recorded 62 of their 100 patients and 35 of their 100 controls would have been classified as regular cornflake eaters ($\chi^2 = 14{\cdot}6$, $P < 0{\cdot}001$).

They have thus shown that 53% of regular eaters of cornflakes abandoned the habit when they developed Crohn's disease, bearing out my comments (9 September, p 767) on the findings of Drs L N J Archer and R E Harvey (19 August, p 540). I accept that recollection may be faulty, but the authors have recorded these data and the inference is there to be drawn.

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[1] James, A H, *British Medical Journal*, 1977, **1**, 943.

## Inadequacy of information on side effects

SIR,—At this hospital three patients have developed haemolytic anaemia due to phenazopyridine (Pyridium) in the past five years. They all showed exactly the same haematological features as the patient described by Drs H C Drysdale and M D Hellier (7 October, p 1021) and in all three the haemolysis ceased when the drug was stopped.

With this experience in one small health district, I find it difficult to believe that this particular complication of Pyridium therapy is as rare as the literature and Dr Witherspoon (p 1021) suggest. It should certainly not be classed as a "rather rare suspect event."

C J T BATEMAN

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## Computer confidentiality

SIR,—The second of the three ethical principles which the Child Health Computing Committee has put forward to govern computing systems (11 November, p 1382) does not protect the right of the patient's parents to control the distribution of medical information about their child. I consider the following addition (in italics) to be essential:

(2) "Access to identifiable information held in medical records is to be confined to the author and to the person clinically responsible for the patient during the episode for which the data has been collected (or their successors) unless specifically authorised by the clinician in the clinical interest of the patient *and by the patient (or his or her parent or guardian)*."

I would have thought that this point was elementary and am very surprised by the apparently widespread British practice of sending copies of children's medical reports to school medical authorities without the knowledge and consent of the parents. Such behaviour, irrespective of its motives, should be made clearly illegal. It cannot be excused by saying that it is "well meant" or "for the ultimate good of the patient"; it is for the patient (or his parents) to decide what is for his ultimate good and it is for him to decide whether a copy of a medical report should be sent to the school medical authorities, Uncle Tom Cobley, or anyone else. As soon as patients learn that a "mailing list" (of which they have no knowledge) may be appended to any information which they divulge in the consulting room they will learn to be selective when talking to their doctors. And that, as you probably realise, would be the beginning of the end of the doctor/patient relationship which people often enthuse about.

PATRICK A CASEY

Wohlen, Switzerland

## Scombrotoxic fish poisoning?

SIR,—I recently observed a reaction which occurred 30 minutes after eating a Bombay duck, which is a type of dried fish. The patient developed headache and nausea concurrently with a flushing of the face, chest, and shoulders, and the lips became swollen. The redness of the face and upper trunk gave way to a blotchy urticarial pattern with weals after a further five minutes. An intramuscular injection of chlorpheniramine maleate 10 mg was followed by a dramatic improvement and one hour later the patient was completely recovered and had no further relapses.

I am not sure whether this reaction was due to scombrotoxic fish poisoning (9 September, p 739) or to simple allergy, but the patient has no allergic history and has eaten Bombay duck since with no ill effects.

A J WARING

Limavady, Co Londonderry

## Intrauterine hiccup

SIR —Having just returned from five years of North American investigative medicine I find it delightful to read that the diagnosis of intrauterine hiccup is yet another use for real-time ultrasound scanning (Dr I Swann, 25 November, p 1497).

Most senior house officers who deal with postnatal patients would confirm our own clinical impression that intrauterine hiccups occur frequently (approximately one per 50 live births). They are noted by the end of the second or beginning of the third trimester and recur in subsequent pregnancies. They frequently occur at the same time of day for each patient and persist after birth. All the babies that we have seen have been normal. Most of our mothers correctly diagnosed themselves antenatally. This was usually confirmed by their midwife and so far there has been no need for a scan.

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## Conservation surgery for laryngeal cancer

SIR,—Your leading article (11 November, p 1318) on this subject was timely, factual, and well informed. In the last paragraph you ask whether British laryngologists are perhaps unduly hesitant to use these techniques—presumably supraglottic partial laryngectomy—for irradiation failures. I therefore write to assure you that our unit at this hospital is devoting time and study to this problem.

Patients with suitable lesions are uncommon and assessment of the extent of disease after irradiation so difficult that a firm decision for a partial operation can be made only on the operating table. In my experience no more than a small minority prove to be treatable and curable in this way, the majority requiring total laryngectomy. Nevertheless, such efforts are rewarding and further salvage may be possible by total resection if recurrence takes place. It must also be said, with emphasis, that all patients with laryngeal cancer at any site must be observed before and regularly throughout irradiation treatment by the radiotherapist and the surgeon, who will operate if treatment fails. Only in this way can the surgeon hope to gain an approximate idea of the extent of disease. It is also my belief that by ignoring the curative value of treatment by initial supraglottic laryngectomy as now demonstrated in many centres outside Britain we are condemning more patients to eventual total laryngectomy if irradiation fails.

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## Nutrition and the cancer patient

SIR,—Mr A J Strain and his colleagues (4 November, p 1295) discuss the unavailability of appropriate animal models for the study of cancer-associated cachexia. I would certainly agree that the readily available rapidly growing transplantable tumours of laboratory rodents do not provide realistic models of cachexia in that significant loss of body weight does not usually ensue until tumours approach 40% of the body weight. Large tumours, especially when ulcerated, are commonly associated with extreme anaemia; the coincident weakness may itself discourage animals from eating and so give rise to a constitutional state indistinguishable from starvation.

In my experience of over 30 mouse tumours which have been maintained by serial transplantation for prolonged periods wasting is rarely seen in mice bearing tumours of up to 3 g ($\approx 10\%$ of body weight). The exceptions have been three squamous carcinomas (one arising in skin and two in the fore-stomach); all have been associated with extreme wasting at relatively small tumour sizes. In a comparative study of one of these tumours with a mouse mammary carcinoma (MMC) growing at about the same rate we observed that the squamous tumours when grown to a mean weight of only $1{\cdot}1 \pm 0{\cdot}8$ g were associated with a mean loss of body weight of 16% (range 0-30%). In contrast no loss of body weight was associated with growth of the MMCs to a mean weight of $4{\cdot}6 \pm 2{\cdot}3$ g. The wasted mice bearing squamous carcinomas rapidly became moribund and showed a depression of blood glucose concentration from the normal 8 mmol/l (145 mg/100 ml) to between 5·6 and 4·4 mmol/l (100 and 80 mg/100 ml) (as seen in mice starved for 24 h). Wasted mice did not appear to reduce their food intake (as measured by reduction in the weight of the food pellets to which they had access), but we did have some evidence that the food taken was not being masticated or swallowed. Since one of our squamous carcinomas has been shown to produce epidermal chalone[1] we entertained a hypothesis that such chalone inhibited mitoses in the normal squamous epithelia of tumour bearers and that this could reduce cell replacement in squamous mucosa and so give rise to painful mastication and swallowing. In support of this hypothesis was our finding that the mitotic rate in squamous epithelia (tongue, oesophagus, and fore-stomach) of wasting mice was reduced to between 50% and 20% of normal. However, we could not establish whether the mitotic inhibition preceded or followed the wasting.

It is of interest that the diet given to mice which exhibited cachexia was a standard formulation and fully supported weight onput of weanlings. Wasting was not seen when the diet was changed to one with a higher fat content.

The point to be made here is that distinctive

cachexia-inducing tumours *are* encountered in mice; a chemically induced cachexia-producing murine gastric carcinoma has been described previously.[2] It is suggested that the use of such tumours would avoid the complications underlying the system developed by Dr Strain and his colleagues—that is, xenografts of a human hypernephroma in immunodepressed mice. In the case of our tumours the effect of diet modification would seem to provide a valuable opening for experimental investigations relevant to clinical cancer cachexia.

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[1] Bullough, W S, and Deol, J U, *European Journal of Cancer*, 1971, **7**, 425.
[2] Liebelt, R A, *et al*, *Proceedings of the Society for Experimental Biology and Medicine*, 1971, **138**, 482.

## Squares, cubes, and power

SIR,—Your semantic juggling with O-level arithmetic (25 November, p 1501) really will not do for a supposedly science-based journal. *Of course* Mr Redman is right—surface increases as the square and volume as the cube of length, as every schoolchild knows. Volume therefore increases as the 3/2 power of surface, which is why small particles are more soluble than large and large vessels cool more slowly than small ones.

Power of a muscle depends on its cross-sectional area and its length—that is, on its volume so your argument is fallacious. Bridges have nothing to do with it as they do not have any power; the reasons why they sometimes fall down are most lucidly explained in Gordon's *Structures*.[1]

Why older spina bifida patients fall more than young ones I do not know but I expect there are a number of reasons. Reliance on dubious arithmetic will not discover them.

B M WRIGHT

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[1] Gordon, J E, *Structures or Why Things Don't Fall Down*. Harmondsworth, Penguin Books, 1978.

## Physiotherapy in obstetrics and gynaecology

SIR,—As a specific interest group of the Chartered Society of Physiotherapy specialising in obstetrics and gynaecology we are seriously concerned that many opportunities are missed for assessing and treating women with symptoms which arise from laxity of the pelvic floor primarily related to childbearing.

We would like to make some suggestions. The postnatal examination six to eight weeks after delivery is usually the first occasion on which the pelvic floor can be assessed, and digital examination per vaginam affords an opportunity to feel the contracting levator ani. This examination often reveals weakness of these muscles which would respond to treatment—re-education by means of exercises—as a valuable preventive measure against future gynaecological problems.

In the hands of a specialist physiotherapist this treatment is simple and economical in terms of patient and professional time. The patient is given a very simple description of the pelvic floor and the aims of treatment, followed by digital examination to assess the tone of the levator ani as well as to instruct the patient in the use of the muscles. Once the method is learnt the patient is encouraged to contract the muscles throughout the day at regular intervals without the need to interrupt normal activities. A monthly check is all that is required, and three months is the average length of treatment.

This simple preventive regimen can be useful for the treatment of genuine stress incontinence, moderate degrees of genital prolapse, and diminished sexual sensation (affecting both partners) where this is due to laxity of the pelvic musculature, and if its application were more generally appreciated by the family doctor, the midwife and the health visitor there would be far fewer women requiring surgery.

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Chairman,
SHEILA HARRISON
Ex-Chairman,
Association of Chartered Physiotherapists in Obstetrics and Gynaecology
DOROTHY MANDELSTAM
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## Lithium carbonate and dental caries

SIR,—I wish to draw attention to what appears to be an additional hazard of treatment with lithium carbonate.

A number of patients on prolonged prophylactic treatment with this drug have reported an unusual deterioration of their dental condition, with an aggravation of dental caries. In one patient treated by Dr A Markitziu at the Department of Oral Medicine, Hebrew University-Hadassah School of Dental Medicine, sialography of the left parotid gland showed early atrophy and sialometry recorded 1 ml in 15 min. In all these patients thyroid function tests gave results within normal limits.

It is suggested that patients on prolonged lithium medication should pay special attention to dental care.

AARON GILLIS

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## High-density lipoprotein cholesterol in diabetes

SIR,—Dr A L Kennedy and his colleagues (28 October, p 1191) confirm the work of others[1 2] in showing normal or even elevated plasma concentrations of high-density lipoprotein HDL cholesterol in insulin-dependent diabetics.

Nikkila[3] has suggested that a major determinant of plasma HDL cholesterol concentration, in both normals and diabetics, may be the rate of catabolism of the triglyceride-rich lipoproteins (chylomicrons and very-low-density lipoproteins), which is in turn partly dependent on adipose tissue lipoprotein lipase activity. The levels of HDL cholesterol found in various diabetic groups may therefore depend strongly on their degree of hypertriglyceridaemia as well as the type of diabetes We have studied a group of normotriglyceridaemic, non-insulin-dependent diabetics[4] and found their mean plasma HDL cholesterol concentration did not differ significantly from that of controls.

Probably because non-fasting blood samples were taken, the authors give no information on plasma triglyceride concentrations, thus making it difficult to interpret the lowered HDL cholesterol levels in their non-insulin-dependent diabetics. The lowered HDL cholesterol levels found in diabetic groups of various types in the Framingham study[5] and by Lopes-Virella *et al*[6] were almost always associated with hypertriglyceridaemia.

We therefore feel that in population studies of plasma HDL cholesterol concentrations fasting samples are preferable to non-fasting, since the triglyceride status of the groups can then be adequately defined. The use of an unstated number of blood donors as part of the control group for HDL comparisons, as in this study, would also make it difficult to define some other important determinants of HDL cholesterol concentrations, such as alcohol intake[7] and oral contraceptive use.[8]

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[1] Nikkilä, E A, and Hormila, P, *Diabetologia*, 1976, **12**, 412.
[2] Mattock, M B, Fuller, J H, and Stringer, K, *Diabetologia*, 1977, **13**, 417.
[3] Nikkilä, E A, *European Journal of Clinical Investigation*, 1978, **8**, 111.
[4] Mattock, M B, *et al*. To be published.
[5] Gordon, T, *et al*, *Annals of Internal Medicine*, 1977, **87**, 393.
[6] Lopes-Virella, M F L, Stone, P G, and Colwell, J A, *Diabetologia*, 1977, **13**, 285.
[7] Castelli, W P, *et al*, *Lancet*, 1977, **2**, 153.
[8] Bradley, D D, *et al*, *New England Journal of Medicine*, 1978, **299**, 17.

## Antibiotics for cough and purulent sputum

SIR,—The failure of the Netherlands College of General Practitioners to recruit sufficient patients to their controlled trial of antibiotic therapy in patients with cough and purulent sputum in the absence of chest signs has been attributed by Dr S Thomas (11 November, p 1374) to a difference in consulting rates for the symptom complex between the United Kingdom and the Netherlands.

Our original study[1] was extended by a year to permit recruitment of sufficient patients and so we agree that this is not a common condition, even in the United Kingdom. The importance of the research was to establish whether acute infections below the larynx associated with purulent sputum need antibiotic therapy and our finding of a null conclusion in otherwise healthy adults has been confirmed by two other studies[2 3] in children. Whether these results will modify established prescribing habits remains to be seen, but we hope that they will modify what is written in textbooks and lecture notes about respiratory infections.

The doctors in our study did differ in the number of cases they recruited into the study and we suspect that part of the reason for this was that a symptom complex was identified which hitherto had been regarded as part of either upper or lower respiratory tract infection. We coined the term middle respiratory tract infection (MRTI) to describe it and we have preliminary evidence that doctors who took part in our trial are more likely to use that diagnostic label now than those who did not participate. This suggests that