Similarities between our data and those of Mr. Kaim-Caudle and Dr. Marsh are quite marked and we would like to reiterate their statement that further such surveys could be of considerable value.—We are, etc.,

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N.H.S. Reorganization

SIR,—In your leading article on N.H.S. reorganization (28 June, p. 705) you state that many of those concerned "believe that the structure is fundamentally right." My belief is that the majority of those working in the N.H.S. think it is fundamentally wrong. The principle of unification may be right, but the five-layer structure is cumbersome and bureaucratic.

If one of these tiers were deleted millions of pounds a year could be saved. If, for instance, the area health authorities were completely abolished not only would public funds be saved but the whole organization could be streamlined. The renting of expensive accommodation in new office blocks in various parts of the country would no longer be necessary and thousands of skilled staff could be released.

The basic administration of the N.H.S. would continue to be carried out, as now, by the district management teams and their work co-ordinated by the regional health authorities. To have a filter or buffer between them is simply wasteful.

In the absence of A.H.A.(T)s the R.H.A.'s would hold the contract of all consultants so that another cause of divisiveness would disappear, and they would also liaise with universities and medical schools. Finally, social services could be put back into the N.H.S., where they belong, organized on a regional basis.—I am, etc.,

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"Functionless" Pituitary Tumours

SIR,—The article by Dr. D. F. Child and others (15 March, p. 604) reported 18 patients who presented with symptoms of hypogonadism and were found to have an enlarged sella turcica and hyperprolactinaemia. Amenorrhea, galactorrhea, or impotence was the only clinical symptom of pituitary dysfunction and only one patient had a visual field defect. In these patients the authors showed a linear relation between sella size and basal serum prolactin and suggest that prolactin level may be determined by tumour size despite the absence of granule activity in some of the pituitary tumours. Vezina and Sutton[1] have reported prolactin-secreting microadenomas causing the amenorrhea-galactorrhea syndrome and Zimmerman *et al.*[2] have demonstrated secretion of prolactin in pituitary tumours by immunoperoxidase technique. All patients were symptomatic and surgical therapy was performed.

Occasionally patients with an enlarged sella are asymptomatic or present with only headache, and management is more complex. An analysis of 46 patients with asymptomatic enlargement of the sella turcica with pneumographic evidence of an intrasellar mass[3] included 13 patients who had no visual or endocrine symptoms referable to the presence of a pituitary tumour and who were clinically unchanged after a follow-up extending to 15 years. This indicates that not all chromophobe adenomas are clinically detectable and that asymptomatic patients with a clinically silent intrasellar mass lesion may not require therapy. An unpublished study of 75 consecutive patients evaluated for an enlarged sella and who had no visual signs or symptoms[4] demonstrated the following results: 27 patients were diagnosed as having an intrasellar pituitary tumour and 25 were diagnosed as "primary empty sella" syndrome by pneumoencephalography; 13 patients were found to have an extra-sellar process; 10 patients had no final diagnosis because pneumoencephalography was not done, but no endocrine or visual symptoms have developed with follow-up extending to three years.

In asymptomatic patients or those with only headaches sella size and configuration and the results of tests of hypothalamic pituitary function were not characteristic enough to differentiate an intrasellar pituitary tumour from primary empty sella syndrome; air study is necessary to make the correct diagnosis. If the enlarged sella is empty no further evaluation or treatment is necessary. If a clinically silent intrasellar pituitary tumour is present management is more complex, and the possible non-progressive course of pituitary adenomas must be weighed against the probability of the usual progressive course.—I am, etc.,

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1 Vezina, J. L., and Sutton, T. J., *American Journal of Roentgenology*, 1974, **120**, 46.
2 Zimmerman, E. A., Defindini, R., and Frantz, A. G., *Journal of Clinical Endocrinology and Metabolism*, 1974, **38**, 577.
3 Weisberg, L. A., *Archives of Neurology*. In press.
4 Weisberg, L. A., Zimmerman, E. A., and Frantz, A. G. In preparation.

Spontaneous Pneumococcal Peritonitis

SIR,—In response to your interesting leading article "Diagnostic Ascitic Tap in Cirrhosis" (29th March, p. 701) we should like to describe a patient who has had two episodes of spontaneous pneumococcal peritonitis.

A woman with a long history of seronegative polyarthritis was found to have hepatosplenomegaly and pancytopenia in 1970 at the age of 36 years. Liver biopsy showed non-specific inflammatory features but no definite evidence of cirrhosis. Thereafter she remained well and without ascites until 1972, when she developed an acute febrile illness with abdominal pain and distension, but without hepatic decompensation. A diagnostic peritoneal tap produced fluid with numerous polymorphonuclear leucocytes and a protein content of 10 g/l. Pneumococci were isolated from both aspirate and peripheral blood. She recovered with intravenous fluids and antibiotics. A similar episode occurred in 1974, again without preceding ascites. Portal venography later demonstrated portal vein dilatation and oesophageal varices, but the patient refused further liver biopsy. Immunoglobulin studies (1972-4) revealed absent IgA, much reduced IgG, and normal IgM, while cellular immunity was intact. Two daughters also have immunoglobulin deficiency.

The value of diagnostic peritoneal tap was rightly emphasized in the leading article, but we feel the relevance of pre-existent ascites to the development of spontaneous peritonitis is uncertain. The patient we describe had no preceding ascites (though we have no histological proof or cirrhosis). In spontaneous peritonitis of childhood the great majority of patients are previously healthy with no previous ascites. As the bacteriological spectrum is so similar in children and cirrhotics there appears little reason to regard the two groups as separate entities. Finally, while it appears that our patient's immune deficiency was an important factor in the development of spontaneous peritonitis, we have found no previous reference to this condition arising in primary hypogammaglobulinaemia.—We are, etc.,

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Statistics of Child Abuse

SIR,—A few years ago the idea that parents could cruelly mistreat their own children would have been hotly denied by most people. We were, of course, familiar with the "wickedness" of step-parents from fairy tales and novels, which were less communicative about the "goodness" of other step-parents. Denial, which is no longer possible, has been replaced by shock, anger, and public outcry against "battering parents." Everybody knows that it happens, agrees that it should not happen, and when a child is killed we now assume that "someone" outside the family has made a mistake and merits public rebuke. No public inquiry has yet shown who this really is. I would enter a plea now that since no useful purpose is served, no more such inquiries be held. The problem is so complex and involves so many people that it can never be true that one person or one profession is to blame.

Now the inevitable reaction is occurring. Yes, the problem exists, but surely it has been grossly exaggerated. So correspondence in the general and in the professional press seeks to cut the problem down to size (see Dr. Catherine S. Peckham and Miss Megan Joblin (21 June, p. 686) and the correspondence columns of *The Times*).

The number of families in which children suffer from deprivation, abuse, and non-accidental injury could become known only through statutory notification. This in turn would require strict definition of categories and the exercise of both the skill and the will to apply the definitions by a large body of citizens, including social workers, teachers, doctors, and all those under a statutory obligation to notify. The minutest search in the Registrar General's Statistical Reports will never reveal data which were not put into it.

The next steps will, I hope, be our calm acceptance as a society that, however large or small it is, the problem really exists. We must seek to understand why, and until we do we must extend sympathy to the families