

ments committees, grant awarding bodies, etc, are more impressed by the quantity than by the quality of published work.

Unfortunately, the medical profession cannot seek guidance in proper behaviour from the scientific community, whose morals are questioned because of duplication and fraud.² Among so called pure scientists the ethic of "publish or perish" seems even more revered. Only when it is agreed that scientific communications are intended to further knowledge, rather than careers or egos, will we reach the peak of the present, senseless, exponential growth in the number of journals and publications.

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1 Lock S. Repetitive publication: a waste that must stop. *Br Med J* 1984;288:661-2.

2 Altman L, Melcher L. Fraud in science. *Br Med J* 1983;287:1569-70.

City of the plain speaking

SIR,—I have no wish to attack the homosexual way of life but on reading the leading article by Drs G Leach and A Whitehead on AIDS (23 February, p 583) I was struck by the fact that the word "gay" was used 12 times—11 as an adjective. Gay to most people means happy and joyful and to debase the English language by applying it to telephone switchboards and those practising anal intercourse is an abuse of our language in a learned journal. As female homosexuals are happy to be named after the locality of their way of life cannot the males be known after their ancient city of origin?

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Points

Application of viewdata systems to medicine

Dr GÜNTHER PFAFF (Department of Paediatric Surgery, University of Heidelberg, D-6900 Heidelberg) writes: After reading a recent article on a videotex system for poisons information¹ I arranged for an access code with the authors and have since repeatedly used the Edinburgh system. No technical problems—except for busy international telephone lines at times—were encountered. The poisons information system is in my experience one of the best viewdata applications currently available in medicine. The simplicity of its use and a favourable cost/benefit relation for the mediation of medical expert knowledge invite the further development of videotex, particularly now that new standards (CEPT, Picture Prestel) allow for better use of graphic presentation.

1 Proudfoot AT, Davidson WSM. Acceptance of viewdata for poisons information. *Br Med J* 1984;289:1420-1.

Precipitation of laryngeal obstruction in acute epiglottitis

Dr M H YARDLEY (Taunton, Somerset TA2 7HD) writes: The paper by Dr William O Tarnow-Mordi and others (23 February, p 629) serves as a reminder of the serious and life threatening nature of acute epiglottitis. However, the opening two sentences should be qualified by the words "in paediatric practice." Contrary to widespread belief, acute epiglottitis and supraglottitis do

occur in adults, in whom they may be just as life threatening as in children, though the progression is usually not quite so rapid. There is an impression that it is becoming much more common, and many cases have been reported from North America.¹ . . . Although in adults the condition may be due to infection with *Haemophilus influenzae*, streptococci and staphylococci have often been implicated, as have pneumococcus in immunocompromised patients² and other organisms on isolated occasions.^{3,4}

1 Sarant G. Acute epiglottitis in adults. *Ann Emerg Med* 1981;10:58-61.

2 Shalit M, Gross DJ, Levo Y. Pneumococcal epiglottitis in systemic lupus erythematosus on high dosage corticosteroids. *Ann Rheum Dis* 1982;41:615-6.

3 Lindquist JR, Franzen RE, Ossoff RH. Acute infectious supraglottitis in adults. *Ann Emerg Med* 1980;9:256-9.

4 Berthiaume JT, Pien FD. Acute klebsiella epiglottitis: considerations for initial antibiotic coverage. *Laryngoscope* 1982;92:799-800.

Further developments in psychogeriatrics in Britain

Dr J M A SMITHIES (Moorgreen Hospital, Southampton) writes: Professor Elaine Murphy (16 February, p 562) is anxious to convert good general psychiatry trainees into enthusiastic psychogeriatricians, but to aim to do this at senior registrar level is leaving matters a little late. My interest in psychogeriatrics was kindled by working in an excellent unit as a registrar, and I seized the chance to apply for my present "one holder" post advertised while I was waiting for my MRCPsych result. It was the first senior registrar job I applied for and I certainly do not consider myself a member of the "second best brigade." I believe, from my own and fellow trainees' experience, that subspecialty choices in psychiatry are usually made at registrar level, and it is then that good psychogeriatric training can improve recruitment.

Talking points in child abuse

Dr B THALAYASINGAM (Paediatric Unit, Dryburn Hospital, Durham DH1 5TW) writes: Many paediatricians will agree with Dr D A P Addy that the diagnosis of child abuse often gives scope for dispute (26 January, p 259). Dr Stephen Cordner suggests seeking the advice of a forensic pathologist to help solve the diagnosis (16 February, p 564). I am sorry that neither suggest seeking the help of a consultant child psychiatrist, who would not only help with the diagnosis but also treat the family as a whole. I find the child psychiatrist an invaluable member of the team sharing the burden of responsibility and the correct management of the child. A previous leading article¹ also ignored the value of child psychiatry and missed the opportunity to encourage courts of law to call on child psychiatrists to help with the difficult diagnosis.

1 Anonymous. Child abuse: the swing of the pendulum. *Br Med J* 1981;283:170.

Is the flow rate used to drive a jet nebuliser clinically important?

Dr IAN W B GRANT (Kirknewton, West Lothian EH27 8EA) writes: I can assure Drs R L Page and A G Wardman (23 February, p 640) that I still approve of the cautious and selective use of home nebulisers in the United Kingdom and indeed throughout the world. . . . Much tighter control has always been exercised on this form of treatment in the United Kingdom than used to be the case in New Zealand.¹ Normally air compressor nebuliser units are loaned by hospitals on the recommendation of respiratory physicians or paediatricians, but patients can also obtain them, if so advised by their doctors, by private purchase or from a charitable body. In both circumstances, however, salbutamol or terbutaline solution for use with these nebulisers is unobtainable without a prescription. This safeguard remains, regardless of

whether a disposable nebuliser (still available only from a hospital) is driven by an air compressor or by an oxygen cylinder (5 January, p 29). The doctor who prescribes the nebuliser solution (and, incidentally, the oxygen cylinder) should, and no doubt will, give the patient detailed instruction on how to administer and monitor this form of treatment. It is therefore illogical, and also a little unfair to general practitioners, to suggest that the use of oxygen cylinders instead of air compressors for nebulisation of bronchodilator drugs will "open the door" to uncontrolled and unsupervised domiciliary treatment. The availability of an oxygen cylinder in the home of a severe asthmatic might also in certain circumstances prevent death from hypoxic cardiac arrest.

1 Grant IWB. Asthma in New Zealand. *Br Med J* 1983;286:374-7.

Dutch doctors in campaign on nuclear weapons

Dr W J E VERHEGGEN (chairman NVMP, 5014 EG Tilburg, The Netherlands) writes: A news item about Dutch physicians helping British doctors in their campaign on nuclear weapons (9 February, p 479) mentioned that a third of Dutch doctors are members of the Dutch Medical Association for Peace Research (NVMP). Unfortunately some details have got confused. Only 5% of Dutch physicians are members of NVMP. A third (10 000) of Dutch physicians, dentists, and midwives did not meet their legal obligation to fill in their registration forms under the Emergency Act, which provides for organising medical help in case of war. Several hundred wrote giving their arguments about the impossibility of organising medical care in a future war. This action was preceded by an intensive discussion in the journal of the Royal Dutch Medical Association over the past three years. Up till now nobody has been prosecuted, and the government has kept silent. Civil disobedience on this scale is a remarkable phenomenon for a traditionally law abiding group.

Underprivileged areas: validation and distribution scores

Dr JOHN WILLIAMS (West Glamorgan Local Medical Committee, Swansea SA2 8RD) writes: I have been asked to point out that the LMC map for West Glamorgan in Professor Brian Jarman's article (8 December, p 1587) was completed at short notice by me to meet the publication date for the General Medical Services Committee report and there was no time for discussion by the full LMC. The matter has recently been discussed by the full LMC and it is agreed that the whole of West Glamorgan should be shaded equally; the lighter shading tends to represent areas of low population, not of low workload, as there are proportionately fewer doctors working in the areas and there are seasonal increases in population by holidaymakers during the summer and by students at Swansea University at other times of the year. It seems to me that the map of underprivileged area scores must also tend to reflect population density and that the number of GPs practising in these areas should also be taken into account.

Correction

Can we afford screening for neural tube defects?

We regret that an error occurred in this letter by Dr K Spencer and Mr P Carpenter (2 March, p 711). Their definition of efficacy in the third sentence should have read "proportion of open neural tube defects in the pregnant population terminated as a consequence of the screening programme."