were inserted into the fossa navicularis, approximately 10 mm. from the exterior. It may be significant that the swabs were transported in our mycoplasma transport medium, which contains yeast extract and 20% unheated horse serum,[3] and were not frozen. We have frequently isolated H.S.V. from cervical swabs transported in nutrient broth, but it is possible that a higher number of isolations of H.S.V. might be achieved by using a transport medium enriched with serum.—We are, etc.,

C. S. GOODWIN.
J. V. T. GOSTLING.
P. J. PEAD.

Public Health Laboratory,
Portsmouth.

E. H. SIMS.

Royal Naval Barracks,
Portsmouth.

REFERENCES

1 Harkness, A. H., *Non-gonococcal Urethritis*, p. 196. Edinburgh, Livingstone, 1950.
2 Hutfield, D. C., *British Journal of Venereal Diseases*, 1968, **44**, 241.
3 Taylor-Robinson, D., Addey, J. P., and Goodwin, C. S., *Nature*, 1969, **222**, 274.

Sign in Gall-bladder Disease

SIR,—I think we should be thankful that Sir Zachary Cope has used his own ills to improve our knowledge of gall-bladder disease (18 July, p. 147).

The pathogenesis of acute cholecystitis is still far from clear, and there remains disagreement on the role played by bacteria versus noninfective inflammation. In addition to the clear account of the anamnesis it would be very much worth while, I believe, to know whether a bile culture was taken at surgery on this distinguished patient, and if so, what the bacteriologist reported.—I am, etc.,

RODOLFO HERRERA-LLERANDI.

Universidad de San Carlos,
Guatemala City, Guatemala.

Calcium Metabolism in Patients with Epilepsy

SIR,—I was interested in the papers by Professor C. E. Dent and his colleagues (10 October, p. 69) and Mr. D. J. F. Richens and Dr. A. Rowe (p. 73). In 1968 when Kruse and Stecher[1] published their findings of rachitic changes in the bone and blood in nearly 15 out of 60 patients aged between 4 and 23 years of age examined at the Kinderclinik Heidelberg we were doing a survey of serum folates in 41 children. All these children had been under treatment with phenobarbitone or phenytoin, or both, for a duration of 1-11 years. *X*-ray films were taken of the wrist joints of these children and there was no evidence of disturbance of ossification in any child. The serum calcium estimations ranged from 9·0 to 11·7 mg./100 ml. (only one specimen was 11·7). The main range was from 9·0 to 11·1. However, the alkaline phosphatase levels all showed an increase ranging from 14·8 to 41·2 K.A. units. Despite the very high levels of serum alkaline phosphatase recorded it is interesting to note that no hypocalcaemia was demonstrated in any of these children.

The children were originally selected because their anticonvulsant treatment had been relatively stable over the years, and though other drugs had been given at times this had been only for relatively short periods. At that stage only one of the children had had pheneturide and that only for a period of three months, a year before these investigations took place. His serum alkaline phosphatase was 16·6 K.A. units and calcium 10·7 mg./100 ml.

I am grateful to Dr. Albert Sachs, lately consultant pathologist to the Queen Victoria Hospital, East Grinstead, who did the estimations for us, and to Dr. William Campbell, radiologist to the Queen Victoria Hospital, who reported on the *x*-ray examinations.

JAMES BOWE.

Lingfield Hospital School,
Lingfield,
Surrey.

REFERENCE

1 Kruse, R., *Monatsschrift für Kinderhellkunde*, 1968, **116**, 378.

Wrong Operations

SIR,—I am not impressed by Dr. J. N. Thorpe's suggestion (24 October, p. 242) of using the patient's date of birth as an identity code. It is said that "there is one born every minute" so that it would seem that there are 1,440 of the less sapient members of the genus *Homo* with identical birthdays for every day of the year.

A friend of mine with a mathematical turn of mind assures me that if a room contains 20 people the chances are even that two will share a birthday. Perhaps they arrange things differently in Sweden.—I am, etc.,

IAN W. PAYNE.

Plymouth.

Oxygen and Myocardial Infarction

SIR,—Dr. A. L. Muir and his colleagues (31 October, p. 276) show that in patients with myocardial infarction mixed venous oxygen saturation is reduced when they are clinically in left ventricular failure or cardiogenic shock. The authors claim that these measurements correlate with cardiac output, and suggest they should be used when the apparatus for estimating cardiac output is not available as "an important aid to the rational treatment of patients. . . ."

Inspection of the data in fact suggests that their clinical assessment gave a better guide to cardiac output than mixed venous oxygen saturation in cases complicated by cardiac failure. This may be because the most severely affected group were receiving oxygen when the measurements were made, whereas the group classified as left ventricular failure were not.

Although the data taken overall reveal a correlation the scatter between individual results is such that measurements of mixed venous oxygen saturation would be an unreliable substitute for measurement of cardiac output in monitoring a patient's progress.—I am, etc.,

RICHARD WALDRAM.

St. Thomas's Hospital,
London S.E.1.

Motoring

SIR,—In fairness to the British manufacturer may I enlarge on your Motoring Correspondent's comments (7 November, p. 374) concerning the Britax Twin-Lok seat belts which can be put on and adjusted with one hand? In fact, this type was originally designed for the Triumph 2000 Mk. II from the blue-print stage, and was shown for the first time in London at the 1969 Motor Show. Since then it has featured on an increasing number of new cars. Just to remove any ambiguity, automatic retraction is not unique to the Volvo belt, as the Twin-Lok is also available in static and automatic forms.

On another point raised may I suggest that the smallest engine in any given body shell is by no means always the most economical—for example, the Ford Capri 1300 and 1600 respectively? In give-and-take driving the smaller engine has to work harder to yield any set performance and quite often therefore uses more petrol than its more lightly stressed bigger stable-mate. In addition, the larger engine often proves more durable for the same reason, and is usually less noisy and more pleasant to sit behind.—I am, etc.,

KEITH E. JOLLES.

Birmingham 8.

Skin Disease and the Gut

SIR,—Those of us with children under our care have long been aware of the close link which exists between the skin and the gut (leading article, 1 August, p. 240). Could it be otherwise, when the prototype disorder linking both was recognized nearly 30 years ago and appropriately named acrodermatitis enteropathica by Professor Niels Danbolt, who still holds the chair of dermatology at Oslo? We ourselves[1 2] were among the first to report enzyme histochemical and ultrastructural studies of this disorder, and later recognized genetic variants which had previously been considered to be diodoquin-resistant forms of the disease. We were able to show that impaired tolerance of disaccharides and monosaccharides was responsible for this, and elimination of these from the infant's diet was followed by prompt response to didoquin (sugar-free), and all three children are now thriving and well. No gross or light miscroscopical changes were detected in jejunal or duodenal biopsy from any variants of the disease, but it would be quite misleading for changes in morphology to be considered the sole of this or indeed any disease, because gross functional disturbances may present without any detectable morphological change even at the ultrastructural levels.

As to the question of possible links between dermatitis herpetiformis and coeliac disease: I cannot recollect a single child with coeliac disease who had anything amiss with the skin during the several years that I shared a ward at the Hospital for Sick Children with Sir Wilfred Sheldon, who is prominent among the pioneers in the investigation of this disorder. During the same period, and subsequently, several children suffering from both forms of dermatitis herpetiformis (the bullous and small vesicular form) were under my care, but showed no signs or symptoms suggestive of any enteropathy. It would seem, therefore, that if the northern workers are correct, coeliac disease in adults is very different from that seen in children as we meet it in the south of England.

With regard to "regional" differences, surely a more profitable approach would be to study the distribution of both gluten enteropathy and dermatitis herpetiformis in different ethnic populations. We already possess sufficient information about the gene for gluten enteropathy throughout Europe, and we know too, that ethnic differences are reflected in the British population, shown by the appreciably higher incidence of this disease in children of Irish, Welsh, and Scottish

extraction. This is precisely the distribution to be expected if wheaten flour is the selective factor which determines the incidence of the gene in different populations, and the frequency of the disorder in any given population should, therefore, provide a good index, not only of the current dietary habits of the population concerned, but should also tell us when wheat became an important item in their diet. We know that wheat was first domesticated somewhere on the Eastern seaboard of the Mediterranean (probably Anatolia) soon to become part of the triad wheat—olives—vine, on which some of the great civilizations of antiquity were built. It is also known that cultivation of wheat spread slowly into the hinterland of mainland Europe and did not reach its northern limits until fairly recently; these include the British Isles.

This spread of wheat has been accompanied by the gradual elimination of the coeliac genotype from the populations concerned as wheat became a more substantial part of the diet, because of the high mortality of untreated coeliac disease in these early populations. Indeed, until communications became more effective and greater supplies of wheat became available, it did not figure prominently in the diet of Scottish, Welsh, and Irish populations until quite recently.

Isophenes, as they are termed, may be drawn on the map of Europe to represent the incidence of coeliac disease in the indigenous populations, and should reveal that the lowest incidence is found in countries close to the region where wheat was first demonstrated, with increasing incidence as one moves away from the centres where wheat originated. Therefore, it would seem probable should there be a close link between dermatitis herpetiformis and coeliac disease that the isophenes in both conditions should approximate very closely to each other, and in the present circumstances in the British Isles, we should, therefore, find a higher incidence in those of Irish or Scottish descent than the incidence in children of East Mediterranean origin. As a corollary to this, dermatitis herpetiformis should be an extremely rare disorder in Greece or Turkey, but if it is common in these populations then this would indicate that any relationship between the diseases is merely fortuitous.

Our knowledge of population genetics is increasing and is already sufficient to be able to give fairly reliable answers to questions of this kind. Sickle cell disorders, thalassaemia, favism, milk intolerance are among those conditions which result from gene mutations in which diet and disease may play selective roles, and it will be interesting to see if the same can be sustained for coeliac disease and dermatitis herpetiformis.—I am, etc.,

E. J. MOYNAHAN.

Dermatology Department,
Guy's Hospital,
London S.E.1.

REFERENCES

1 Moynahan, E. J., Johnson, F. R., and McMinn, R. M. H., *Proceedings of the Royal Society of Medicine*, 1963, **56**, 300.
2 Moynahan, E. J., *Proceedings of the Royal Society of Medicine*, 1966, **59**, 445.

Forgotten Medicine?

SIR,—In these days, when one new drug follows another for the treatment of various types of tremor, unfortunately none of them can be considered reliable or wholly predictable in their action. The type of case for which I believe an old remedy can be helpful is the severe familial tremor affecting a small proportion of old people, and this can be so severe as to appear to be Parkinson's disease.

I have known three such cases. In each case great relief was afforded by a medium dose of ethyl alcohol, not obtainable from diazepam, barbiturates, or the like. A number of old people realize this, but with spirits at the present price, they cannot afford their medicine.

The point I wish to bring out here is that if the prescribing of so much whisky or gin, or even Sp. vini rect. per week were permitted, it would actually save money as compared with various tablets.

The patients I am anxious to see helped are not alcoholics, but people in dire need of a form of treatment which would materially ease their lot. At present many of them must be groping in the dark amidst a shower of ineffective, or upsetting, tablets.—I am, etc.,

GUY BOUSFIELD.

Broadbridge Heath,
Sussex.

Conference of Medical Association of New Zealand

SIR,—The biennial conference of the Medical Association of New Zealand (formerly N.Z. branch of B.M.A.) is being held in Palmerston North from 15 to 18 February 1971. My committee would like to extend a very warm welcome to any members of the British Medical Association who may be visiting New Zealand at this time to attend the conference.

Although we may have changed our name we still retain many links with the B.M.A. Indeed, one of my colleagues in this city has only recently returned from attending the B.M.A. meeting at Harrogate, and has spoken warmly of the hospitality he received during his visit. We hope that we may be able to extend similar hospitality to members of the B.M.A. The scientific programme has as its theme "Man and His Environment," and it has been arranged to provide lectures of interest to most of the medical specialties.

An advertisement (p. iv, 31 October) has given details of tours which have been centered around the conference. I would be only too happy to supply any additional information any member of the B.M.A. may wish.—I am, etc.,

J. C. MOORE,
Biennial Conference Secretary.

P.O. Box 655,
Palmerston North,
New Zealand.

Royal Medical Society

SIR,—There is one surprising omission from your list of distinguished past members of the Royal Medical Society (14 November, p. 386)—namely, Charles Hastings. During his time in Edinburgh Hastings played a very active part in the affairs of the society, of which he was elected senior president in 1817.

It can fairly be said that it was in the Royal Medical Society that the young man from Worcester, who was to become the founder of the B.M.A., began his career as perhaps the foremost medicopolitical leader of his time.—I am, etc.,

E. R. C. WALKER.

Dalkeith,
Midlothian.

Pay for Overtime

SIR,—As members of the consultant and registrar staff of a busy peripheral hospital, we are deeply disturbed by the recent introduction of regulations concerning the payment of hospital junior staff for overtime work (*Supplement*, 19 September, p. 96). In this hospital we have up to now encouraged and practised continuity of patient care, so that the doctor who institutes a patient's treatment continues that treatment whenever possible, and is informed of and deals with any complications arising from it. Consultant cover is of course available at all times. Junior staff in training have readily acquiesced in this arrangement.

The introduction of overtime payments necessitates a fairly exact delineation of times on duty and off duty and this in turn leads to the drawing-up of a rota whereby the supervision and the care of patients is regularly transferred from one doctor to another. We are convinced that this will result in a deterioration in the standard of patient care and is contrary to the best traditions of training of junior staff.

We do not believe that the medical profession as a whole favours the scheme, which has been introduced after the minimum of consultation with those most closely involved. We suggest that the Association conducts a postal ballot of hospital junior staff throughout the country in order to assess what support there is at this level for continuation of the scheme in its present form.—We are, etc.,

I. J. COUR-PALAIS.
D. E. BOLT.
J. A. FLEMING.
P. H. PATTISSON.
J. SCHOLEFIELD.
D. S. SUMNER.
O. N. TIKU.
M. J. WHARTON.
J. G. WINGFIELD.

Isleworth, Middx.
West Middlesex Hospital,

G.M.C. Retention Fee

SIR,—Many members of the medical staff of this hospital are now receiving a second notice from the General Medical Council requesting payment of the annual retention fee and giving warning that ". . . unless your annual retention fee is received by the Council within a period of twenty-eight days from the date of issue of this Notice, your name may be erased from the Register. . . ."

The introduction of this fee has been deplored here as elsewhere. At a meeting of the medical staff of this Group, the following resolutions were adopted unanimously: (1) we deplore the proposed introduction of the annual retention fee to the G.M.C. as at present constituted; (2) we will resist any action to remove from the Register any colleague on the grounds of non-payment of the retention fee; (3) we recommend to all our colleagues in the Group that they with-