, for unavoidable inhalants had to be considered, as it is currently the only method that offered the patient any hope of basically modifying his state of hypersensitivity.—I am, etc.,

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1969 Medical Directory

SIR,—Early in June, after a number of regrettable delays, copies of *The Medical Directory 1969* (the 125th annual issue) will be dispatched to subscribers.

During 1968 the book was transcribed on to magnetic tape, and the new edition has been printed by the use of computer-aided typesetting techniques. The setting-up of the very complicated file, and the processing of the 30,000 amendments needed in the 1969 book, have been beset by the sort of difficulties seemingly encountered by everybody in the early stages of computerization. The publishers much regret that the 88,448 entries include some hundreds that are not as they should be. Some of them are garbled, and in some the intended amendments have not appeared in the printed book, for a variety of technical reasons. A few names have been omitted altogether.

The staff and computer consultants are doing everything in their power to solve the problems, so that the expected benefits of computerization may be achieved as soon as possible, and we have every hope that the next edition will approach the high standard of previous issues.

The annual schedule for the 1970 book, produced by computer and in an entirely different form from the schedules of the past, will be dispatched in a few weeks' time by an outside contractor. It will be much appreciated if the appropriate sheet is posted to our new editorial office (105 Baker Street, London W1M 2BE) as soon as possible after receipt and verification.

The Editor of *The Medical Directory* would welcome with gratitude details of errors noticed by users of the book if sent by letter to the address above. It is regretted that owing to pressure of work it will not be possible to send an acknowledgement.—I am, etc.,

B. STANTON,
Editor, *The Medical Directory*.
London W.1.

Improving the Hospital Service

SIR,—The attraction of general practice has been much improved in recent years, but what has been done for the hospital service? Some years ago an excellent salary rise was obtained for house officers, but the time spent at this grade is only one or two years. There is still great dissatisfaction felt among registrars, senior registrars, and consultants.

As a hospital junior doctor I do not want to air the grievances of my colleagues, but I wish to put forward some constructive ideas for the future of the consultant grade, in which we hope to spend the majority of our years of service. The attraction of this grade is all-important if we are to maintain a high standard of service, and some kind of completely new approach is necessary if we are to achieve this.

A full-time hospital service has been suggested, but, while so many people want and are able to pay for their medicine, can this right be denied to them? Unfortunately treatment is not as yet equal for all. There are many deficiencies in the hospital service because of the shortage of beds, staff, etc. With private treatment patients can often avoid the results of these deficiencies.

The time has come when we should no longer speak of "full-timers" and "part-timers." The only way to abolish this distinction would be to make all consultants "part-timers." If all consultants were required to do 10 sessions, and then allowed to do private practice on top of this, many of the present grievances would disappear, provided an appropriate salary scale was instituted. I would suggest that consultants should begin by earning £4,000 per annum, and that their salary should rise over 15 years to £8,000 per annum. A salary scale of this order would compensate for any loss in private fees, and would even up the inequalities in income which occur between different specialties and between different areas. Also this would reduce the need to have a private practice in order to make up an adequate salary. A further inequality—namely, that resulting from appointments being made at different ages in different specialties—could be eradicated by considering 34 years of age as a desirable age at which a consultant be appointed, and allowing one salary increment per year of age to be added on to the salary of those who are appointed after this age, up to, say, five increments.

A system, based on the ideas put forward above, would, I think, go a long way towards keeping people in the hospital service.—I am, etc.,

R. J. N. TURNER.
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"Inducement Awards"

SIR,—Has the time not come to review the special distinction awards to consultants? I concede that among those at present in receipt of "A" and "A plus" awards there are many whose work can be justly considered to be of special distinction. Of the "B" and "C" award recipients, however, although conscientious and hardworking, there can be few who produce original work which can truly be labelled of special distinction. It would appear therefore that these awards are simply a form of largesse, distributed by the Ministry to a proportion of the country's consultants in an attempt to avoid instituting realistic salary scales for all consultants.

I would suggest in future that the number of "B" and "C" awards be increased—and possibly a "C plus" award instituted, but would further suggest that they be called "inducement awards"—and to be used as such. In this way, by offering young consultants an inducement, it would perhaps be possible to attract men of the right calibre to work in the less attractive areas of the country, away from the confines of the teaching hospitals. Their inducement award would offset the lack of private practice in such areas.

In such a scheme it should also be possible to allocate awards among the various specialties. I suspect at present that a greater proportion of awards go to those engaged in either medicine or surgery, simply because there are more consultants working in these fields. And yet these specialties are those which attract most private work. An inducement award—equivalent to the present "C" award—could therefore be offered to a new consultant on taking up his appointment in one of the peripheral hospitals. A higher award—such as a "C plus"—could be offered to those engaged in one of the less popular specialties.

I have no personal axe to grind. I do feel, however, that the time has come for consultants to organize their affairs so that they obtain a realistic salary structure, and yet at the same time ensure a fair and equal distribution of their talents throughout the country.—I am, etc.,

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