regarded as incompatible with clinical medicine.

The construction of questionnaires remains a ticklish problem. I have recently attempted to simplify my own questionnaire[1] by identifying and rejecting redundant questions. A correlation matrix was drawn up from 100 consecutive completed forms. The matrix showed which pairs of questions were or were not obtaining substantially the same information from the patient. If they were, then one of the pair could be left out. Furthermore, even elementary cluster analysis of the matrix revealed significant grouping of symptoms. "Neurotic" and "senile" groups were easily definable, and a more detailed factorial analysis is at present being undertaken. The emergence of factors —that is, symptom patterns—raises interesting questions as these do not always seem to correspond to our preconceived notions of so-called objective diagnoses.

Anyone who uses questionnaires will soon find himself fascinated and stimulated by the light they throw on the theory and practice of the medical interview.—I am, etc.,

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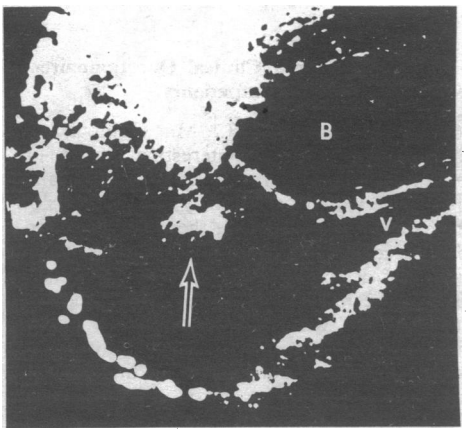
1 Hall, G. H., *British Medical Journal*, 1972, 1, 42.

Radiographic Location of the Dalkon Shield

SIR,—The use of radiographic methods to establish the possible expulsion or translocation of a Dalkon Shield entails considerable irradiation of the patient, especially if one of the "soft tissue" techniques suggested by Dr. Ursula E. Mountrose and Mr. L. Whitehouse (1 June, p. 503) is used and both anteroposterior and lateral films are taken.

In the majority of cases an ultrasonic scan of the uterus through a full bladder is all that is required.[1 2] The procedure is quick, simple, and free from harmful irradiation.



The Dalkon Shield in the uterus is arrowed. The vagina (V) and bladder (B) are clearly seen.

All types of intrauterine devices can be readily shown (see fig.). If the uterus is empty, then *x*-rays will of course be necessary to exclude translocation.—I am, etc.,

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1 Cochrane, W. H., and Thomas, M. A., *Radiology*, 1972, 104, 623.
2 MacKay, D., and Mowat, J., *Lancet*, 1974, 1, 652.

Lactose Intolerance in San Populations

SIR,—In a recent paper (6 April, p. 23) we described the investigation of a San ("Bushman") population for lactose tolerance and animadverted on the possibility (to which others[1 2] have drawn attention) that the supplementation with dried milk of the diet of peoples in which adult tolerance of lactose is very unusual might be inadvisable. We have recently investigated two further Khoisan peoples by the same methods and present a brief summary of our findings.

The populations investigated were: (1) the ǂhuâ:, a small San group found scattered in southern Botswana, the subject of some speculation regarding the affiliations of their language, which appears not to fall into any of the hitherto reorganized Bush groups;[3] and (2) the Nama of Keetmanshoop, representatives of the largest extant group of Khoi ("Hottentots"), resident in the semi-desert south of South-west Africa. The ǂhuâ:, like the !Kung, are not known ever to have been cattle-keepers or milk-drinkers; some of them do, however, live in a client/patron relationship with cattle-keeping Kgalagadi, and the latter, in common with the other Tswana, use both fresh and sour milk.[4] The Khoi peoples first enter recorded history[5] as cattle-keepers, and though the Nama of Keetmanshoop today possess few bovine cattle they do have an abundance of goats, whose milk they drink both fresh and sour.

Lactose tolerance tests were performed on 34 ǂhuâ:, but nine were excluded from the final calculations because of close family relationship or technical faults. Of the remaining 25, two proved to be tolerant, giving a phenotypic frequency for lactose tolerance of 8%. With the exception of three children about 10 years old, all of them intolerant, all persons in the ǂhuâ: series were adult. Among the Keetmanshoop Nama the results, after the exclusion of closely related individuals, showed a 50% frequency among children (4 out of 21); the difference was significant at the 5% level ($\chi=4{\cdot}18$ for 1 D.F.).

The frequency of lactose-tolerant individuals in San populations seems to be turning out to be rather higher than the hypothesis put forward by Simoons,[6] that lactose tolerance represents an advantageous adaptation consequent on the development of dairying, would lead one to expect. Moreover, the significant difference between adults and children among the Nama would appear to favour the possibility that induction of lactase in response to milk-drinking plays a larger part in the production of adult tolerance than has previously been supposed, were it not that the youngest member of our series, a 7-year-old, was lactose tolerant. It seems to us that our latest findings may be of some interest in the study of human evolution.

We should like to thank the Director, Professor J. F. Murray, and the Deputy Director, Professor J. Metz, of The South African Institute for Medical Research, as well as the Directors of Medical Services of Botswana and South West Africa, the medical superintendent and staff of Keetmanshoop Hospital and the District Surgeon, Keetmanshoop, the Rev. Fr. Jansen, the Sister Superior and staff of the Don Bosco Nama Laerskool, Keetmanshoop, Mr. Thompson of the S.A.I.M.R. Laboratories in Keetmanshoop, Mr. Tony Traill, the Ministry of Commerce and Industry, Gaborone, Botswana, and, of course, the 77 volunteers who made the whole project possible. The work of the unit is supported in part by the Medical Research Council of South Africa.

—We are, etc.,

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1 Cook, G. C., and Kajubi, S. K., *Lancet*, 1966, 1, 725.
2 Jersky, J., and Kinsley, R. H., *South African Medical Journal*, 1967, 41, 1194.
3 Traill, A., *African Studies*, 1973, 32, 25.
4 Schapera, I., *The Tswana*. London, International African Institute, 1953.
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6 Simoons, F. J., *American Journal of Digestive Diseases*, 1970, 15, 695.

B.M.A. and B.M.S.A.

SIR,—On behalf of past members of the British Medical Students Association, we would like to express our sincere gratitude to the B.M.A. for all the help that they gave the association over the years. We would also like to thank Mr. A. E. Vince for his hard work and forbearance in dealing with our many problems.—We are, etc.,

H. G. STURZAKER
J. E. P. SIMPSON
ALAN BAILEY
MICHAEL GARRAWAY

Harrow, Middlesex

Temporarily Dependent Patients in General Practice

SIR,—I would like to reply to the letters of Drs. Joyce E. Leeson and R. J. Robertson (18 May, p. 385). It is impossible to say whether the patients described in my article (30 March, p. 625) are ill or not ill in the absence of a universally accepted definition of illness; hence my use of such terms as "undiagnosed," "succesfully untreated," and "ill in the accepted sense of the word."

These patients were called "temporarily dependent" because, having come to their doctor with no objective evidence of disease and having been given no pharmacologically effective treatment, they made no further effort to seek help either by returning to me, as they were invited to do, or to any of my three partners, as they could easily have done. The implication is that in that particular situation at that particular time they were in a state which was altered and improved by reassurance from their doctor. Dr. Robinson's point is well taken. It would have been more accurate to say "patients who received no pharmacologically effective treatment."—I am, etc.,

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Drugs and Xylose Absorption from Intestine

SIR,—Absorption of xylose from the human intestine has been reported[1] to be decreased by metoclopramide and increased by propantheline. These drugs also alter the absorption of paracetamol[2] and digoxin.[3] These effects were thought to be due to delayed gastric emptying[2] or to altered gastrointestinal motility.[3] The indirect evidence quoted in support of this view does not ex-