themselves to be vaccinated, who comprise most of the worrying cases that we have seen. Certainly some of them are infected by vaccinated siblings with modified whooping cough unlikely to be recognised as such prospectively. A further breakdown of Dr Jenkinson's figures would help to answer this question.

It may also be of interest to report a recent experience involving a child who developed fits followed by developmental standstill after vaccination and whose younger unvaccinated sibling now shows signs of what must be the same condition, though a precise diagnosis has not been made. Perhaps vaccination precipitates rather than causes brain damage in such cases.

JOHN A DAVIS

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Manchester

Misdiagnosis of amoebiasis

SIR,—Congratulations on your excellent leading article (5 August, p 379). I agree with the views of Dr T H Foley and his colleagues (p 428), also clearly stated in your leader. It seems a pity that the supraregional specific unit for the diagnosis of amoebiasis, developed by Air Vice Marshal Stamm in St Giles's Hospital and already well known nationally and internationally, should have been so abruptly absorbed into a more general department of pathology, where it will have to compete with routine diagnostic practice. In this respect I derive little comfort or sense of urgency from the assurances of Drs D S Ridley and D C Warhurst (26 August, p 632) that the services provided by the unit "are unabated and continue to be freely available, though the unit now operates with a reduced staff." I hope the Department of Health and Social Security will accept Dr Foley's advice and emphasise the importance of the diagnosis (and misdiagnosis) of amoebiasis, and will also give the widest publicity within the profession to the facilities which are available.

I was pleased to read that Sir Francis Avery Jones (19 August, p 565) agrees that "the diagnostic pitfall between ulcerative colitis and amoebiasis is . . . a very real one." His statement that in patients diagnosed as ulcerative colitis but unresponsive to steroids the diagnosis should be quickly reviewed is undoubtedly valid. However, I wish he had put it the other way. As your leading article infers, the real point is to exclude amoebiasis in all cases of suspected ulcerative colitis or Crohn's disease *before* using steroids or surgery.

The diagnosis of amoebiasis is especially important today because of the increasing risks of acquiring the more virulent forms of the infection abroad as the number of travellers goes up steadily. It may be relevant here to mention a guess we made in Liverpool at the end of the second world war, when we estimated, as a projection of the number of cases of amoebiasis we diagnosed and treated, that probably several hundred thousand members of the British Forces may have returned home infected with *Entamoeba histolytica*. At the time, with only a few hundred "tropical" beds in the whole country, it was impossible to deal with such a situation in any depth.

From subsequent records it would seem that most infections must have been overcome spontaneously. But as the age group involved rises I wonder how many of them are still with us, tagged as ulcerative colitis or suspected of colonic carcinoma. This is surely where a specific and well-advertised diagnostic centre for amoebiasis would have been of real value in resolving some of the current confusion.

BRIAN MAEGRAITH

Liverpool

SIR,—Your leading article "Misdiagnosis of amoebiasis" (5 August, p 379) and the letters from Dr T H Foley (p 428) and Sir Francis Avery Jones (19 August, p 565) emphasise the need for more awareness of this disease as a possible diagnosis and for wider use of the specialised laboratory investigations that may be needed for its recognition. Details—including names, addresses, and telephone numbers—of the reference facilities available for diagnosing this and other exotic parasitic infections are to be found on pages 27 and 28 of the *Public Health Laboratory Service Directory*.

May I use your columns to inform pathologists and others who have not already received the *Directory*, or who may wish to receive additional copies, that they are obtainable on request from: the Secretary, Public Health Laboratory Service Board, 61 Colindale Avenue, London NW9 5EQ?

J E M WHITEHEAD

PHLS Head Office,
London NW9 5EQ

SIR,—Drs D S Ridley and D C Warhurst (26 August, p 632) miss the point in their assertion: "The same could be said of malaria." There has been a malaria reference centre for many years, and, although it may have made contributions to the epidemiology and academic knowledge of malaria, it has achieved little, if anything, towards reducing mortality from malaria in the United Kingdom. Deaths from malaria in the United Kingdom are almost always caused by infection with *Plasmodium falciparum*; the patient is initially diagnosed by his general practitioner as having influenza; when he is almost moribund he is admitted to hospital, where the correct diagnosis is made, but the patient dies within 48 hours of admission.[1]

Amoebiasis, on the other hand, is a much more chronic condition and the fault in diagnosis is usually made in hospital, where the patient has resided undiagnosed for weeks or months (24 May 1975, p 452). In this case a well-publicised reference laboratory can save lives.

If the reference laboratory at the hospital for tropical diseases "meets the need," how is it that the patient of Dr T H Foley and others (5 August, p 428) died? Could it be that the amoebiasis unit has lost its identity?

No one has suggested that a "reference centre can undertake the first-line investigation of all the stool specimens from all the patients who might have amoebiasis." Your leading article (p 379) suggested that "the right specimens, taken and preserved in the right way, [should] be sent to a laboratory where adequate skill is available." This does not mean that all faecal specimens should be sent to a central reference unit, but that, as Drs Ridley and Warhurst suggest, there should be more thorough training of more pathologists and technicians in diagnostic pathology. Preserved specimens are very satisfactory if properly taken, but despatch to a reference laboratory should be used only for second-line investigation, when some unidentified object resembling an amoeba has been seen or when a biopsy specimen requires more expert examination.

I regret that I must doubt the accuracy of Dr S G Hamilton's (26 August, p 632) "diagnostic-therapeutic test" in the form of metronidazole. Anaerobic organisms are the causative agents of a considerable proportion of abscesses of the liver and metronidazole is a very effective antibiotic against anaerobes; therapeutically the result may be excellent, but diagnostically response to metronidazole is open to doubt.

I am very glad to see that Sir Francis Avery Jones (19 August, p 565) agrees that the clinical distinction between ulcerative colitis and amoebiasis is difficult, but I would make a plea for serology for amoebiasis to be carried out *before* the giving of steroids and *before* the surgeons sharpen their knives.

W P STAMM

May and Baker Ltd,
Dagenham,
Essex

[1] *The Times*, Law Report, 5 November 1975.

Course in diagnostic parasitology

SIR,—Drs D S Ridley and D C Warhurst (26 August, p 632) plead for a much more thorough training of pathologists and technicians in diagnostic parasitology. In this context we thought we should mention the situation in Liverpool.

Ever since 1966, at the request of the director of the Public Health Laboratory Service, we have been running a short course on diagnostic parasitology as an annual event. The programme lasts for five days and is designed for people with a high degree of technical competence but with little or no knowledge of medical parasitology. The ground covered is essentially practical and directed towards the recognition of parasitic infections which are not uncommonly imported into this country. The work takes place in the laboratory, with some informal talks but no formal lectures. The inaugural course was held in May 1966, when 26 members of the PHLS attended. Since then 300 persons have attended this course.

It is unfortunate that the Institute of Medical and Laboratory Science ceased to offer parasitology as a subject in 1975. There is an obvious need to reconsider this premature decision.

W PETERS
H M GILLES

Liverpool School of Tropical Medicine,
Liverpool

Sexual pressures on children

SIR,—Does the occurrence of two almost identical paragraphs, each containing approximately 40 words, appearing almost side by side in two separate and independent letters (19 August, p 564) from doctors representing the Family Planning Association and the Health Education Council constitute the first authenticated example of telepathy

between doctors or can any of your readers cite another example of this phenomenon occurring over the last 121 years of the *BMJ*'s history?

THOMAS WARD

Stowmarket, Suffolk

SIR,—I joined the Responsible Society some years ago because I felt the young needed protection not only against sexual exploitation but from all sorts of pressures—to spend beyond their means, take out credit cards, drink brandy, and all the other money-gathering ploys devised for them by those that Dr S E Ellison and his colleagues (29 July, p 353) would have us believe are their betters. Alas, I found the society to be as obsessed with sex as those they sought to condemn. At one point, and very much as a last resort, I was asked to appear on television in a programme on premarital sex and it is interesting, in the light of your recent correspondence, that when I rang the producer she made it clear that it was confrontation and not reasoned comment she was after. When I saw the programme I was thankful I had had no part in it, and when I told the secretary of the Responsible Society that I could not, in all honesty, condemn all premarital sexual experience I received no more literature from the society. Obviously I was not responsible enough.

This distresses me not, but the attitude of Dr Ellison and his colleagues does. I firmly believe that all medical consultations are confidential and any child of any age has the same rights in that respect as an adult. Young people desperately need dispassionate counsellors, or at least listeners, and I can only feel that the doctors who signed the letter hold the views they do because few teenagers confide in them, their attitudes being known. I am left with one troublesome doubt. Do the medical signatories of that letter warn their young patients that "anything they may say..." etc, or do they, to use school parlance, sneak behind their backs?

ANNE SAVAGE

London NW11

Postoperative pain

SIR,—Your excellent leading article (19 August, p 517) on postoperative pain could not be expected to cover all aspects of management. Analgesics and regional analgesia are not always uniquely indicated. Postoperative pain can be a warning symptom of a serious complication. In these days of peroperative prophylactic heparinisation, increased demand for postoperative analgesia, associated with reluctance to move in bed, may indicate an enlarging wound haematoma. This is especially likely if a transverse suprapubic incision has been used in an obese woman and the wound closed without suction drainage. Should drainage be used the blood loss is obvious. Slow persistent intraperitoneal and retroperitoneal bleeding may have a similar effect to that of a wound haematoma, but tachycardia, hypotension, and abdominal distension should lead to early diagnosis. Retention of urine, which may occur after lower abdominal as well as pelvic operations, may cause pain: analgesia rather than catheterisation may then be disastrous. The headache after a dural tap encountered during epidural analgesia demands skilled management by a "blood patch" rather than simple analgesics.

Postoperative pain is aggravated by insomnia, often the result of discomfort due to malarrangement of pillows, intravenous infusions, and, not least, noise. After lower abdominal and pelvic operations performed under epidural analgesia which has been continued to relieve postoperative pain patients recover remarkably smoothly with significant reduction in the time spent in hospital as shown by Dr Mogens R Brandt and others (29 April, p 1106). Such anaesthetic techniques, however, are time consuming and perhaps should be reserved for radical pelvic surgery and vaginal hysterectomy and for patients who have been cured of drug addiction.

ALAN M SMITH

New Cross Hospital,
Wolverhampton

SIR,—I refer to your leader on postoperative pain (19 August, p 517). There is a simple measure which I have found very useful in managing painful states such as terminal malignancy. This is the use of a pain chart. I believe it would be useful in the management of postoperative pain.

At its simplest the nurse is asked to question the patient every hour or half-hour on his amount of pain and record his subjective estimate on a chart, together with a record of analgesic drugs given. As you say, pain relief postoperatively is a matter which tends to be treated in a haphazard way by junior doctors and nursing staff. It is remarkable how quickly a proper analgesic regimen can be established by a simple and systematic observation of pain.

P W HUTTON

Shifnal, Salop

British Epilepsy Association

SIR,—"What's in a name?" you might ask. Quite a bit when we are wrongly identified in your leading article "Patient package inserts" (26 August, p 586) as the British *Epileptic* Association. It's the fits that are "epileptic," not the 300 000 people in the UK with a tendency to have them.

Our work on their behalf as people rather than "patients" takes us into all areas of life and work and we produce an extensive range of informative literature for professionals and lay people in addition to the item your article mentioned. If only more *BMJ* readers would acquaint their patients with our existence and services, then the incidence of social problems often associated with epilepsy would be much diminished.

ANDREW GORDON CRAIG
Education Secretary,
British Epilepsy Association

Wokingham, Berks

**We apologise to the British Epilepsy Association for our inadvertent misspelling of its name and welcome this opportunity to give further publicity to its valuable activities.—ED, *BMJ*.

Medicine and the media

SIR,—I have been interested in the correspondence on this subject in your columns recently. I would like to offer my own experience, some of which supports the protestations of Dr D Tunstall Pedoe (29 July, p 351) while some provides a happier tale.

A few years ago a series of four television programmes were made at Guy's Hospital, London, by Trevor Philpott and his team from the BBC. I was asked to participate and spent much time and effort explaining and attempting to demonstrate the work of the consultant physician in geriatric medicine. I was not allowed to participate in the editing of the film or to see the finished version before its public showing and I had the usual fears that the message might be distorted. Not so. Apart from a little overemphasis on the psychiatric aspects of the elderly the BBC team did an excellent job—as evidenced by the many kind comments which have reached my ears over the ensuing period. The secret seems to be to give time, and then more time, to repeated in-depth expositions of the subject matter and the philosophy of one's contribution and to have a strong, intelligent, experienced, and sympathetic interviewer, like Trevor Philpott, who is willing to listen, absorb, and digest the material and to keep the editors and producer from injecting their own bias or from distorting the material for "entertainment" purposes. One requirement is clearly for the producer to retain sufficient unbroken stretches of film or interview to get ideas across in their proper context so that the argument may be presented from various standpoints.

It was quite different when I was asked to give an interview for the BBC Radio 4 programme *5 pm*. I taped a 30-minute interview with the reporter, at three hours' notice, concerning various aspects of aging. My message was (as usual) one of optimism, since it is my contention that when considering the problems of old age only professional optimism can lead to the achievement of the best results. In the event the item was given an extremely brief airing and followed the usual format: the announcer posed a question to the audience (a question which had not been asked me by the reporter) and then used a few seconds of my taped interview to provide an "answer." In so doing he managed to represent my view of old age as totally opposed to the true one which I had given to the reporter in such careful detail; and this message of apparent gloom was followed by a facetious closing remark by the announcer which showed that even he did not believe any of it!

To conclude constructively, I believe that interviews for the media should be given by doctors only if one of two conditions are satisfied: (1) confidence in the integrity of the interviewer *and his power within his organisation*; or (2) involvement at some point in the editing process.

D E HYAMS

Westfield,
New Jersey

SIR,—The programme on multiple sclerosis shown on BBC2 on 11 August is described as "disappointing" in the column headed "Medicine and the Media" (19 August, p 560). I would go further and say it was distressing to those afflicted with this condition.

It is now eight years since I retired from practice but I still pay friendly visits to a patient whose condition has been deteriorating for more than 20 years. In spite of his steady