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.,

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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