ceivably be playing a part in the aetiology of other disease entities,[9] and halogenated salicylanilides and related compounds may not be the only drugs retained in this manner.[10]

Dr. R. H. Champion, in the article "Diseases of the Skin: Drug Therapy of Urticaria" (22 December 1973, p. 730) states that "antihistamine drugs may, if necessary, be continued for months or years with safety." How can he be sure of this? How can we be certain that any of the photosensitizing drugs which cover a wide therapeutic range and include several antihistamines are not retained in the dermis for long periods, eventually playing a part in the production of actinic reticuloid in susceptible subjects? Promethazine, an antihistamine, and chlorpromazine, a tranquillizer, two phenothiazine derivatives, may cause persistent photodermatitis which depends upon concomitant oral administration and external application.[11-13] The active photocontact sensitizers cause multiple cross-sensitivities[14] and it is conceivable that one or several photosensitizing drugs retained in the dermis might be immunologically activated by an external powerful sensitizer such as fenticlor, leading to actinic reticuloid.—I am, etc.,

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Looking after Schizophrenics

SIR,—Your leading article (4 May, p. 236) is to me a sad one as you seem to support the view that our old large mental hospitals should not be closed if only because of all the schizophrenics still needing treatment in them. But is the present chronicity rate really necessary? The trouble may be that many schizophrenic patients are being inadequately treated at present. For instance, drugs remedying the affective component of a schizophrenic illness, such as lithium, trimipramine and Parstelin (tranylcypromine + trifluoperazine), are not being used enough, more electric convulsive therapy (E.C.T.) should often be given in early cases, and insulin sopor and modified narcosis with further intensive E.C.T. may be needed in resistant obsessive patients.

In 1961[1] and again in 1965[2] we showed at St. Thomas's Hospital that over 80% of schizophrenics treated actively with modified insulin, E.C.T., and chlorpromazine were at home in a two-year follow-up and mostly at work. And this needed only an average hospital treatment stay of *six weeks*. In 1972[3] we published the results of treatment of 74 schizophrenic and schizoaffective patients, many considered chronic, who were given modified narcosis, phenothiazines, intensive E.C.T., and the combined antidepressants all together, and many were helped who had been sent for considered leucotomy. Fifty-two of the 74 patients were still helped.

On retirement from St. Thomas's in 1972 I was able to re-establish a narcosis ward in a psychiatric nursing home and today, among other patients, 25 often considered "chronic" schizophrenics have had the full combined narcosis and E.C.T. treatment with additional insulin sopor when needed. It has sometimes needed more than 20 E.C.T.s and over two months of narcosis to bring no less than 22 out of these 25 patients into remission. Five patients had been ill with schizophrenia for 10 years or more, eight for five years or more, and 12 for less than five years.

With a really skilled and intensive physical treatment approach there could be many fewer recent schizophrenics going into our old asylums and many are now recoverable in them.—I am, etc.,

WILLIAM SARGANT

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1 Rohde, P., and Sargant, W., *British Medical Journal*, 1961, **2**, 67.
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Confidentiality in Medicine

SIR,—"Whatsoever I shall see or hear in the course of my profession . . . I shall never divulge, holding such things to be holy secrets." On this Hippocratic principle many of us were taught and so have practised. Until recently the public were justified in expecting and respecting our ability to vouchsafe any statements made at consultation.

One of the few disadvantages of group practice is the fact that medical records are now largely kept in a central office to which ancillary workers have ready access. In my opinion the doctor is the patient's confidant and in order to remain so these notes must really not be so generally available to all and sundry, however discreet they may be. To my consternation the other day I learned that some of my colleagues actually encourage the perusal of their files by these very folk. It is surely a very grave matter that should be seriously considered by the profession. Some of our patients are beginning to ask, "Is everything confidential?" Years ago it was taken for granted and I think the decline in standards is sad. —I am, etc.,

JOHN TAYLOR

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Screening—G.P. or Family Planning Doctor?

SIR,—In taking the medical history in the ordinary family planning session factors come to light from time to time—such as a history of hepatitis, a familial history of diabetes, or the possibility of sickle-cell anaemia—in which laboratory investigation is desirable. Conditions requiring further investigation and treatment must be referred to the patient's general practitioner and, ideally, perhaps all such matters should be so referred. But this is often cumbersome, certainly delaying, and unfortunately not always followed through by every G.P. This raises the question who should be primarily responsible for such screening.

G.P.s have direct access to outpatient pathological services. I consider that family planning doctors to have an obligation to arrange certain screening investigations directly as an integral part of advice on oral contraception. If similar outpatient pathological facilities were available to them, provided these were used sensibly and only where indicated, I believe this would greatly improve the work of the family planning doctor and could relieve the load on the G.P. if this procedure is agreeable to him. Where direct referral to the G.P. is not done for any reason he should, of course, always be informed of the results.

It would be interesting and helpful to hear the views of G.P.s (and pathologists) on such direct screening being arranged routinely by the family planning doctor.—I am, etc.,

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Encroachments on the Patient's Responsibility

SIR,—There seems to be a tendency for doctors, and surgeons in particular, to accept responsibility for matters that are not primarily their own concern and, even more alarmingly, to exclude the patient in a somewhat dictatorial manner from any say or responsibility in the matter.

Two recent examples are the question of surgery and the birth control pill and the 10-day rule for *x*-ray examinations. I suggest that it is the responsibility of the prescribing doctor to point out the risks and complications of the pill, and thereafter it is the patient's responsibility whether she takes it or not. While the reasons for the 10-day rule for *x*-ray examinations are appreciated, I see no reason why the patient should not be allowed to waive the rule herself by signing on the request form. To refuse to allow this is an alarming interference with a patient's independence and will cause unnecessary inconvenience and even anxiety.

There is an increased morbidity after surgery in overweight patients, cigarette smokers, etc. The next step could be to refuse these patients the right to surgery rather than the present system of giving strong advice and leaving the final decision to the patient.—I am, etc.,

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Acute Brucellosis Presenting as Epididymo-orchitis

SIR,—The letter (27 April, p. 221) by Dr. D. J. H. Payne prompts us to report an unusual presentation of acute brucellosis in which, happily, the serology was helpful.

A dairy farmworker, aged 32 years, presented to his general practitioner on 7 February 1974 with fever and signs of a right epididymo-orchitis.

Results (Reciprocal Titres) of Serial Serological Tests for Brucellosis

Date	Agglutination Test	Agglutination Test after 2-Mercapto-ethanol	Complement Fixation Test	Anti-human Globulin Test	Agglutination of Fractions	
					IgM	IgG
7.2.74	512	16	<4	<4	32	<4
4.3.74	⩾512	64	64	320	—	—
8.3.74	2,048	64	128	—	—	—
3.4.74	640	256	256	—	—	—

There were no other symptoms at this time. A midstream specimen of urine was examined and found to be sterile on routine culture but contained 30 mg of protein/100 ml and 40 leucocytes/mm^3. Serological tests for brucella were requested since the herd with which he worked, though now accredited, was known to have had brucellosis in the past. After a period of bed rest and chemotherapy with co-trimoxazole 2 tablets twice daily the epididymo-orchitis settled. However, when seen on 15 March he was lethargic with aching limbs, and the serological findings presented in the accompanying table were consistent with a diagnosis of active infection with *Brucella abortus*. Though the initial serological results were consistent with acute infections, in the absence of other symptoms of the disease it was thought originally that the agglutinating antibody was the result of past infection in a man exposed by way of his occupation. After fractionation by gel filtration in a Sephadex G200 column the agglutinating antibody was contained in the IgM fraction, and no IgG was detected by radial immunodiffusion (Hyland plate) in this fraction.

Epididymo-orchitis is described as a complication of acute and chronic brucellosis[1] and occurs in between 2 and 5% of affected males.[2] With infections caused by *Brucella melitensis* in Malta it is reported to be more common in young adults, involves the corpus of the testis, and resolves spontaneously within six weeks.[3] This case is unusual in that the orchitis was the presenting complaint and the patient later developed other manifestations of the disease. Though isolation of the causative organism was not achieved, we believe that we have strong serological evidence of an acute infection. The diagnosis would undoubtedly have been missed if an association had not been made with his work, and this cause of epididymo-orchitis should be remembered by practitioners, particularly in country practice.—We are, etc.,

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1 Williams, E., *British Medical Journal*, 1973, **1**, 791.
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T.V. Programme on Heart Disease

SIR,—The letter from Dr. M. O'Donnell and Mr. K. Sabbagh (18 May, p. 383) was written to draw our attention to—perhaps I should say warn us about—the impending T.V. broadcast of their programme "Cross Your Heart and Hope to Live." Their outline of what the programme would say caused me some disquiet, which turned into outright dismay when I saw it on 21 May.

In support of the broadcast they refer to the article by Turner and Ball.[1] This article was followed by a great deal of correspondence from which it emerged once again that there is still no consensus as to the role of diet in the causation of ischaemic heart disease. There are many serious, knowledgeable, and experienced workers who are far from being convinced that the fat or the cholesterol in the diet is involved in producing the disease, or that a man who decreases his consumption of milk, butter, eggs, and cheese decreases his risk of developing the disease. Still less is there agreement that the risk is decreased by an increased consumption of polyunsaturated fats, such as occur in the margarine for which full-page advertisements appeared in the press almost simultaneously with the broadcast—a most extraordinary coincidence. The only "solid" piece of evidence adduced in the programme that these dietary changes reduce the risk of a heart attack was a distorted interpretation of the 12-year Helsinki experiment, which no unbiased worker can possibly accept as proof of the fat hypothesis.

From the conversations, letters, and telephone calls I have had it is clear that the programme has had a tremendous effect on the viewing public. Many people are now convinced that they must take less milk and cheese and fewer eggs and start eating margarine instead of butter.

Before we ask people to substitute one food for another we should be pretty certain that the food they give up does not reduce the nutritional value of the diet and that the food they take in its place is entirely innocuous. Milk, cheese, and eggs are highly nutritious and they also happen to be relatively inexpensive sources of a wide range of nutrients. If they are excluded from the diet, or considerably curtailed, what are people supposed to substitute for them? More meat and fish, certainly nutritionally desirable but already very expensive? Or more cakes, biscuits, and confectionery, cheaper but certainly nutritionally undesirable?

As for butter, we are told that we should replace this by polyunsaturated margarine. The suggestion that this might increase the risk of cancer has quite correctly now been withdrawn. There remains, however, evidence that it increases the risk of cholelithiasis and that it may induce deficiency of vitamin E. These risks may be small, or indeed they may in due course be disproved, but if they do exist they would be worth taking if we were certain of the advantages of eating polyunsaturated margarine instead of butter. But we are far from being certain that there are any such advantages.

I cannot believe that I am the only person who considers that "Cross Your Heart and Hope to Live" should never have been broadcast. I feel sure that there are many consultants and general practitioners who are now being bombarded with questions by anxious and bewildered patients whom they had reassured about the alleged dangers of dietary fats, and who have now been impressed by the opposite message given so didactically and categorically on that most potent and influential medium, television.—I am, etc.,

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1 Turner, R., and Ball, K., *Lancet*, 1973, **2**, 1137.

Cephaloridine and Gentamicin in Prophylaxis of Surgical Wound Infection

SIR,—Recent work from this hospital[1 2] has shown a significant reduction in the rate of wound infection in a general surgical practice by the use of parenteral or topical cephaloridine. In an attempt to reduce this still further we assessed the value of another potent antibiotic, gentamicin, against cephaloridine in a random controlled trial.

The antibiotic was instilled into the wound before closure in a volume of 2 ml, the dose of cephaloridine being 1 g and of gentamicin in 80 mg. All wounds were studied for a minimum of four weeks. As in previous trials, a wound infection was defined as the discharge of pus from the wound. In this trial for the first time we have divided infections into primary (most of which were relatively minor stitch abscesses) and secondary.[3 4] The latter comprises the group of infections acquired on the basis of a discharging haematoma or fistula, and its prevention does not depend on antibiotic prophylaxis at the time of operation. We have classified wounds as clean or potentially contaminated, and the latter group has been further divided by separating wounds associated with perforated appendicitis and colorectal surgery, which have a considerably higher infection rate.

Of the 603 surgical wounds studied 22 were rejected either because the patient was receiving preoperative antibiotics or died within 14 days. Of the remaining 581, 253 wounds received cephaloridine and 328 gentamicin. The overall primary infection rate was 5·1% with cephaloridine and 7·3% with gentamicin (see table). Statistical analysis using the χ^2 test showed no significant difference in any group.

We have failed to show any significant improvement in the rate of primary wound infection with gentamicin as opposed to cephaloridine, and therefore we will con-

Wound	Cephaloridine		Gentamicin	
	Total No.	No. Infected (%)	Total No.	No. Infected (%)
Clean	139	1 (0·7)	181	4 (2·3)
Colorectal	22	5 (22·7)	28	8 (28·6)
Other potentially contaminated ..	92	7 (7·8)	119	12 (10·7)
Total	253	13 (5·1)	328	24 (7·3)