patients cannot even face a public appearance in an outpatient waiting chair. The Dermatologists Group Committee, who know well the vastly differing standards of competence among those practising electrolysis in this country, felt that the existing ethic of prima facie covering was now unrealistic in the absence of any medical alternative, and moreover that it would seem medically much more reprehensible simply to advise electrolysis to deserving patients and then to leave them exposed to the incompetent charlatan rather than refer them directly to a fully qualified and skilled practitioner.

It is apparent that there are at present areas of the country without service from members of these organizations, though demands to their secretaries might in time redress this imbalance. But we feel strongly that, even where the service exists, prerequisites to a referral by a doctor should be confirmation of the presenting standards of medical knowledge, of equipment in a clearly professional suite, and of the quality and results of the work itself. Full information on these points can be gleaned from the publications listed below.[1-3] To avoid confusion, we find it necessary to regret and to dissociate ourselves from the relevant paragraphs in the B.M.A. Family Doctor publication, *So Now You Know about Your Skin.*—I am, etc.,

IAN W. CALDWELL
Chairman,
B.M.A. Dermatologists Group Committee

1 *Which*, November 1966, p. 357.
2 Blair, S., *Journal of the Medical Women's Federation*, 1971, **53**, 92.
3 Dopson, L., *Pulse*, 1972, **25**, 4.

Cutaneous Lesions in Multiple Myeloma

SIR,—I note with interest in the article by Dr. D. G. Beevers (4 November, p. 275) the statement that cutaneous deposits of myeloma have not been reported in the British press before.

I should like to draw the attention of readers to an article by Dr. P. B. Haribhakti[1] entitled "Multiple Myeloma with Extramedullary Plasmacytomas," published in 1966, and to a second article, published in 1961 by Dr. M. A. Cowan, entitled "Ulceration of the Skin in Multiple Myeloma."—I am, etc.,

C. F. H. VICKERS
Liverpool Royal Infirmary,
Liverpool

1 Haribhakti, P. B., *British Medical Journal*, 1966, 2. 1118.
2 Cowan, M. A., *British Journal of Dermatology*, 1961, **73**, 415.

Septo-optic Dysplasia

SIR,—In their article on septo-optic dysplasia (30 September, p. 811) Dr. C. G. D. Brook and others did not mention an important diagnostic clue to the presence of midline cerebral anomalies associated with hypoplastic optic nerves—bitemporal hemianopia.[1] Blindness is not necessarily a feature of this syndrome as they state; visual acuity may be normal.[1 2]

Hypoplasia of one or both optic nerves without cerebral malformation may be associated with other abnormalities in the visual field, including small arcuate defects,[3] altitudinal hemianopia,[2] and centrocaecal scotomas.[4] Only bitemporal hemianopia, however, indicates selective involvement of ganglion cell fibres crossing in the optic chiasma and thus suggests that other midline forebrain structures are also dysplastic. (Unilateral temporal hemianopia may be present if the opposite eye is completely blind.) Does dysgenesis of the optic chiasma, a structure closer to the hypothalamic-pituitary pathway than the septum pellucidum, correlate with the presence of endocrinologic abnormalities?—I am, etc.

CARL ELLENBERGER, JUN.

Washington University School of Medicine,
St. Louis, Missouri

1 Ellenberger, C., and Runyan, T. E., *American Journal of Ophthalmology*, 1970, **70**, 960.
2 Gardner, H. B., and Irvine, A. R., *Archives of Ophthalmology*, 1972, **88**, 255.
3 Ellenberger, C., and Burde, R. M., *American Journal of Ophthalmology*. In press.
4 Seeley, R. L., and Smith, J. L., *American Journal of Ophthalmology*, 1972, **73**, 882.

Closure of Colostomy

SIR,—It is a pity that Mr. T. P. S. Thomson and Mr. P. R. Hawley, in their informative review of the results of closure of loop transverse colostomies (19 August, p. 459), did not indicate the method of construction of the colostomy in comparing the incidence of complications.

Apart from problems at the primary lesion anastomosis, most of the troubles with closure of colostomy are related to fibrosis and scarring and the subsequent difficulty of dissection of the colostomy from the layers of the abdominal wall. I suggest that the time-honoured method of using a glass rod and the consequent secondary union between skin and mucous membrane encourage this fibrosis and make the subsequent colostomy closure difficult. (The Paul-Miculicz type of resection is even more culpable in causing pericolostomy fibrosis.) This can easily be avoided by performing a mucosa-to-skin suture at the time of construction of the colostomy. This can be done even in the presence of obstruction, making possible the immediate fitting of a colostomy apparatus or Coloplast bag. A glass rod is used during the procedure but is removed when the last sutures are placed; this manoeuvre creates an acceptable "bar" between the two colon openings. The ease of subsequent closure of the colostomy in these cases is quite remarkable and is accompanied by few, if any, complications.

The idea of mucosa-to-skin suture in the performance of a colostomy is certainly not new, and in fact was a feature of the earliest known colostomy (caecostomy) by Pillore in 1776.[1] Keynes[2] more recently advocated mucocutaneous suture, though he suggested leaving the glass rod in for three days, a procedure which I find unnecessary.—I am, etc.,

K. B. ORR
Kogarah,
New South Wales,
Australia

1 Cromar, D. L., *Diseases of the Colon and Rectum*, 1968, **11**, 262.
2 Keynes, W. M., *British Medical Journal*, 1969, **1**, 187.

Plasma versus Serum

SIR,—A comparison has been made of the fasting blood glucose values obtained with plasma (using lithium heparin anticoagulant) and with serum prepared from the same sample of blood. Determinations were made immediately after preparation of the plasma and serum and again after 24, 48, and 168 hours' storage at −20°C.

The method of Sokoloff modified for use on the AutoAnalyzer II[1] was used and the following results were obtained (mean of 15 samples):

Period of Storage (hours)	Glugose (mg/100ml) Serum Value minus Plasma Value	S.E. of Mean Differences
0	−2	1·2
24	23	16·2
48	21	10·4
168	0	4·3

Values for stored plasma did not differ from initial values over the whole period, but standard errors were about five times as great for the serum series as for the plasma series, though this parameter decreased with storage. In determining blood glucose we consider it important, therefore, to use plasma samples, especially as our work often necessitates deep-frozen storage. I am, etc.,

L. F. GREEN
Beecham Products,
Brenford, Middlesex

1 Sokoloff, P. A., unpublished information provided by the Boehringer Corporation (London) Ltd.

Pulmonary Aspiration after Fibre-endoscopy

SIR,—With reference to the paper on pulmonary aspiration after fibre-endoscopy of the upper gastrointestinal tract by Drs. B. J. Prout and Metreweli (4 November, p. 269) we would like to make the following observations. The induction of local anaesthesia by spraying the back of the throat with lignocaine in addition to sucking a benzocaine lozenge inevitably anaesthetizes the larynx as well as the pharynx. Obstructing the oesophagus with the fibre-endoscope in the presence of laryngeal anaesthesia not surprisingly increases the likelihood of aspiration if the patient is asked to swallow. Surely, patients should be requested *not* to swallow their saliva.

In contrast to the large doses used in this study we find an average of only 10-15 mg diazepam intravenously allows sufficient relaxation without completely abolishing the laryngeal cough reflex; if the instrument touches the cords the patient immediately coughs. Furthermore, correct positioning of the trunk and head allows saliva to passively run out of the mouth so that swallowing becomes unnecessary.—We are, etc.,

S. R. GOULD
D. E. BARNARDO
Queen Mary's Hospital,
Roehampton

Creatinine Clearance Tests

SIR,—The calculation of the renal clearance of creatinine from measurements made on a single specimen of plasma and a 24-hour urine collection presupposes a steady state of plasma creatinine during the 24 hours. Thus there is no special reason for taking the plasma sample half-way through the urine collection, as is the usual practice, and it would seem just as reasonable to take the plasma at the time of completion of the collection.

This procedure would have two advantages. The first is that it would overcome many of the administrative difficulties, both on the ward and in the laboratory, which arise from the necessity of sending a plasma sample and request card to the laboratory on one day and the 24-hour urine sample with a second request card on the following day. If the plasma is taken when the collection is completed, both specimens can be sent with a single request card. The second, perhaps less important, advantage is that with this procedure the change in creatinine clearance will be greater than with the conventional method should the plasma creatinine be rising or falling during the period of the urine collection. For example, if renal function were deteriorating and plasma creatinine rising the creatinine clearance would be lower if the plasma is taken at the end of the urine collection than if it is taken in the middle.

There is no doubt that clinical biochemistry laboratories would welcome this change in procedure, and it appears to have no clinical disadvantages.—We are, etc.,

R. B. PAYNE
S. M. ROSEN
P. H. SMITH

Leeds (St. James's) University Hospital, Leeds

Guillain-Barré Syndrome after Measles

SIR,—We thank Dr. P. E. Phillips (7 October, p. 50) for his interest in our report on two cases of Guillain-Barré syndrome and encephalitis after measles (3 June, p. 572). A few comments are needed.

As stated in the case histories of our patients, they were admitted to the hospital six and seven days respectively after the onset of the rash. At that time, Koplick's spots are of course not to be expected. We did not consider it necessary to point out to the readers of the *B.M.J.* that acute and convalescent sera were titrated simultaneously. The spinal fluid cell values on admission were given in the paper. The very slight pleocytosis in Case 1, 11 mononuclears mm^3, is not unusual in measles. Cell counts of fluid obtained later during the course of the disease were consistently normal (0-4 cells/mm^3) in both cases, whereas the protein concentrations were high.

Thus we feel that the diagnoses of measles and polyradiculoneuritis are well established. Also, we certainly agree with Dr. Phillips that our patients had encephalomyelitis with a polyneuritis. That the latter conformed to the criteria of the Guillain-Barré syndrome is, we think, an interesting point.—We are, etc.,

GUNILLA LIDIN-JANSON
ÖRJAN STRANNEGÅRD

Institute of Medical Microbiology, University of Göteborg, Sweden

Vasectomy in the Surgery

SIR,—With reference to Dr. E. R. Seiler's letter (28 October, p. 232) on the subject of vasectomies, I would like to report that over the past 2½ years my partner and I have performed this operation more than 200 times in our surgery.

I am happy to say that, apart from one failure, we have had no haematomas, sepsis, or other complications. Like Dr. Seiler I at first had difficulty in immobilizing the cord, but after the first few operations this became relatively easy and nowadays we find the operation a very simple procedure which is over in about 20 minutes.

Although we have never used a general anaesthetic we feel that under local anaesthesia the patient probably has a better chance of avoiding complications, especially haematoma formation. Our patients suffer only minimal discomfort.

In conclusion I would add that I entirely disagree with Dr. Seiler's last sentence and suggest that if a doctor is adequately trained in this operation it is one that can be carried out with ease in general practice.—I am, etc.,

C. G. BROWN

Slough, Bucks

Defence Societies and Disciplinary Actions

SIR,—The Medical Protection Society has recently successfully defended a member against an allegation of serious professional misconduct brought before the Disciplinary Committee of the General Medical Council by the Medical Defence Union.

In recent weeks many members of the profession have expressed concern that an action should have been brought in this way and have sought information regarding the policy of this society. This is that we do not see as one of our functions the initiation of actions of this nature against members of the profession. Indeed, we regard such as being inconsistent with our aims and sympathies.—I am, etc.,

J. LEAHY TAYLOR
Secretary, Medical Protection Society

London, W.1

Occupational Health Services

SIR,—Dr. T. A. I. Rees (28 October, p. 230) draws attention to an important point—that of lack of planning for the provision of occupational health services for local authority employees after integration of the National Health Service in April 1974.

Local authorities are one of the largest employers of staff, employing over three-quarters of a million people in England and Wales in a great variety of occupations. While few people would claim that local health authorities have led the field in promoting occupational health services, many medical officers of health have been instrumental in pioneering occupational health services in their areas, to the benefit of the worker, the authority, and the public they serve. While it is proposed that the future National Health Service will have an occupational health service[1] this service will apparently be available only to National Health Service staff.

The working party on collaboration between the National Health Service and local government might well keep in mind the aphorism of Dr. L. G. Norman when chief medical officer to London Transport: "The interests of employer and employee usually coincide: both want a healthy employee." The most effective way to achieve this would be for local authority employers to establish comprehensive occupational health services for their employees. These services should be staffed by occupational physicians and occupational health nurses seconded to the local authority but working within the National Health Service.—I am, etc.,

A. R. BROADBENT

Health Department, Hounslow

1 Department of Health and Social Security, *Arrangements for the Reorganized National Health Service*. London, H.M.S.O., 1972.

C.C.H.M.S. and Consultant Contract

SIR,—At a recent meeting of the medical committee of this large district hospital a discussion took place about the composition and function of the Central Committee for Hospital Medical Services. As a result of this discussion I was asked to write to you summarizing the views of the medical committee.

Serious doubts were expressed about the competence of the C.C.H.M.S. to represent the views of consultants—indeed, several members of my committee expressed surprise at the claim that they were represented by this body, since no direct communication exists between members of the C.C.H.M.S. and themselves. The committee feels that the C.C.H.M.S. is quite unrepresentative of the views of consultants as a whole, who have no effective voice to speak for them.

The occasion for this expression of views was a discussion on the proposed new consultant contract. We are informed that, at the Annual Representative Meeting, a motion was tabled by our representative on the regional committee for hospital medical services. This motion, hostile to the introduction of the new consultant contract and genuinely representative of the views of my committee, was not discussed at the A.R.M. The committee deplores the fact that in a supposedly democratic Association no opportunity for open discussion of such an important issue was permitted.

Even if the C.C.H.M.S. were a democratic body (which it is not), and therefore competent to speak on behalf of consultants, it is most undesirable that an issue of such importance as a change in contract should be decided without reference to consultants as a whole. The only way in which this can be effected is by a national referendum of consultants, and it is the unanimous view of my committee that this should be arranged without delay. If the cost of such an undertaking should be a deterrent, each consultant participating could be invited to make a suitable contribution; it is unlikely that anyone would object to doing so.—I am, etc.,

J. A. FLEMING
Chairman, Medical Committee, West Middlesex Hospital

Isleworth, Middlesex

*** Among its 104 members the constitution of the C.C.H.M.S. allows for 32 members engaged in consultant or specialist practice to be appointed by regional committees for hospital medical services in England, Wales, and Northern Ireland (each committee appoints two). Five members engaged exclusively or predominantly in consultant or specialist practice are appointed by the Scottish Committee for Hospital Medical Services. Of the 66 consultants on the C.C.H.M.S. for 1972-3 two are from North-