never been a briefing stage at which we were able to tell the architects what we needed." The explanation for this and other allegations may lie in the fact that when his partnership was invited in February 1966, as were other partnerships in that area, they stated their accommodation requirements but chose to take no active part in the detailed discussions until 1969. During this time a working party consisting of representatives of the executive council, the local authority, and of the general practitioners was established and met on many occasions. The working party, including another general practitioner representative and myself, drew up the specifications from which the architect made the plans. We then considered these plans, and revised them on a number of occasions bearing in mind the needs of general practice. I and another general practitioner were in the party which visited the (then) Ministry of Health, following which the plans were recast again.

The tenor of Dr. James's article is reflected in his statements that "Nearly all patients attending a health centre wish to see only their general practitioner," and "the occasional case in which the "health team" may be required." His objection to his consulting room being used by anyone else and his insistence on a separate telephone number also give an indication of how he sees the role of a general practitioner in a health centre. This presents quite a different picture from our conception that doctor, nurse, midwife, clerk, and (we hope) social worker co-operate closely as a team in the interests of our patients regardless of our executive council, local authority, or hospital allegiance.

Finally, Dr. James uses emotive phrases of having "to fight" and of fierce resistance "by the representatives of the local authority" and finally "we won the argument." These come from someone who took a positive part only after the plans were agreed and accepted by all—that is, the Ministry, the local authority, the executive council, and the general practitioner representatives. No allowance is given for the problems caused by a difficult site and for the fact that the scheme is a joint one involving a multi-storied block of flats. Dr. James is hardly fair to his fellow doctors in general practice or in local authority service and the many others who spent many hours trying to evolve a new building and organization for family medicine.

I conclude confident that Dr. James would wish the record to be correct so that his other valuable criticisms may be viewed as constructive contributions. I would like to state that I have found the Portsmouth Local Authority, the local executive council, and more especially the departments with which the Medical Officer of Health is concerned to be at all times most helpful and have received their very valuable co-operation in many spheres.—I am, etc.,

J. J. BRENNAN

Southsea,
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Glove Powder

SIR,—Granulomatous peritonitis arising from French chalk used as powder on operating gloves has been recognized for many years. This type of talc was abandoned and replaced by a series of dusting powders which we have been told from time to time have been starches or sugars.

In the last two months I have had two cases of granulomatous peritonitis with very serious consequences. Both presented as intestinal obstruction and both have been confirmed histologically as starch granulomas. I am sure I am not the only surgeon who has tried to keep operative fields as dry as possible by refraining from washing gloves after putting them on, and in fact if one tries to remove the powder from the surface of the modern disposable surgical glove it is practically impossible without running water.

The purpose of this letter is to call the attention of my many surgical colleagues to this very obvious danger in view of the fact that there must be many thousands of patients who have been put at risk. A colleague who has had three similar cases within the last few months is preparing a scientific paper but a timely warning is called for, and I should be happy to receive any communications on the subject from surgeons who have found a similar condition. The manufacturers have been informed, but their only comment was that the condition was extremely rare. This is clearly not the case. In one of my patients who had previously undergone a gastrectomy, the peritoneal surface was studded with nodules that looked carcinomatous and had a biopsy not been taken the misinterpretation would have been perfectly reasonable. Whether there has been some recent change in the composition of the powder used on these disposable gloves we have not been able to ascertain as yet. Similar starch and "starch" granulomas have been reported by Cox in Melbourne.[1]—I am, etc.,

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1 Cox, K. R., *British Journal of Surgery*, 1970, **57**, 650.

Ileus and Pseudo-obstruction

SIR,—With reference to your leading article (26 June, p. 727) I would like to re-emphasize that these two conditions share the same mechanism—namely, reflex sympathetic inhibition of intestinal motility.[1] The first step in the management of these syndromes is therefore release of this sympathetic inhibition and only then is it permissible to use cholinergic drugs.[2]—I am, etc.,

JULIAN NEELY

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Crawley, Sussex

1 Neely, J., *British Medical Journal*, 1970, **2**, 793.
2 Neely, J., and Catchpole, B. N., *British Journal of Surgery*, 1971, **58**, 21.

Jejunal Diverticula

SIR,—In your leading article (26 June, p. 728) treatment of jejunal diverticula was either restricted to replacement therapy with vitamin B_{12} and intermittent courses of antibiotics or to operation. Operation has consisted of resection with end-to-end anstomosis, but in some patients needing operation resection is not necessary, though it may be quicker to perform than the operation of multiple diverticulectomy. This operation I have employed twice with good success, with excision of more than 20 diverticula in each patient. As implied, multiple diverticulectomy may be a little tedious, but if tried may prove to be more rewarding than excision of a length of jejunum.—I am, etc.,

MILO KEYNES

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Haemorrhage Mimicking Intravascular Haemolysis

SIR,—We were interested to read Dr. Jeanne D. Reeve's account of methaemalbuminaemia in a ruptured ectopic pregnancy (12 June, p. 654) as we encountered a similar problem in a 23-year-old Caucasian girl recently admitted to this hospital.

She was admitted complaining of abdominal pain, malaise, and chest pains. Nine days previously she had collapsed with sharp abdominal and chest pains, and later developed diarrhoea. She continued to feel unwell with intermittent abdominal pain and two days before admission began to pass dark urine ("like stewed tea") which continued for about 36 hours. On the day before admission she was seen as an outpatient, and found to have a right-sided pleural rub. She had been on the Pill for six weeks and her last period had been 13 days before admission and apparently normal.

Her haemoglobin was 10 g/100 ml, W.B.C. 9,700/mm^3, platelets 326,000/mm^3, and the reticulocyte count 4·2%. On separation of the serum it was noticed to be dark brown and found to contain methaemalbumin. The serum bilirubin was 1·5 mg/100 ml, and the urine contained excess urobilin but no haemoglobin. It was thought that intravascular haemolysis had occurred and this was investigated accordingly. There was no G6-PD deficiency; the direct Coombs's test was negative, as were the Paul-Bunnell and Donath-Landsteiner tests, and no appreciable cold agglutinins were detected. The Ham's test for paroxysmal nocturnal haemoglobinuria was negative and no haemosiderin was found in the urine. There was no methaemoglobinaemia. No haptoglobins could be demonstrated in the patient's serum.

She was subsequently found to have an ectopic pregnancy and at operation adhesions and altered blood were found in the peritoneal cavity.

The problem of the cause of methaemalbuminaemia remained. Methaemalbumin following acute haemorrhagic pancreatitis is well documented,[1 2] but in all cases the serum haptoglobins were preserved. Winstone[2] suggests that the extravasated blood is broken down to haem and globin and that the haem is then oxidized to haematin. The latter is absorbed into the circulation and combines with albumin to form methaemalbumin. As there is no free haemoglobin entering the circulation, the serum haptoglobins are unaltered. One might expect similar findings in bleeding due to an ectopic pregnancy.

Lemberg and Legge[3] state that haematin has been found in large blood extravasations, particularly in ruptured ectopic pregnancies, and refer to four papers (one by Schumm himself, in 1916). These papers were all published before haptoglobins were de-

scribed. In a study of the haptoglobin content of serum in haemolytic anaemias, Brus and Lewis[4] found the haptoglobin level reduced not only in cases of intravascular haemolysis but also in occasional cases where the haemolysis was considered to be extravascular.

In our particular patient the possibility of an episode of intravascular haemolysis owing to self administered drugs, or as a complication of local douching could not be excluded. We should be interested to know if the serum haptoglobin levels were normal in Dr. Reeve's patients.—We are, etc.,

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London W.C.2

1 Northam, B. E., Rowe, D. S., and Winstone, N. E., *Lancet*, 1963, **1**, 348.
2 Winstone, N. E., *British Journal of Surgery*, 1965, **52**, 804.
3 Lemberg, R., and Legge, M., *Haematin Compounds and Bile Pigments*. New York, Interscience, 1949, p. 574.
4 Brus, L., and Lewis, S. M., *British Journal of Haematology*, 1959, **5**, 348.

Gaps in Venereology

SIR,—In recent years the number of training posts in venereology has been increased considerably in an attempt to meet future consultant requirements. Unfortunately, as you point out (5 June, p. 547), many of the new posts remain vacant and to this it should be added that many of the others have been occupied by graduates from overseas, who are unlikely to be permanent acquisitions to the National Health Service.

This failure to attract a sufficient number of trainees into venereology has surprised no-one in the specialty, and most venereologists would endorse your opinion that a career in the specialty must be made more attractive. Indeed, the necessity for this was discussed at length in these columns last year. Great emphasis was placed on the need for general recognition of the breadth of work dealt with by the venereologist and it might help to achieve this if a standard training programme was adopted in which due regard was given to the non-venereal medical conditions which make up a large part of the venereologist's work. In the same correspondence attention was drawn also to the poor financial return offered to the venereologist and to the necessity of inducements in this direction (1 August, p. 408). As most of the trainee vacancies and all the consultant vacancies are in the provinces it might be necessary, as in general practice, to include in this inducement an element designed to attract candidates to posts in unpopular parts of the country.

Although not mentioned in your leading article, the efficient working of the V.D. service is threatened, not only by a shortage of consultants, but by a shortage of nursing staff. Again, in order to attract staff, it is necessary to make a career in venereology more attractive. The special allowance given for work in V.D. clinics should be raised at least to the level of that given for geriatric work, while steps should be taken to ensure that nurses employed in this specialty or indeed, in any other specialty, might have the opportunity of attaining a position higher than grade 6, without having to leave clinical work.—We are, etc.,

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Sterilization of Young Wives

SIR,—I note with interest the findings of Mr. D. B. Whitehouse (19 June, p. 707) that in North Wales 45% of women developed menstrual disturbances after sterilization by tubal ligation, and 25% reported deterioration in marital relations.

In a survey of 302 patients sterilized by tubal ligation at the Hammersmith Hospital in the years 1962-6, 83 have so far returned to this hospital with gynaecological disorders. Of the 56 who had no previous gynaecological disturbance, 30 complained of menorrhagia, 12 of irregular menstruation, and 7 of dysmenorrhoea. Another nine complained of such problems as intermenstrual bleeding, dyspareunia, or the symptoms of a non-existent pregnancy. Ten women have required hysterectomy. The results of a survey currently being conducted of women who have not actually returned to this hospital with complaints are making it clear that the actual incidence of post-sterilization symptoms is somewhat higher than the above figures suggest.

It is possible that hysterectomy should be employed more commonly in this country as a primary procedure for sterilization, as advocated by Montague,[1] even though the immediate physical complications[2] and minor psychiatric sequelae[3] are somewhat greater than with tubal ligation. Perhaps diathermy sterilization through the laparoscope will eventually prove to be the procedure of choice.[4]

The nature and implications of tubal ligation to be explained to husband and wife should perhaps include reference to the possibility of subsequent development of gynaecological disorders.—I am, etc.,

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Department of Obstetrics and Gynaecology,
Hammersmith Hospital,
London W.12

1 Montague, C. F., *Obstetrics and Gynecology*, 1959, **14**, 28.
2 Powell, L. C., Jr., *Obstetrics and Gynecology*, 1962, **19**, 387.
3 Barglow, P., Gunther, M. S., Johnson, A., and Meltzer, H. J., *Obstetrics and Gynecology*, 1965, **25**, 520.
4 Steptoe, P. C., and Imran, M., *British Medical Journal*, 1969, **3**, 751.

Malathion Poisoning

SIR,—Dr. F. H. Ekin's account of a case of malathion poisoning (3 July, p. 47) emphasizes that atropine is the drug of choice in treatment with the oximes used as adjuvants. One point not brought out is that atropinization occurs earlier when both drugs are used than when atropine alone is administered.

Most authorities are agreed, I think, that P2S (2-hydroxyiminomethyl-*N*-methylpyridinium methanesulphonate) is more effective than 2-PAM (pralidoximes chloride). Ladell[1] has pointed out that oximes are relatively ineffective against dimefox, mipafox, schradan, etc., where a diaminoalkyl group is directly connected to the phosphorus atom. Fortunately, these dangerous compounds have been replaced by the much less toxic malathion.

The account of petit mal attacks in Dr. Ekin's patient is interesting. I had not previously seen any account of such attacks in either organophosphorus poisoning or its treatment.
—I am, etc.,

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1 Ladell, W. S. S., *British Medical Journal*, 1958, **2**, 141.

Survival in Severe Congenital Heart Disease

SIR,—I have read with interest your leading article (26 June, p. 723) on survival in severe congenital heart disease. It surprises me that the writer of this article, although stressing the importance of early diagnosis and treatment of infradiaphragmatic total anomalous pulmonary venous drainage, has failed to mention an article in the *B.M.J.* from this hospital, which mentions the successful correction of such a case.[1] So far as I know, it is the only case in this country to have survived. The boy is now four years old and doing well.—I am, etc.,

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Paediatric Cardiology Unit,
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1 Llewellyn, M. A., Cullum, P. A., Thomas, J. B., and Anderson, I. M., *British Medical Journal*, 1968, **3**, 35.

Breach of Confidentiality

SIR,—Recently I met a disturbing breach of confidentiality. I recommended to a certain local authority that they help to finance one of my patients in a hostel for students with psychiatric problems. My application was sent to the medical officer of health, but as hostels are now dealt with by the director of social services it was passed on to him. A few days ago my patient approached me in great distress to tell me that his home had been visited by a social worker and his mother told that, since her son had had a nervous breakdown, the local authority was prepared to support him in a hostel.

My patient is a 20-year-old student attending a college some distance from my home town. His father has been in a mental hospital since a road accident a few months ago, and in order not to worry his mother further he had kept all knowledge of his emotional problems from her. Needless to say, this sudden disclosure was a severe shock to her.

I understand that the local authority needs to have all the facts about a case before financial help can be given, but this can surely not excuse such a disclosure without