conference Dr. Stock from Stoke was able to produce the plans of the North Staffordshire Institute which commenced building later that year. Planning had started in 1959, an appeal for funds was launched in 1960, and it was thus the first centre of its kind, not only to be built, but to be conceived and planned.

To pay tribute to the foresight of Stoke is in no way to diminish the vast importance of the Christ Church conference, and the support of the Nuffield and the King's Fund. Not to do so, however, is to permit the establishment by default of false history, and the creation of a perpetual injustice. I make this point in the sense of historical accuracy and with the vicarious pride of an honorary member of the section of general practice in the North Staffordshire Medical Institute.—I am, etc.,

P. S. BYRNE

Manchester

Influence of pH on Radioimmunoassay of Angiotensin I

SIR,—It has been demonstrated by Pickens and coworkers[1] that a pH of 5·5 is critical for the reaction of human renin with human renin substrate. While studying the radioimmunoassay of angiotensin I we observed that the plasma pH varied from physiological levels to pH 8 according to the length of time of storage of the plasma. We then tried to evaluate the variation in angiotensin I values in a pool of plasma obtained from 110 subjects for hypertensive hormone assay, according to the usual technique,[2] with the addition of enzymatic blockers. From this plasma pool we prepared 10 aliquots of 15 ml each and with pH values of from 4·5 to 9, increasing in steps of 0·5. The activity of plasma renin was maximum at pH 6, while a striking decrease of activity was observed at pH 7-8.

It seems as if the curves of hormone formation at each pH value are the linear function of the incubation time. The curves of angiotesnin I formation in relation to pH values show a gaussian distribution, the highest slope being pH 6. Therefore to avoid mistakes during the assay of angiotensin I we suggest that the plasma should be at the optimum pH 6. In this way the highest hormone production is obtained, and when plasma renin activity is low hormone values are easier to measure.—We are, etc.,

B. BAGNI
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Servizio di Nefrologia,
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Arcispedale S. Anna,
Ferrara, Italy

1 Pickens, P. T., Bumpus, F. M. Lloyd, A. M., Smeby, R. R. and Page, I. H., *Circulation Research*, 1965, **17**, 438.
2 Bagni, B., Gilli, P., Imbimbo, G. C., Squerzanti, R., and Farinelli, A. *La Ricerca Clinical Laboratory*, 1971, **1**, 399.

Brodrick Report

SIR,—A recent leading article (15 July, p. 131) implies that if the Brodrick Committee's proposals (20 November 1971, p. 498) are accepted then coroners' postmortem examinations will be provided free under the National Health Service. While certainly recommending that they should be provided under the N.H.S., I can find no mention in the report that they should be provided free.

The majority of pathologists are of the opinion that the coroners' service should be independent. This opinion is held for legal and ethical reasons—to avoid conflicts of interest and loyalty. One should not give the impression that the Brodrick recommendation is opposed for financial reasons. Actually it would be to the pathologists' advantage if they were paid by the N.H.S. as then this remuneration would count for their pensions.—I am, etc.,

G. BEHR

Department of Pathology,
Burnley General Hospital.
Burnley

Sulphonamide Crystalluria with Acetazolamide

SIR,—Acetazolamide is a heterocyclic sulphonamide and a carbonic anhydrase inhibitor. It used to be used as a mild diuretic. Since more effective diuretics are now available the drug is mainly used for the treatment of glaucoma; its sulphonamide basis tends to be forgotten. In the following case anuria, renal colic, and uraemia, considered to be due to sulphonamide crystalluria, resulted from administration of this drug.

A 49-year-old man was treated with acetazolamide 250 mg three times daily for glaucoma secondary to iritis. After seven doses he developed nausea, vomiting, and bilateral renal colic. On admission to hospital he was apyrexial, his blood pressure was 150/95 mm Hg, pulse rate 98, and he had some bilateral loin tenderness. Acetazolamide therapy was discontinued. He became anuric and catheterization produced 10 ml of heavily blood-stained urine. On microscopy only erythrocytes and leucocytes were seen. Culture was sterile.

The blood urea after 24 hours was 144 mg/100 ml and it rose to 258 mg/100 ml the day after. The serum potassium also rose from 4·4 mEq/l. to 6 mEq/l. Intravenous pyelography with 80 ml of Conray 420 showed on a six-hour film widening of the collecting system, including the ureters, with no contrast in the bladder, suggesting lower ureteric obstruction. Ureteric catheterization three days after admission showed bilateral lower ureteric blocks with cellular debris. No calculi were seen. Only the left ureter could be cleared by flushing with saline. Subsequently the patient was treated with sodium bicarbonate 4 g and 3 litres of oral fluid daily. A good diuresis was obtained, and the blood urea fell to 38 mg/100 ml within four days. Repeat intravenous pyelography a week after admission showed normal excretion.

Sulphonamide crystalluria has been reported previously with acetazolamide therapy of four to nine days duration.[1-4] Only seven 250 mg doses of acetazolamide were given to our patient. This rare but grave complication should be remembered because of its rapid response to therapy.—We are, etc.,

R. T. ORCHARD
D. J. E. TAYLOR
R. A. PARKINS

Charing Cross Hospital,
London W.C.2

1 Glushien, A. S., and Fisher, E. R., *Journal of the American Medical Association*, 1956, **160**, 204.
2 Yates-Bell, J. G., *British Medical Journal*, 1958, **2**, 1392.
3 Davies, D. W., *British Medical Journal*, 1959, **1**, 214.
4 Bertino, J. R., Rodman, T., and Myerson, R. M., *Archives of Internal Medicine*, 1957, **99**, 1066.

Ergocryptine

SIR,—In our article (24 June, p. 743) on the suppression of puerperal lactation with an ergot alkaloid 2-Br-alpha-ergocryptine was referred to throughout as "egocryptine." To avoid any confusion we would like to state that ergocryptine is a natural alkaloid existing in two isometric forms (alpha and beta) which both differ markedly in their pharmacological profiles and being both different from the pharmacological profile of 2-Br-alpha-ergocryptine. It is therefore misleading to use ergocryptine as a sort of generic name for 2-Br-alpha-ergocryptine.—I am, etc.,

J. S. PRYOR

Norfolk and Norwich Hospital.
Norfolk

Cot Deaths and Hypokalaemia

SIR,—It would be interesting to speculate on whether some unexpected cot deaths may be the result of an acute hypokalaemia and could be averted by the simple addition of potassium supplements in infant feeding.

A situation might easily develop where a baby sweating profusely in a warm room with a mild unnoticed pyrexia could suffer rapid electrolyte changes with potassium depletion and sudden death, and of course postmortem examination would not give any explanation for the tragedy. I submit this suggestion in all humility, fully appreciating the massive work which has been done on this subject.—I am, etc.,

J. A. FRAIS

Shipley, Yorks

Diagnosis of Sarcoidosis by Labial Gland Biopsy

SIR,—The article by Drs. G. R. V. Hughes and N. J. Gross (22 July, p. 215) prompted the biopsy of a labial salivary gland at the same time as a parotid biopsy in a 50-year-old woman with bilateral parotid gland enlargement who had a chest x-ray strongly suggestive of sarcoidosis. The labial biopsy showed a minor salivary gland, the histology of which was normal. The biopsy of the accessory part of one parotid gland, however, showed non-caseating tubercles typical of sarcoidosis. The tuberculin skin test was negative at 1 in 1,000. The Kveim reaction has not yet been done.

Drs. Hughes and Gross suggest that pathological changes in the minor salivary glands of the lip reflect those of the major salivary glands, though Waterhouse and Doniach,[1] whom they quote, do not mention this. This may well be the case, but the finding of a histologically normal labial gland does not exclude sarcoidosis in the major salivary glands. I wish to thank Mr. R. V. Fiddian for permission to refer to this case.—I am, etc.,

T. BATES

Luton and Dunstable Hospital,
Luton LU4 0DZ

1 Waterhouse, J. P., and Doniach, I., *Journal of Pathology and Bacteriology*, 1956, **91**, 53.

Malathion-resistant Pediculosis Capitis

SIR,—The resistance of the pediculus to DDT and to gammexane has been well reported. I have to report my first case of

Pediculus capitis infestation which has proved resistant to a lotion, Prioderm, containing 0·5% malathion. Treatment was properly and repeatedly carried out and re-infestation has been ruled out, so far as this is ever absolutely possible.

It will be worthwhile for departments of dermatology to look for similar experiences, and to report whether higher concentrations of malathion prove to be effective in these cases.—I am, etc.,

NEVIL SILVERTON

Leeds

Sexual Freedom

SIR,—I feel sorry for Dr. Violet Anderson, who has revealed in her thoughtful article (26 August, p. 524) a true analysis of our falling moral standards but regrettably confessed defeat in finding the correct remedy. She assumes throughout that young people today are neither born with a moral instinct nor acquire one by education or religious teaching. Moreover, she has no belief in female willpower.

To say that since chaperones have disappeared one must issue unmarried girls with contraceptives on demand is almost as misleading an assumption as saying that such girls will run risks anyway so if you refuse them the pill they will inevitably need an abortion. This may be so in some cases, but it does not automatically follow that doctors therefore have a duty to condone a practice which they believe to be wrong.

It is indeed unfortunate that an easy female contraceptive has been invented, not only because it has encouraged unchastity but also because of its undesirable side effects and potential long-term dangers. Surely the right course for doctors to take in this difficult situation is to uphold the Christian ideal rather than condone this "sexual freedom" which is stimulated by alcohol and drugs and applauded by the less desirable elements of youthful society. It is my experience that after the first rather painful interview successive refusals of pill prescriptions to the unmarried is no very difficult matter. If all doctors and family planning clinics took the same line, and if the women themselves were therefore frightened into a more restrained reaction to male advances, both immorality and the problems of abortion and illegitimacy would largely disappear. Chastity is unquestionably the best contraceptive.—I am, etc.,

HUGH CANE

Bungay, Suffolk

People with Epilepsy

SIR,—Like Dr. E. M. R. Critchley (22 July, p. 232), we also found some gaps in an otherwise most progressive report by the Reid Committee.[1]

Dr. Critchley mentions the lack of recommendation on problems of superannuation, insurance, and accident liability, and it is interesting that at the joint conference on employment and the invisibly handicapped, organized by the British Diabetic Association, the British Epilepsy Association, and the National Association for Mental Health, a very senior spokesman from one of Britain's largest insurance companies stated flatly that there was no problem in obtaining superannuation for epileptics. He said further that, though his firm had no evidence that it was necessary, for those who were worried on the question of an earlier death liability it was quite simple to omit death cover from such a policy. He mentioned that the superannuation problem was often unfairly presented, making the insurance companies the villains of the piece, merely to provide an easy excuse for employers not to employ epileptics.

Other insurance spokesmen belittled the theory of accident liability being a special risk, and my association still has no proof of any accident being due to epilepsy in an employee working with machinery adequately safeguarded under general factory legislation.—I am, etc.,

JOHN JARRETT
Deputy Director,
British Epilepsy Association

London W.C.1

1 Department of Health and Social Security, Welsh Office, and Central Health Services Council, *People with Epilepsy*. London, H.M.S.O., 1969.

Treatment of Early Breast Cancer

SIR,—There is one paragraph in Mr. R. S. Murley's interesting letter (26 August, p. 526) which requires immediate reply—namely, the omission in our paper of attribution to previous workers in the field.

When our rather long paper was submitted for publication the Editor understandably had to cut out certain sections; among these was the section on the history of the development of our premises. I am sorry if this has appeared discourteous.—I am, etc.,

HEDLEY ATKINS

Downe, Kent

Trapped Nerves

SIR,—The letter from Sir Reginald Watson-Jones (20 May, p. 463) was most heatening to those who have interested themselves in this subject. Personally speaking, such distinguished support, inter alia, of my published work[1] on lateral popliteal neuropathy was very encouraging, particularly as this work has had grave doubt cast on its accuracy and reliability in two leading articles in the *B.M.J.*—"Entrapment Neuropathies" (14 March 1970, p. 645) and "Trapped Nerves" (6 May 1972, p. 307). I hope that Sir Reginald's remarks may induce a more kindly view of material which was carefully documented and equally carefully followed up. This work has subsequently been expanded and a second article is in preparation.

The view expressed in Sir Reginald's letter that many entrapment neuropathies are related with abnormal fibrosis and autoimmune reaction is of great interest, but not all such neuropathies can be so caused. I am thinking particularly of subcostal entrapment under the lateral arcuate ligament, of which I have some years' experience, which causes pain often mistaken for appendicitis, hernia, gynaecological disorders, or renal pain, and also of the condition of posterior interosseous neuropathy at the distal part of the supinator muscle mentioned by Messrs. R. H. Maudsley and N. C. Roles (3 June, p. 593). My experience of this latter condition exactly coincides with theirs. Though it is included under "tennis elbow," it is, in my opinion, a different entity, which I have christened the "supinator syndrome."

I was also glad to have confirmation in Maudsley and Roles's letter of the view that lateral popliteal entrapment is caused by fixation under the fibrous crescentic arch of origin of peroneus longus and not in the fascial tunnel which carries the nerve around the neck of the fibula. It is because this fibrous arch is not divided when decompressing the lateral popliteal nerve that the operation may fall into disrepute.

Finally, I found surprising Sir Reginald Watson-Jones's view that the wide range of trapped nerves described by him is well known. In my experience, very few surgeons have more than knowledge which embraces ulnar neuropathy at the elbow, carpal tunnel syndrome, and meralgia paraesthetica, and they are unconcerned about any other nerve entrapments. It is therefore hardly remarkable that clinicians in general show little or no interest.—I am, etc.,

J. D. SIDEY

Adelaide, S. Australia

1 Sidey, J. D., *British Medical Journal*, 1969, **3**, 623.

**Sir Reginald Watson-Jones died last month (see obituary, 26 August, p. 533).—ED., *B.M.J.*

SIR,—We have recognized peripheral nerve entrapment as a source of abdominal wall pain for the past four to five years. In view of the interest in this topic aroused in your columns, particularly the leading article (6 May, p. 307) and Dr. W. V. Applegate's letter (5 August, p. 351), may I draw attention to a simple method of treatment by injection of 1-2 ml of 5% aqueous phenol? In difficult cases the procedure is facilitated by the use of a peripheral nerve stimulator-locator. The results of injection therapy in over 100 patients, observed over a three-year period, are reported elsewhere.[1,2]—I am, etc.,

MARK MEHTA

United Norwich Hospital,
Norwich, Norfolk

1 Mehta, M., and Ranger, I., *Anaesthesia*, 1971, **26**, 330.
2 Ranger, I., Mehta, M., and Pennington, M., *Practitioner*, 1971, **206**, 791.

Occupational Health Service

SIR,—It was gratifying to read the Occupational Health Committee Chairman's comments (*Supplement*, 5 August, p. 119) on the Robens Report[1] when presenting the annual report of council under "Occupational Health." It is indeed very evident that the Robens Committee failed to understand the true function of an occupational health service and, in accepting the evidence of the Department of Employment that the National Health Service with the employment medical advisory service is all that is necessary, has unquestionably weakened the intended purpose to achieve better safety and health at work. It also deprecates the practice of treatment at work but it is unquestionably to the mutual advantage of both patient and employer and economic to provide it. The work time lost would be very much greater and the casualty departments more overloaded and inefficient if this service lapsed.

The published written evidence[2] submitted to the Robens Committee did not