that might have been taken to endorse a particular political stance. He can hardly be held culpable for that.

I hope sincerely that the new Health Education Authority will be able to establish its rightful independence and skill in health promotion, but health policy is the responsibility of the health departments, not of the Health Education Authority. The independence of the new authority must be shown in its freedom to promote as it thinks best the aims of the health policy that the departments should formulate clearly and for which they should provide adequate resources. Both these things have yet to be done.

Meanwhile, as a private person, I was able to obtain a copy of *The Health Divide* by writing for it, and I hope others who are interested will do the same.

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SIR,—Since Disraeli's time there has been discussion about two nations in Britain, and in an election year opponents of the government have inevitably increased the frequency and voracity of argument about the inequalities in society. True to form, the leading article by Drs Stephen Lock and Richard Smith (4 April, p 857) again used the *BMJ* to voice a sweeping condemnation of government policy and how this relates to health. But what is the basis of such comment?

Certainly, the health of any society is related to socioeconomic deprivation, and the Black report in 1980 confirmed this. It is therefore clear to all who are interested in the nation's health and welfare that to make any lasting impression on the general wellbeing of our society we need to improve the socioeconomic climate of the country. If any government can do this in the teeth of a recession it should be congratulated.

Drs Lock and Smith imply that the country's health has declined recently, but the fact that there has been greater benefit in some sections of society than in others belies the point that the health of the whole nation has improved under the present government, as has the socioeconomic state of the country. As Drs Lock and Smith mention, there has been increasing spending on the National Health Service. Their argument therefore revolves around the failure of the government to remodel the NHS on that of Finland. This could prove to be an interesting debate, but it is hardly a big stick with which to beat the government.

The only certain way to improve the NHS is to encourage national economic growth. Improvement in health will follow as night follows day. If we wish to take the long view our path must lead down the road of economic recovery.

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What contribution has cardiac surgery made to the decline in mortality from coronary heart disease?

SIR,—In his letter about our paper Dr R Beaglehole (4 April, p 905) again makes the major error of using a totally inappropriate trial, the European trial,[1] to estimate the contribution of coronary artery surgery to the decline in mortality from coronary heart disease. The European trial specifically excluded patients "who did not require surgery for relief of symptoms," and consequently patients with severe, intractable angina, the very patients who are usually recommended to undergo surgery, were not included. Furthermore, in this trial 22% of the randomised "medical" treatment group underwent surgery when they developed severe symptoms.

Because of the association between major symptoms of angina and mortality we were careful to use studies of comparable populations with either major symptoms or strongly positive results of exercise tests. Studies of exercise testing confirm that patients with severe symptoms of angina continue to have a poor prognosis.[2-4] Data from the recent coronary artery surgery study, showing a 5·4% annual mortality for patients treated medically (58% subsequently required surgery),[5] gave us a lower limit of prediction of the contribution of surgery to the fall in mortality of 26%. We think that this figure can be accepted with confidence. It does not in any way argue against the importance of primary prevention in decreasing mortality from coronary heart disease.

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1 European Coronary Surgery Study Group. Long term results of prospective randomised study of coronary artery bypass surgery in stable angina pectoris. *Lancet* 1982;ii:1173-80.
2 Bruce RA, De Rouen TA, Hammermeister KE. Criteria for enhanced survival after CABG. *Circulation* 1979;60:638-46.
3 McNeer JF, Margolis JR, Lee KL, *et al*. The role of the exercise test in the evaluation of patients for ischaemic heart disease. *Circulation* 1978;57:64-70.
4 Dagenais GR, Rouleau JR, Christen A, Fabia J. Survival of patients with a strongly positive exercise electrocardiogram. *Circulation* 1982;65:452-6.
5 Mock MB, Ringqvist I, Fisher LD, *et al*. Survival of medically treated patients in the coronary artery surgery study (Cass) registry. *Circulation* 1982;66:562-8.

Long term urethral catheterisation in the elderly

SIR,—Mr R B Kinder (28 March, p 792) states that "Retention of urine and severe bladder outflow obstruction are best treated by an endoscopic operation, which is rarely contraindicated with current anaesthetic techniques." As urologists, we would have agreed with Mr Kinder—until, that is, we recently reviewed the management and outcome of all patients with acute retention at this hospital.

Using the Hospital Activity Analysis records and having excluded those with blocked catheters and inaccurate diagnoses, we identified 81 men who had painful acute retention recorded as their presenting complaint or during their admission in 1985. Forty one (mean age 72) required endoscopic surgery (with no hospital mortality); 20 voided after the catheter was removed and had no further problems (mean follow up 18 months); and of the remaining 19, 17 (mean age 79) had bladder outflow obstruction but were deemed not fit for surgery and treated with long term urethral catheters. Fourteen of these patients (82%) were dead within a year (mean survival seven months).

This raises several questions. Was the excess mortality related to a complication of the catheter, or is there a significant population of very elderly patients who can truly be recognised as unfit and have such a poor prognosis that surgery is contraindicated? There is no evidence in the notes of our patients to suggest septicaemia or other causes of death related to the catheter, but our review was a retrospective assessment and thus incomplete.

Interestingly, just over half of these patients were never referred to a urologist and were managed by geriatricians or occasionally by general surgeons. Do geriatricians in other hospitals have a similar population of unfit patients with true urinary retention, and is their prognosis as bad as our figures suggest? Perhaps in Mr Kinder's experience, as in our own, many of these patients do not get referred and his optimism for curing all obstructive uropathies in such an elderly population is founded on a preselected group of fairly fit elderly patients.

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Indigenous strongyloidiasis in Nottingham

SIR,—We were intrigued to read the report by Dr Veronica Sprott and colleagues of strongyloidiasis in Nottingham (21 March, p 741). Our hospital has been screening ex-prisoners of war from the Far East for this organism since 1978, and, having examined more than 1500 patients, we have a larger series than any yet published. The Liverpool experience reported a 13% carriage rate of *Strongyloides stercoralis* in ex-prisoners of war from the Far East,[1] but our patients seem to have a far lower rate. This led us to examine carefully our diagnostic criteria for this nematode infestation.

One important feature is the history. Diarrhoea, often intermittent and associated with prolonged mild malaise, is typical, often with a history of negative results on investigation. A history of the pathognomonic itchy skin rash of larvae currens is rarely volunteered, even by ex-prisoners of war, but is found to be quite common when patients are questioned, and it would be interesting to know if the patient described by Dr Sprott and coworkers had this.

Unless the rash is present examination is not helpful, and the following investigations are done at Woolwich: absolute eosinophil count, three fresh stool examinations, a duodenal string test for rhabditidiform larvae, and an estimation of IgE concentration. Patients are treated with thiabendazole if any of these investigations yield abnormal results (unless they have an eosinophilia for some other reason), but only definite identification of larvae is conclusive. Eosinophilia is by no means always present in patients with proved strongyloides infestation.[2]

We have been storing serum for serological testing but have no experience of this as yet. How this young lady came by her worms is mysterious, but all physicians and pathologists should be aware of this wily nematode.

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1 Gill GV, Bell DR. Longstanding tropical infections amongst former war prisoners of the Japanese. *Lancet* 1982;i:958-9.
2 Gill GV, Bell DR. Strongyloides stercoralis infection in former Far East prisoners of war. *Br Med J* 1979;ii:572-4.

Portraits from Memory: 7—Dr E C (Ted) Smith

SIR,—Sir James Howie's portraits make very interesting and enjoyable reading, especially for those of us who served in the tropics with the armed services or in other capacities. There is, however, some inaccuracy in the paragraph on Dr Ted Smith's version of the saga of yellow fever (21 February, p 501).

Noguchi did not perform a postmortem examination on Stokes. In fact, Stokes died on 19 September 1927 in Lagos and Noguchi died in

Accra on 21 May 1928, having gone there in November 1927. There was certainly doubt as to how Noguchi became infected with the virus of yellow fever, but there was an accidental infection at the postmortem examination performed on Noguchi, the victim being Dr W A (Bill) Young, pathologist to the Gold Coast. Dr Young died a few days after the necropsy and embalming. An account of the first protection against yellow fever in monkeys was reported by Hindle in the same issue of the *BMJ* (9 June 1928) as Dr Young's obituary, sadly too late for the three who had fallen victim to the disease that they were fighting.

Finally, Stokes was not English but Irish and the grandson of the great physician William Stokes. Oddly enough, though Young was reared in Forfar, his place of birth is recorded as Stamford Hill in the *BMJ* but Fulham in the *Lancet*.

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Points

Eating disorders in young diabetic women

Dr GEOFFREY GILL (Arrowe Park Hospital, Wirral, Merseyside L49 5PE) writes: Dr Judith Steel and colleagues report an unusually high occurrence of eating disorders among young diabetic women (4 April, p 859). Their patients were also poorly controlled, and most had evidence of diabetic complications. These results add to other evidence that young diabetic women present greater management problems than their male counterparts. Thus almost all severely "brittle" diabetic patients are women,[1,2] in particular those with the so called "syndrome of subcutaneous insulin resistance."[3] Bed occupancy rates for young diabetic patients are also higher among women[4]; and, finally, mean glycosylated haemoglobin concentrations are significantly higher in diabetic women.[5,6] The Edinburgh study on eating disorders in young diabetic women adds further support to the concept of the "fragile female diabetic."[7] An adequate explanation for these peculiarly sex related problems remains to be found. The occurrence of acute painful neuropathy in some of the Edinburgh patients is also interesting. This may, as the authors suggest, be nutritionally related. Alternatively, however, some of the patients are reminiscent of those with the syndrome of "diabetic neuropathic cachexia," in which pronounced weight loss and painful neuropathy coexist, usually followed (as apparently in three of the four Edinburgh patients) by eventual spontaneous recovery.[8]

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2 Pickup J, Williams G, Johns P, Keen H. Clinical features of brittle diabetic patients unresponsive to optimised subcutaneous insulin therapy (continuous subcutaneous insulin infusion). *Diabetes Care* 1983;6:279-84.
3 Schade DS, Duckworth WC. In search of the subcutaneous insulin resistance syndrome. *N Engl J Med* 1986;315:147-53.
4 Government Statistical Service. *Hospital in-patient enquiry*. London: HMSO, 1978.
5 Strickland MH, Paton RC, Wales JK. Haemoglobin A_{1c} concentrations in men and women with diabetes. *Br Med J* 1984;289:733.
6 Jones RB, Johnston DI, Allison SP, Peacock I, Hosking DJ, Tattersall RB. Haemoglobin A_{1c} concentrations in men and women with diabetes. *Br Med J* 1984;289:1381.
7 Gill GV, Walford S. The fragile female diabetic. *Diabetic Medicine* 1986;3:284.
8 Ellenberg M. Diabetic neuropathic cachexia. *Diabetes* 1974;23:418-23.

Do adhesions cause pain?

Dr T P NASH (Basingstoke District Hospital, Hampshire RG24 9NA) writes: Mr John Alexander-Williams (14 March, p 659) concludes that intra-abdominal adhesions are unlikely to produce pain and that patients with this pain frequently have a functional element. What he did not consider was the not uncommon pain syndrome of nerve entrapment in the abdominal wall.[1,2] This syndrome commonly occurs at the lateral border of the rectus abdominus, where there is often a point of maximum tenderness, which increases when the muscles are tensed. This pain often responds to injection of local anaesthetic and steroids into the rectus abdominus at this site, where the nerve is bound to the posterior sheath. For longevity the injection of phenol 6% in aqueous solution or 10% in glycerine and water, 50-50 solution, may be used. The few patients who are not helped by this treatment may benefit from a simple exploration of the rectus abdominus at its lateral margin and freeing of the intercostal nerves where they are tethered posteriorly. Many of the patients who respond to this treatment have been labelled "functional" in the past or have undergone multiple explorations of the abdomen, and it is therefore an important syndrome to consider in this group of patients.

1 Mehta M, Ranger I. Persistent abdominal pain—treatment by nerve blocks. *Anaesthesia* 1971;26:330.
2 Mehta M. *Major problems in anaesthesia*. Vol 2. London: Saunders, 1973.

Original pack dispensing

Dr J H DOWNTON (Department of Geriatric Medicine, Hope Hospital, Salford) and Mr R HOMER (Ladywell Hospital, Salford) write: As well as the potential benefits of original pack dispensing (21 March, p 724) there may also be problems, particularly for the elderly. As part of a larger study of the difficulties the elderly experience in taking medication, we looked at the ability of a group of old people to extract tablets from a blister pack. Among 44 patients attending a geriatric day hospital who were responsible for taking their medication at home (33 women; mean age 78 years (range 64-87)) 20 had a disability which interfered with manipulative dexterity (Parkinson's disease, rheumatoid arthritis, hemiparesis) and 25 could not remove a tablet from a blister pack; even after explanation and instruction 18 were still unable to do so. Subjects with disabilities were equally divided between those who succeeded and those who did not. Our subjects may not be typical of the elderly in the community, but they do represent a group which may require regular medication to maintain independence. Therefore we suggest that a significant proportion of old people are likely to experience difficulty in manipulating blister packs.

Time for action on hepatitis B immunisation

Mr M P SHOOLMAN (London W1M 7TB) writes: Dr Roger G Finch (24 January, p 197) emphasises the need for dental nurses and hygienists to be vaccinated against hepatitis B. Resistance to supplying the vaccine for dental nurses is, however, being met from the issuing centre at the infectious disease unit at Colindale, where staff seem to have an inadequate knowledge of the procedures carried out by staff in general dental practice. In most general dental practices dental nurses handle, clean, and sterilise contaminated instruments and are as likely to be in contact with contaminated blood as the dental surgeon unless they are confined to reception duties. The hepatitis B immunisation programme seems to be slow in getting off the ground; it will not be helped if some of those who need the vaccine have difficulty in obtaining it.

Effects of breast conservation on psychological morbidity

Dr P J SAXBY (Wessex Centre for Plastic and Maxillo-facial Surgery, Odstock Hospital, Salisbury SP2 8BJ) writes: Ms G McClare describes how her life was dramatically improved after implantation of a breast prosthesis six years after a mastectomy (28 February, p 574). I think, however, that she is wrong to conclude that she would have been better treated by lumpectomy and radiotherapy in the first place.

Conservative treatment for breast cancer has been popularised by the media and many women may thus embark on such treatment expecting little alteration in the appearance of the breast. Lumpectomy which removes a growth with an adequate clearance may not only significantly reduce the volume of the breast but is also likely to distort the nipple position, producing even greater asymmetry. Radiotherapy will damage the breast further: it may produce a woody texture and can still produce appreciable radiodermatitis. The results of such conservative treatment need to be assessed with regard to the final appearance. Breast reconstruction has developed considerably in recent years, and most procedures entail more than the simple insertion of a silicone gel prosthesis. The result obtained usually satisfies both patient and surgeon and in many cases may have a more natural appearance than that achieved by conservative treatment.

Case note chaos

Dr P R COOK (General Infirmary, Leeds LS1 3EX) writes: I agree with Dr Stephen M Hutchison that structuring case notes would benefit the clinician in providing quicker access to information, but there is a pitfall for the unwary in overenthusiastic removal of "useless" material. As an anaesthetist I need rapid access to patient information from the records, including details of recent anaesthetics. This is now becoming of increasing medicolegal importance—for instance, with the recent worries over halothane. Unfortunately anaesthetic records are often not saved, lost, or removed from notes. This can cause inconvenience to both patient and anaesthetist and lead to the use of more expensive anaesthetics needlessly. If structuring of notes is decided on all specialties should be concerned in such decisions.

Why women are not receiving anti-Rh prophylaxis

Dr P A GOVER (District General Hospital, Eastbourne, East Sussex BN21 2UD) writes: There is a more topical reason for failure to give anti-Rh immunoglobulin than those mentioned by Dr Ruth M Hussey (10 January, p 119), Dr L A Derrick Tovey (21 February, p 508), and Sir Cyril Clarke and others (18 April, p 1001): refusal for fear of HIV infection. To date some half dozen women in Eastbourne have refused anti-D immunoglobulin for this reason. Several women have refused immunoglobulin prepared in the USA but have been persuaded to accept UK immunoglobulin. Eastbourne is unlikely to be alone in finding women reluctant to receive anti-Rh prophylaxis, and in a few years we shall almost certainly see an increase in cases of Rh sensitisation.

Long term urethral catheterisation in the elderly

Ms CHRISTINE SETH (Bard Urology Division, Sunderland SR4 9EW) writes: Independent unpublished research conducted on behalf of Bard Limited during 1986 further supports the findings of Kennedy and Brocklehurst to which Mr R B Kinder alludes (28 March, p 792). Clearly selection of the correct type of catheter for long term use is not in itself a guarantee of optimal performance, and the management of this invasive device is also critically important. The benefits of pure silicone and silicone elastomer coatings in comparison to the use of latex,[1-3] Teflon coated latex, and plastic materials are well documented, but Blannin and Hobden showed that excellent results are achievable with latex catheters provided that nursing care is of the highest standard.[2] Nevertheless, given equal standards of nursing care, catheters of clinically superior materials will yield clinically superior results. The recent use of Hydrogel materials of the same family as those used to make contact lenses and the search for a truly non-toxic construction material attest to the progress which may still be made in providing safer long term indwelling urethral catheters. We welcome Mr Kinder's call for a more considered