Points

Predictive value of rectal bleeding in screening for rectal and sigmoid polyps

Professor MICHAEL D HAGEN (Department of Family Practice, University of Kentucky College of Medicine, Lexington, Kentucky 40536, USA) writes: Mr P H Chapins and colleagues have provided information useful to practising physicians (25 May, p 1546). Although the authors viewed sigmoidoscopy as unhelpful in differentiating neoplastic (polyps, adenocarcinoma) from non-neoplastic sources (haemorrhoids, diverticula, etc), the data can be viewed as valuable in assessing the validity of rectal bleeding as a historical screening tool. Specifically, the simple characteristic of "no rectal bleeding" appears quite accurate in identifying those individuals without neoplastic disease. The 2×2 table is reconstructed from data in the article. The predictive value of a

Relation between rectal bleeding and findings on sigmoidoscopy

	Findings on sigmoidoscopy	
	Carcinoma or polyp >10 cm	No polyp or carcinoma >10 cm
Rectal bleeding	4	44
No rectal bleeding	8	263

positive finding, as described in the paper, is 4/48 or 8%—quite low. In contrast, the predictive value of a negative finding is 263/271 or 97%—that is, a history of no rectal bleeding accurately identified patients without neoplastic processes. While these results must be used cautiously when applied to a population different from that described in their study, it appears that a negative response to inquiry about rectal bleeding may be useful in identifying patients at low risk for rectosigmoid neoplasia.

Failure of acyclovir cream in recurrent herpes labialis

Dr J W FARQUHAR (Department of Child Life and Health, University of Edinburgh, Edinburgh EH9 1UW) writes: A personal series of one case is no answer to the careful paper about acyclovir cream (6 July, p 7) but it prompts one question and one comment. How soon was "as soon as possible" in relation to the start of treatment? For 50 years I have suffered attacks of herpes labialis every six weeks or so. For more than one year I have carried acyclovir cream about with me. I have had much experience of the early local burning sensation and at this stage usually see little more than a pink macule, smaller than the area of discomfort. I apply acyclovir immediately and hourly for a few hours before following the manufacturer's instructions. On every occasion but one in that time the lesion has not progressed to beyond a small papule or local induration. The exception coincided with my not having acyclovir with me and treatment was delayed for about 12 hours. . . .

Screening patients with retinitis pigmentosa for Refsum's disease

Drs F B GIBBERD and J M GOLDMAN (Westminster Hospital, London SW1P 2AP) write: We were interested to read the Point of Mr A T Moore and his colleagues (15 June, p 1829) in response to our article (13 April, p 1109). We agree that the diagnosis can be safely excluded when there is a clear family history of autosomal dominant or X linked inheritance, but often the inheritance is not clear. For example, we have one patient whose mother also had a raised serum phytanic acid value, suggesting the heterozygote can be identified. In another case the family history has been complicated by concealed close consanguinity. The retinal dysfunction may or may not precede the neurological abnormality, but we have yet to know of a patient born with normal smell who has Refsum's disease. Anosmia and a raised phytanic acid concentration in the blood are two of the most important points to consider when excluding or confirming Refsum's disease in a patient with either retinitis or peripheral neuropathy. Screening of sporadic cases only could mean a failure to diagnose this uncommon but treatable disease.

Where are the unemployed doctors?

Dr N D DRIVER (Workington CA14 3BT) writes: It amazes me that Mr N E Scholes (6 July, p 56) should be surprised that unemployed doctors are not applying for posts in his district general hospital. The important jump in the hospital promotion ladder is not from senior registrar to consultant but from registrar to senior registrar. Senior registrar appointments are largely in the hands of teaching hospital consultants, who tend to appoint teaching hospital registrars. I know more than one teaching hospital consultant who does not even bother to read applications from registrars and house officers in peripheral hospitals. Until junior staff in such hospitals stand an equal chance with those in teaching hospitals of getting promotion unemployed doctors would be foolish to take jobs in peripheral hospitals. It is better to wait on the dole for a chance of a job with a future than commit professional suicide by going to the periphery.

British and American spelling of technical words

Dr JAMES HAWORTH (Chambésy, Switzerland) writes: Apart from the difficulty of British editors following consistently the idiosyncracies of American spelling as used in Webster's, which North Americans do not necessarily follow themselves, there is the difficulty of knowing where to stop. How would one spell "traveller" when referring to traveller's diarrhoea? I doubt the correctness of Dr J L Burton's statement (15 June, p 1828), at least outside dermatology, that most overseas scientists learn "USA" rather than "British" English. This certainly does not apply to Africans or Asians, apart from Filipinos and Japanese, or to Europeans, except Italians and possibly the French. The Italian spelling of anaemia is "anemia" and the French "anémie," though the latter retain the ligature in "oesophage."

Garlic and blood lipids

Mr R J BRERETON (Hospital for Sick Children, London WC1N 3JH) writes: I congratulate Dr E Ernst and colleagues (13 July, p 139) on their powers of persuasion and the citizens of Munich for their stoicism. Where else would one find 10 patients capable of swallowing capsules containing 600 g garlic powder?

Therapeutic ranges in anticoagulant administration

Dr A M H P VAN DEN BESSELAAR and Professor E A LOELIGER (Reference Laboratory for Anticoagulant Control, Academisch Ziekenhuis, 2333 AA Leiden, The Netherlands) write: Dr Leon Poller (8 June, p 1683) refers to the new World Health Organisation system for international standardisation of the prothrombin time. This system involves a common scale of reporting, termed the international normalised ratio (INR). The INR is virtually identical with the British ratio.[1] All manufacturers are now expected to calibrate their reagents and provide the relevant INR values, making it easier to derive more precise therapeutic equivalents with individual reagents. The manufacturer of Thrombotest recently published the translation of Thrombotest activity into INR.[2] This Thrombotest conversion table shows a difference from the INR values given by Dr Poller. The origin of the difference is not known, but the possibility cannot be excluded that the properties of Thrombotest were slightly different some years ago. The therapeutic range in the Netherlands sixty-plus reinfarction study[3] was 10% to 5% Thrombotest activity, equivalent to INR 2·8 to 4·8 according to the manufacturer.[2] With the same conversion table, the 15% Thrombotest activity aimed at in the British Medical Research Council's study[4] would now correspond to INR 2.1. The establishment of fixed relations between INR and percentage activity for each reagent will facilitate the introduction of the INR scale.

1 Poller L. Standardisation of oral anticoagulant treatment. *Br Med J* 1983;287:1379.
2 Gogstad GO. The reporting of Thrombotest in international normalized ratios. *Farmakoterapi* 1984;40:88-92.
3 Sixty-plus Reinfarction Group. A double blind trial to assess long-term anticoagulant therapy in elderly patients with myocardial infarction. *Lancet* 1981;ii:989-94.
4 Medical Research Council. Assessment of short-term anticoagulant administation after cardiac infarction. *Br Med J* 1969;i:335-42.

Rh (D) haemolytic disease of the newborn

Dr M J STONE (Stockport SK7 4QR) writes: Dr S J Urbaniak mentions failure to give anti-D immunoglobulin postnatally as one cause of maternal sensitisation (6 July, p 4). Rightly he gives the reason for this as human error. Unfortunately a further cause of human error has to be added to the list—laboratory error in grouping the baby. My son was wrongly grouped at birth and had I not been certain of my rhesus status (owing to my father's work in the blood transfusion service and his need for the occasional guinea pig) and hence had the result checked and found to be wrong my wife would have been added to the statistics.

Delayed healing of BCG ulcers

Dr JOHN MARKS (Cardiff CF4 4BJ) writes: May I add to the advice given by your expert (6 July, p 33). Around 1950 I inoculated my daughter with BCG and was dismayed when the ulcer discharged pus for more than two months and showed no signs of healing. However, when a vaccination cage was applied the ulcer dried up at once and healed rapidly. For those too young to have seen or heard of a vaccination cage or shield it is a wire dome attached by tapes which maintains an air space between the lesion and any covering. Subsequently my advice to my staff at the tuberculosis reference laboratory inoculated with BCG was to attach dressings to their clothing, not to their arms, and the vaccination cage was needed only once more.

Assessing renal function in children

Mr J E POLLET (Halton General Hospital, Liverpool), and Drs P F Sharp and F W Smith (Department of Biomedical Physics, Aberdeen University, Aberdeen AB9 2ZD) write: The aim underlying the management of children with urinary tract infection (29 June, pp 1925 and 1957) and vesicoureteric reflux is the preservation of renal function. Unfortunately, the numbers and shapes of scars tell the clinician little about the ability of individual kidneys to excrete waste matter. Radionuclide imaging can make a valuable contribution to the study of renal function. For example, we have described how a test with a single intravenous injection of ^{99m}Tc pentetic acid (DTPA) can provide useful information on the function of each kidney, gross renal anatomy, and vesicoureteric reflux.[1,2] The test is simple to perform and avoids the unpleasantness and hazards of catheterisation.[3,4] Because it uses a much lower radiation dose than an intravenous pyelogram or micturating cystourethogram it can be used for regular follow up tests.

1 Pollet JE, Sharp PF, Smith FW. Radionuclide imaging for vesicorenal reflux using 99mTc-DTPA. *Ped Radiol* 1979;8:165-7.
2 Pollet JE, Sharp PF, Smith FW, *et al.* Intravenous radionuclidecystography for the detection of vesicorenal reflux. *J Urol* 1981;125:75-8.
3 Glynn B, Gordon IR. The risk of infection of the urinary tract as a result of micturating cystography in children. *Annals of Radiology* 1970;13:283-7.
4 McAllister WH, Cuccianelli A, Shackelford GD. Complications associated with cystography in children. *Radiology* 1974;11:167-72.