It should be emphasized that no fungus grew in culture after the routine autoclaving process used in this hospital for the sterilization of cervical sponges. Thus the organisms were no longer viable and there was therefore no danger of causing any infection of the genital tract. In view of the initial difficulty which we experienced in distinguishing this contaminant from a true fungal infection of the genital tract we felt that cytologists should be aware of this potential source of diagnostic confusion and that care should be exercised in diagnosing a fungal infection on smears made from sponges until such time as the fungus in question has been conclusively identified.—We are, etc.,

A. D. BREMNER
M. H. S. BELL

Pathology Department,
Victoria Infirmary of Glasgow

1 Watson, A. A., *Lancet*, 1966, 1, 957.

Survey of Alimentary Radiological Findings

SIR,—Dr. E. M. Bateson (22 July, p. 233) draws attention to the lack of data about concomitant gastric and duodenal ulcers in our survey of alimentary radiology findings (8 April, p. 78). We were aware of the limitations of the preliminary report of the survey, as only an illustrative selection of the information of the vast amount of data collected could be presented.

The information requested is presented in the accompanying Table. The pattern by age and sex was similar throughout the survey. The combination of gastric ulcer and duodenal ulcer was more often seen in males and also in antral (prepyloric) rather than body gastric ulcers. Reference to the original paper will allow derivation of the estimated rates of detection per 100,000 of population at risk.

We note the surveys quoted by Dr. Bateson and agree that geographical comparisons are of value, especially if related to a defined population and may provide useful information about the aetiology of disease. Further studies based on the north-east of Scotland survey are in process.—We are, etc.,

J. C. PETRIE
C. D. NEEDHAM
L. A. GILLANDERS

Aberdeen Royal Infirmary

Occurrence of Concomitant Duodenal and Gastric Ulcer (Body or Antrum/Prepyloric) 1967-70 by Sex and Age Distribution (19,667 Examinations). Total Duodenal Ulcers Demonstrated: Male, 3,242; Female, 1,290

Ages (Years)	Male		Female	
	D.U. + G.U. (Body)	D.U. + G.U. (Antrum)	D.U. + G.U. (Body)	D.U. + G.U. (Antrum)
12-19	—	—	—	—
20-29	4	2	0	1
30-39	10	7	7	1
40-49	9	10	3	4
50-59	12	13	5	4
60-69	16	15	7	5
70-79	4	5	3	3
80+	1	0	6	1
Total: G.U. + D.U. ..	56	52	31	19
All gastric ulcers (1967-70)	222	157	180	77
Percentage of concomitant G.U. + D.U.	25%	33%	17%	25%

Dialysis and Transplantation in Britain

SIR,—You have drawn attention in leading articles to the need for expansion of the services for the treatment of chronic renal failure in Britain. In Exeter we have been transplanting kidneys for the last five years and we now find that there is one aspect of national policy which restricts development of transplantation. We refer to the policy of the Department of Health that only those hospitals officially recognized as transplant centres can receive cadaver kidneys from the National Organ Matching Service (N.O.M.S.). Transplantation and dialysis go hand-in-hand and should be performed in the same centre under the supervision of the same personnel, who know the frequently complex clinical and social circumstances of their patients. Transfer of patients from an "unrecognized" to a "recognized" centre for transplantation is unnecessary and undesirable, especially from the points of view of hepatitis and prolonged and distant separation from the home.

We have the requisite facilities for transplantation—namely, a large, regular dialysis unit, tissue-typing facilities, a pool of recipients, surgeons experienced and specially trained in transplantation, local good will, the co-operation of colleagues, and all the back-up facilities of a large, major district hospital—but even so access to cadaver kidneys from the N.O.M.S. is still denied to us and our patients. At the same time the N.O.M.S. welcomes any kidneys we may send them, and so far this year we have sent 14 but been allowed none in return.

This policy of the Department of Health is surely retrograde and prevents the development of a comprehensive service for patients unfortunate enough to have chronic renal failure.—We are, etc.,

CYRIL SHALDON
M. S. GOLBY
G. H. HALL

Royal Devon and Exeter Hospital,
Exeter

Tetracyclines for Malaria

SIR,—I write to point out that the leading article under this heading (26 August, p. 487) gives quite a misleading impression of the drug trials that were being reviewed. A combination of quinine and tetracycline, later mentioned as being a ten-day treatment, was stated to have cured a much higher proportion of falciparum malaria infections than had a three-day treatment with quinine and chloroquine. The trials took place in Thailand, where chloroquine-resistant falciparum malaria is fairly common, and the comment was made: "It could be argued that the quinine-chloroquine regimen might have been given a fairer chance if its duration had been extended to at least one week."

I did not see how such trials could provide any evidence of the value of tetracyclines in malaria. If carried out as described, they would merely have confirmed that a three-day course of quinine is insufficient to cure many falciparum infections and that a ten-day course will produce better results. Further judgement however had to be suspended until I could consult the original paper;[1] only when I had done so did it become clear that the description of the trials given by the writer of the leading article was at fault.

The American authors[1] used two drug regimens: (1) quinine sulphate for three days *followed* by tetracycline hydrochloride for 10 days, (2) quinine sulphate for three days *followed by* chloroquine phosphate, 1,500 mg base in 48 hours. (The italics are mine.) As the same small dose of quinine was given in each instance, the results of this comparison do support the assumption that tetracycline has some effect against falciparum malaria when combined with quinine, but the authors warn against using it alone because its action is so slow. The duration of the treatment was 13 days, not 10 as stated.

It is unfortunate that the wording of this particular leading article does not permit a fair assessment of the value of the work it purports to describe.—I am, etc.,

T. WILSON

Portstewart,
N. Ireland

1 Colwell, E. J., Hickman, R. L., and Kosakal, S., *Journal of the American Medical Association*, 1972, **220**, 684.

Abortion Deaths

SIR,—The abortion deaths quoted by Professor H. C. McLaren (30 September, p. 826) are derived from the *Confidential Enquiry into Maternal Deaths in England and Wales, 1967-69*,[1] a period which spans the start in April 1968 of the operation of the Abortion Act, 1967. In the inquiry series of cases totals for abortion deaths were: 1967, 40; 1968, 44; 1969, 34.

These figures and knowledge of the complete figures as well as of the inquiry series presumably prompted Sir George Godber's comment in the preface that "Abortion remains as in the last three reports the largest single cause of maternal death, but in 1969 there was a substantial reduction in the number of deaths due to abortion, even though in that year the number of therapeutic abortions was greatly increased as a result of the Abortion Act." However, the deaths in the inquiry series included three groups of abortions—legal, the illegal, and the so-called "spontaneous" abortions. When these three groups are separated the major decreases are seen to affect both the illegal and spontaneous groups and, as Professor

McLaren has pointed out, the legal abortion deaths have increased.

TABLE I—*Abortion Deaths included in the Inquiry Series, 1967-69*

	Legal	Illegal	Spontaneous	Total
1967 ..	1	28	10	40
1968 ..	5	29	10	44
1969 ..	12	17	5	34

The spontaneous group of abortions in this series includes those cases where the evidence was not clear enough to call the abortion legal or illegal and the group probably includes quite a number of self-induced abortions. It is interesting that since the start of the Abortion Act in 1968 it is particularly this group of doubtfully-classified abortions which have decreased among the deaths counted by the Registrar General, as is shown in Table II.

TABLE II—*Registered Deaths attributed to Abortion as the Underlying Cause*

	Induced for Medical or Other Legal Reasons	Induced for Other Reasons (Illegal)	Spontaneous	Not Specified as Induced or Spontaneous	Total
1963	3	21	5	18	49
1964	3	24	5	20	50
1965	4	23	8	17	52
1966	3	30	11	17	51
1967	1	17	4	12	34
1968	5	22	12	11	50
1969	10	15	8	2	35
1970	10	11	7	4	32
1971*	12	6	3	5	26

*Provisional figures.

With the number of therapeutic abortions having increased by between 30,000-40,000 each year between 1968 and 1971, with the total deaths from abortion becoming less, and with those due to legally-induced abortion remaining at about the same level it is difficult to see the grounds for Professor McLaren's gloomy prognostication that abortion deaths will keep pace with the increasing legal abortions.—I am, etc.,

JOSEPHINE A. C. WEATHERALL

Medical Statistics Division,
Office of Population Censuses and Surveys,
London W.C.2

1 *Reports of Confidential Enquiries into Maternal Deaths in England and Wales 1967-69. Reports on Health and Social Subjects, No. 1.* London, H.M.S.O., 1972.

SIR,—Professor H. C. McLaren (30 September, p. 826) does not appear to believe that abortion deaths have fallen. The official figures[1] are as follows:

1950 - - 62	1966 - - 53		
1961 - - 54	1967 - - 34		
1962 - - 57	1968 - - 50		
1963 - - 49	1969 - - 35		
1964 - - 50	1970 - - 32		
1965 - - 52	1971 - - 27	(provisional)	

It can be seen that in 1967 abortion deaths were unusually low. The Chief Medical Officer notes in his 1968 annual report[1] that maternal deaths for 1967 were also "exceptionally low."

Johnson[2] shows that more abortion deaths occurred before the Abortion Act than were officially notified as such. Hence the real fall in total abortion deaths has been even greater than the official figures indicate.—I am, etc.,

MADELEINE SIMMS

The Eugenics Society,
London S.W.1

1 Department of Health and Social Security, *On the State of the Public Health*, Annual Reports of the Chief Medical Officer to the Department of Health and Social Security. London, H.M.S.O.
2 Johnson, H. R. M., *Medicine, Science and Law*, 1969, **9**, 102.

Rh Isoimmunization from Ruptured Tubal Pregnancy

SIR,—I cannot allow the article by Drs. J. Katz and R. G. Marcus on the risk of isoimmunization in ruptured tubal pregnancy (16 September, p. 667) to pass without comment. From my experience of working in East Africa, where ruptured ectopic pregnancies are common, with a high mortality rate, and where rhesus sensitization is uncommon, many patients will die if they are deprived of the safeguard of autotransfusion.

While a sophisticated blood transfusion service may be available in university centres in big cities this is not the case throughout the greater part of the under-developed areas in Africa. I therefore maintain that irrespective of the risk of rhesus isoimmunization there remains a real need for autotransfusion to take place where the condition of the patient is critical.—I am, etc.,

G. DE B. MITFORD-BARBERTON

Irthlingborough, Northants

Payment by Colour

Sir,—Following Dr. Susan F. O. Dowling's letter (11 March, p. 689) there has been a spate of correspondence on discrimination in medicine in South Africa. I feel that your readers will be interested in the present salary scales (figures in rands) shown in the Table.

Rank	White	Indian and Coloured	African
Chief specialist/professor	12,000	8,400	7,800
1st Specialist	10,800	8,100	7,500
Senior medical officer	7,200 × 300 — 8,400	6,000 × 300 — 6,600	6,000 × 300 — 6,600
	8,400 × 300 — 9,300	6,600 × 300 — 7,200	
Medical officer and registrar	5,700 × 300 — 8,100	4,350 × 150 — 4,800	3,750 × 150 — 4,800
		4,800 × 240 — 6,000	4,800 × 240 — 6,000
		6,000 × 300 — 6,600	
Senior house officer ..	5,400	4,350	3,750
Intern	4,050	3,120	2,760

In 1964 the salary of an African junior houseman was 79% of that of a white junior houseman; in 1967, 67%; in 1970, 66%; in 1971, 62%; and in 1972, 68%. The African medical registrar's salary in 1964 was 80% of the white medical registrar's; in 1971 it was 61%, and in 1972, 65%.

To justify these discriminatory practices various explanations have been given by the authorities, which have included the following: (1) "Non-whites" (Blacks) have a lower standard of living. (2) The salaries must be related to "homelands." The homelands need doctors. If the Bantu (African) doctor is paid the same salary as the white doctor in the urban area the homeland governments will not be able to attract Bantu doctors there as these governments are not in a financial position to give the same salary. (3) The Bantu has yet to prove that he is capable of the same level of intellectual development as the white man.

The salary discrimination among the paramedical personnel is much worse. African nurses earn 40-50% of the white nurses' salary. No explanation has been given why the difference in salary for nurses should be more than those of doctors. The fact there are separate eating utensils (clearly marked N.D. and E.D.), separate dining rooms, separate table cloths (also marked N.D. and E.D.), and separate theatre changing rooms at black (non-white) hospitals does not require explanation. There are many other aspects of the "traditional way of life" affecting doctors and nurses which have not been brought out in your correspondence columns. Interested foreign visitors could easily acquaint themselves with these facts when they come here on lecture tours.—I am, etc.,

"MEDICAL GRADUATE"

SIR,—Mr. M. S. King (19 August, p. 475) gives one side of the picture. It is indeed true that coloured and African doctors do not receive the same pay as their white colleagues.

I was a district surgeon in Cape Town; part of my time was spent looking after staff and prisoners in a large prison. All prisoners (whatever colour) were entitled to see the district surgeon at daily morning consultations and could, of course, call for medical attention in emergencies at any time. There was a hospital staffed by trained personnel in the prison. Should specialist opinion be required, patients would be transported and seen by the specialist in his rooms at any hour of the day or night (no arguing with housemen as to the priority), and if required taken to hospital for further treatment by the same specialist. Needless to say, all expenses were paid by the State.

I worked in the United Kingdom for many years and in my opinion hospital referral (particularly in regard to the time delay) is far superior here.

As regards the medical position here—there is no shortage of doctors in places like Durban, Cape Town, or Pietermaritzburg, but a great shortage in the more remote areas. A person under 35 years old, especially if he is prepared to specialize, will enjoy a much higher standard of living, a better income, and above all more satisfactory working conditions than ever he had in the United Kingdom.

My advice to such persons is please do not believe all you read in the press or see on television; come and see for yourself.—I am, etc.,

N. POVER

Pietermaritzburg,
Republic of South Africa

*** This correspondence is now closed.—ED., B.M.J.