Correspondence

Correspondents are asked to be brief.

Super-specialization in Surgery?

SIR,—The contribution made by Mr. John Charnley (20 June, p. 719) to the surgery of the hip joint is an outstanding one, but I think he is wrong in suggesting that this is related to the special facilities available in a centre devoted entirely to total hip replacement. Surgeons capable of original thought are rare, those capable of translating this into action are even scarcer, but such men will make even the stoniest of hills fertile while the lush valleys below are cropped by their more pedestrian colleagues.

Total replacement of the hip joint has developed on different lines in Norwich in the hands of G. K. McKee and in my own department at Redhill, and in neither has it been necessary to isolate these patients either from the work of the rest of the orthopaedic and traumatic unit, or from the work of a general hospital. Our own rate of joint infection, which is lower than 1%, does not suggest that special theatre facilities are necessary. Sepsis in any orthopaedic procedure is a disaster, and our standards of asepsis should not and cannot vary with the procedure we are undertaking.

The advantages of treating these patients in the orthopaedic department of a general hospital are many, not least of which is the assistance gained from one's colleagues with the many medical and surgical problems encountered in treating elderly patients. Our difficulties, our morbidity, and our mortality are largely associated with intercurrent disease in the elderly, and are not primarily related to operative intervention. Our residents see total hip surgery against the background not only of other orthopaedic procedures but of other operations upon the hip joint. In a specialized unit it is only too easy to be unaware that there are other operations which are performed and which still have some merit. Clearly no surgeon should undertake operations he is incompetent to perform, and training both of those who are still in the apprenticeship stage and those who are fully established but undertaking a new procedure is of the greatest importance.

The concept of a surgical technician, however, as Mr. Charnley advocates, would surely lead to disaster. One can envisage such men only too well performing year after year with great skill and dexterity operative procedures expertly taught by their predecessors. Britain would become a treasure house of surgical antiquities and I doubt if Wrightington would be immune.—I am, etc.,

P. A. RING.

Reigate, Surrey.

Potassium Loss in Diuretic Therapy

SIR,—Dr. J. J. Healey and his colleagues (21 March, p. 716) have demonstrated convincingly the fall in total exchangeable potassium which occurs with diuretic therapy. However, their study is surely too short (5-15 weeks) to allow them to make even a preliminary conclusion that potassium loss of this degree causes no symptoms—indeed the study does not appear to have been designed to test this point.

The authors condemn the use of potassium chloride supplements on the grounds of inconvenience, cost, and gastrointestinal side-effects. The inconvenience to the patients is comparatively trivial and does not make the use of such supplements "undesirable." The cost must certainly be weighed against the desired benefits. The gastrointestinal complications are readily avoided by the use of preparations such as Slow K, which in the experience of the Dunedin Hypertension Clinic hardly ever causes even mild indigestion.

It is certainly reasonable to question the need for the routine use of potassium supplements. However, it is not always easy to predict which patients are going to develop hypokalaemia, nor can one be certain that the maximum degree of hypokalaemia has occurred in the first 5-15 weeks of treatment. The facilities for monitoring serum potassium levels vary, and it may well be a lesser evil that some patients should take potassium supplements unnecessarily than that others should be allowed to be persistently hypokalaemic.—I am, etc.,

F. O. SIMPSON.

Wellcome Medical Research Institute,
Department of Medicine,
University of Otago Medical School,
Dunedin, New Zealand.

Morphine and Papaveretum

SIR,—The article on narcotic analgesics in "Today's Drugs" (6 June, p. 587) perpetuates a common error in stating that 20 mg. of papaveretum is equivalent to 10 mg. of morphine. The morphine content of the former is in fact greater than commonly supposed. The morphine alkaloid, which constitutes 50% of papaveretum, is in the anhydrous form, while morphine sulphate (as used in clinical practice) contains 5 molecules of water of crystallization. If, therefore, 20 mg. of papaveretum contains 10 mg. of pure morphine alkaloid, the corresponding figure for 10 mg. of morphine sulphate is 7·6 mg. Thus, the true morphine content of papaveretum 20 mg. is

nearer to that of 15 mg. of morphine sulphate (11·4 mg. of anhydrous morphine).

Our own studies[1] have shown that 13·3 mg. of morphine sulphate contains the same amount of anhydrous morphine as 20 mg. of papaveretum, and that the effect of these two are indistinguishable clinically.—We are, etc.,

W. B. LOAN.
R. S. J. CLARKE.
J. W. DUNDEE.

Department of Anaesthetics,
The Queen's University of Belfast.

REFERENCE

1 Loan, W. B., Dundee, J. W., and Clarke R. S. J. *British Journal of Anaesthesia*, 1966, **38**, 891.

Upgrading V.D. Departments

SIR,—The question of changing the name "venereology" to some other such as "genitio-urinary medicine" was raised in your leading article (21 February, p. 447), by Dr. J. K. Oates (2 May, p. 296), and now by Dr. J. R. Seale (13 June, p. 670). Dr. Seale accepts the legal definition of venereal disease of 1916 and 1917 and tells us that most of his patients are not suffering from such diseases. Venereal disease is a very old medical term used to describe the various infections commonly transmitted in sexual intercourse. Presumably for legal purposes definitions have to be rigid, and in this instance definition was limited to the diseases of which the causative organisms had been isolated and of which it was possible to make a diagnosis beyond doubt. Dr. Seale must know that the great majority of his patients are suffering or afraid that they may be suffering from sexually communicable disease. Most of these patients have the same kind of problems—sense of shame and guilt, fear of disclosure to their families and others, fear that their spouses and children may be involved, and fear that their marriages may break up in consequence of their indiscretions. This and the need to trace and examine the potentially infected contacts are the justification for making this a separate specialty and keeping it so. Since Venus was the goddess of love, one supposes that the word "venereal" was coined to describe the diseases in a nice way. But because of moral judgments the word soon acquired an unpleasant connotation. If we devise a substitute for this word, as Nelson[1] tried to do in 1936, it will soon acquire the stigma and certainly do nothing to help our patients.

Those who are advocating this change should look more deeply into the matter. Let us suppose that the V.D. department at a major hospital, having built up an efficient organization and considerable resources over the years, has its name changed to the department of urogenital medicine, or genito-urinary medicine, or what you will. While the present incumbent remains the emphasis on venereal diseases and their control will continue. When he departs a fine opportunity presents for an able and ambitious young physician with, say, a special interest in renal diseases. The department is ready made for him; his colleagues will approve and the appointments committee will be impressed with his ability and qualifications. When appointed he will, if true to form, hand over the subject of V.D. to his junior assistant, who will be left to struggle without guidance and without inspiration. Take also the question of a university chair in the subject. It is overdue and, one supposes, it will not be long delayed. Establish a chair of venereology and the subject should derive great benefit; establish a chair of urogenital medicine and the subject will be relegated to the background.

Dr. Oates, in common with a number of other venereologists of his generation, worked in the best-known V.D. clinic in the world, at the Johns Hopkins Hospital. Dr. Oates should know what happened when the distinguished director of that department decided to broaden the scope of its activities and call it a department of chronic diseases. While he remained all was well, but when he went the subject of venereology was soon eliminated. The almost equally famous clinic directed by Dr. John Stokes at Philadelphia suffered a similar eclipse on the venereological side when he was succeeded by an able dermatologist. The consequence has been that no single clinical venereologist of note has emerged in the United States during the past twelve years or more. The Public Health Service has had to struggle with a near epidemic of venereal diseases without trained clinicians and to place chief reliance on epidemiological methods, which is like trying to fly on one wing.

Dr. Oates, Dr. Seale, and those who think like them can call their departments what they like and can adopt various other devices to ease the unhappy lot of their patients. But they should not deceive themselves and they should remember that they have been appointed to diagnose, treat, and control the spread of venereal diseases. I hope they will be proud to remain venereologists. To a great extent their present status has been achieved by the efforts of their predecessors[1] who were willing to enter a despised and neglected subject and, by giving of their best and leaving the subject better than they found it, earned the respect of their colleagues. Only in this way is respect to be achieved—not by calling ourselves something else and changing labels on doors.—I am, etc.,

AMBROSE KING.

London W.1.

REFERENCE

1 Nelson, N. A., *American Journal of Syphilis, Gonorrhoea and Venereal Diseases*, 1936, **20**, 448.

SIR,—I would like to give support to Dr. J. R. Seale's views (13 June, p. 670) regarding a change of name for the two hundred and more V.D. clinics in Britain.

Apart from the greatly increased incidence of gonorrhoea, the other two venereal diseases—syphilis and chancroid—are now numerically in small numbers. The bulk of the work in clinics very largely consists of other sexually transmitted conditions, particularly genito-urinary infections such as trichomoniasis, candidiasis, genital warts, non-specific urethritis, etc. Many general practitioners are loath to refer patients to a department labelled "V.D. clinic" or "special clinic." Even explanations that the venereal diseases are but one facet of the work makes patients refuse to take the practitioner's advice. There is little doubt that these facts do not assist the control of the dissemination of sexually transmitted diseases.

There is no doubt that a change of name is indicated. Colleagues in all specialties and not least in genito-urinary surgery and nephrology are agreed on this point. The problem is to settle on a name. Of all the suggestions put forward to date, I would have thought that "department of genito-urinary medicine" would be the most accurate and appropriate for these establishments.—I am, etc.,

R. S. MORTON.

Sheffield, Yorks.

Mycobacteria from Aquaria

SIR,—I was interested to read the leading article entitled "Hazard from the Home Aquarium" (23 May, p. 438).

We recently reported an aquarium-borne infection with *Mycobacterium marinum* on the lower arm of an owner of tropical fish.[1] In this connexion we had the opportunity of examining two fishes of the species *Gymnocorymbus ternetzi* from his aquarium. Both fishes had died from a disease causing granulomas of the liver. One of them had a tubercle on the tail, consisting of similar granulomas made up of macrophages and showing central necroses. Staining according to a modified Ziehl-Neelsen technique with a shorter decoloration time revealed numerous acid-fast bacilli in the granulomas mainly in the necrotic foci. Cultures for *Mycobacterium marinum* were positive. Epidemiological investigations showed that the bacteria had been introduced into the aquarium with water fleas. *M. marinum* was recovered from the mud of a pond in which the patient caught water fleas for feeding his fish.

The histological changes in the tubercle and liver of the fish in our case are compatible with those which Aronson found in spontaneous tuberculosis of salt-water fish.[2] He observed areas of focal necrosis in the liver in which the liver cells were replaced by large mononuclear cells. The cells were to a great extent necrotic and the foci contained numerous clumps of acid-fast bacilli.

As in our case the man and the fish carried the same bacteria and the fish suffered from a disease agreeing with Aronson's fish tuberculosis, there is further reason to consider *Mycobacterium marinum* and *M. balnei* to be identical.—I am, etc.,

TORE MÅNSSON.

Department of Dermatology,
University of Lund,
Lund, Sweden.

REFERENCES

1 Månsson, T., Brehmer-Andersson, E., Wittbeck, B., and Grubb, R., *Acta Dermato-Venereologica*, 1970, **50**, 119.
2 Aronson, J. D., *Journal of Infectious Diseases*, 1926, **39**, 315.

Respiratory Symptoms and Washing Powders

SIR,—It is of great interest to read Dr. M. Greenberg and others' (13 June, p. 629) account of a survey of workers exposed to derivatives of *B. subtilis*. It would appear