but rather upon the situation which has evoked it.

Laconic though the council minutes often are, there is ample evidence in them that, especially between the Medical Acts of 1858 and 1886, direct professional representation has repeatedly been a burning issue *outside* the council. Though I hope the Brynmor Jones proposals on increased representation will soon become law, the really unfortunate feature of this and other issues is the, apparently, long lag between outside professional feeling and internal council response to it. I say "apparently" because, apart from brief *B.M.J.* accounts of its meetings, the council has kept its public light well turned down—until the spotlights were turned up a few months ago.

Whatever the outcome of the present unfortunate tension one simple step could be taken which might prevent recurrence of the undoubted damage done to all concerned. An annual report by the General Medical Council, sent to every registered doctor, would at least enable the council to claim that it tells those willing to read what it is about, and might even stir the silent majority to take more interest in a body to which for well over a century the profession has been truly indebted. I do not care for the intemperate use of words like "establishment," "autocracy," and "diehards"; I cannot believe that all those who serve, by selection or election, on the G.M.C. are selfish power-lovers; and I deprecate the unfounded, indeed now refuted, charges of extravagance and inefficient administration. Anyone who takes the trouble to read the history of the G.M.C. (did not Aristotle say, He who sees things from the beginning will have the finest view of them?) must become aware that, imperfect though this institution may have been and still is, there is much in its past and present to be thankful for.—I am, etc.,

I. M. RICHARDSON

Department of General Practice,
University of Aberdeen,
Aberdeen

SIR,—It is my opinion that the present dispute has been largely caused by lack of information. I must place most of the blame on the Association as the G.M.C. had no funds to spend on publicizing its activities.

The profession has, for long, been quite ignorant of developments in the work now required of the G.M.C. This was well brought out the other night during an interview on the television. The young hospital doctor insisted on a public inquiry before agreeing to the principle of retention fees. I am sure he did not know that following the Brynmor Jones report there were to be five lay representatives on the council appointed by the Crown. Neither did he know that Lord Cohen of Birkenhead had nothing against a public inquiry. The other general practitioner being interviewed complained of the ineffectiveness of the G.M.C. over drug offences in London. He evidently was unaware that the G.M.C. has no power to move on hearsay evidence only. It must wait for a conviction in the civil or criminal court to be reported to it by the clerk of the Court.

These examples convince me that the B.M.A. has not given the lead to its members that it should have done. Surely mem-

bers are entitled to know why the cost of running the G.M.C. has escalated to such an alarming extent. Why not tell members that the rent at Hallam Street has been raised enormously, that a computer has become necessary, or of the vast increase in postal charges? This is only mentioning a few items and I know there are many others which would show adequately why the retention fee has had to be increased so steeply.

I fail to see that erasures from the *Register* of non-payers should have any bearing on current negotiations on the functions of the G.M.C. The size of the retention fee in the future will naturally depend on the outcome of these discussions. It is obvious that the G.M.C. has made this threat purely because it needs desperately the money from these unpaid fees.

Finally, many of us in the North will be resenting the remarks made in your leader (18 November, p. 377) about Lord Cohen of Birkenhead. One need only mention the confidence placed in this man from the provinces by his colleagues on the G.M.C. by repeatedly re-electing him as their president. His vast experience in medical education alone qualifies him for this post.—I am, etc.,

A. H. HOLMES

St. Asaph,
Flints

** In the last year alone there have been published in the *B.M.J.* the full report of an independent investigation into the G.M.C.'s finances (*Supplement*, 1972, 3, 41), a statement on the G.M.C. in the B.M.A. Council's annual report (*Supplement*, 1972, 2, 77), reports of debates on the G.M.C.'s functions in the Council (*Supplement*, 1971, 4, 61; 1972, 1, 29, 61; 2, 73; 3, 14, 65; 4, 3, 29), and at the A.R.M. (*Supplement*, 1972, 3, 75, 88, 105), reports of the G.M.C.'s own proceedings including its president's addresses and a statement from its registrar (*Supplement*, 1971, 4, 70; 1972, 1, 70, 77; 2, 141; 4, 51), and accounts of other matters on which the G.M.C. has made recommendations such as the registration of overseas doctors (*Supplement*, 1972, 1, 67). The findings of the Brynmor Jones working party were reported in full and the Council's debate on them (*Supplement*, 1971, 1, 55, 67) and the interim report of the Tunbridge working party last month (*Supplement*, 1972, 4, 33). There have also been five leading articles on the G.M.C. in the last 12 months (*B.M.J.*, 1971, 4, 637; 1972, 1, 330; 3, 253; 4, 315, 377); and in 1966 we printed a lengthy summary of the memorandum by the G.M.C. on the reasons for its proposal to charge an annual retention fee (1966, 1, 1164). We cannot agree, therefore, that there has been lack of information for those prepared to read it.—Ed., *B.M.J.*

SIR,—All doctors who belong to, or contract to work for, publicly organized services are already subject to in-service discipline. This applies to the whole N.H.S., the public health services, and the Armed forces. These are the doctors who are expressing grave objections to the recent action by the General Medical Council.

An annual retention fee is a reasonable requirement from those who are engaged in private practice. A small annual fee is also reasonable for doctors whose registration is temporary. For those doctors who are in full-time employment in government or

municipal services an initial registration fee should be adequate. Those who have already paid should not be expected to pay more.

For those in private practice £5 seems a reasonable fee for a G.P. whose principle income is from the N.H.S., a consultant after retirement from hospital work, or the first two years after initial appointment. All others, including those in industrial and medicolegal practice, could be expected to pay substantially more.

This is the outline of a scheme which others may like to amplify.—I am, etc.

NORA WILKINSON

Preston,
Lancs

SIR,—May I draw attention to the cautionary tale by Hilaire Belloc which ends:

"And always keep a hold on nurse
For fear of finding something worse."

—I am, etc.,

P. N. COLEMAN

Northallerton, Yorks

Head Injuries in Children

SIR,—I agree entirely with the statement in the paper by Dr. A. W. Craft and others (28 October, p. 200) that in the majority of cases recovery after head injury in childhood is rapid and complete.

This is supported by our investigations¹ on 963 children with head injuries in the acute, early, and late stages. After clinical and electroencephalographic follow-up for 2-6 years, we concluded that the clinical course in children is usually benign; 60% of the children presented no problems at any time, although only serious cases were admitted to hospital and included in our series, and only 4% of the children died within the first few days after admission. Neuropsychological sequelae were found in 5% of the children in the later stages.

But "the majority" does not mean "all." For this reason we would emphasize that it is possible to assess the child's prognosis with certainty only after two years of continuous follow-up, that a normal electroencephalogram after two years means complete recovery, and that all children should receive phenobarbitone for 1-3 years.—I am, etc.,

LILIANA DECIU

Bucharest, Romania

¹ Horvath, L., and Deciu, L., *Pediatrics* (Bucharest), 1971, 20, 141.

Australia Antigen in Rheumatoid Arthritis

SIR,—Dr. C. J. Burrell and others (7 October, p. 23) were unable to demonstrate the presence of the Australia antigen in 29 patients with rheumatoid arthritis by counter-current immunoelectro-osmophoresis, even after treatment of the serum with heat and mercaptoethanol.

We recently demonstrated Australia antigen, sub-group ay, in a 39-year-old Algerian patient suffering from rheumatoid arthritis with a positive serodiagnosis, confirmed histologically, by electroimmunodiffusion without pretreatment. The antigen has persisted for six months in this patient. The role of the Australian antigen in provoking and maintaining rheumatoid arthritis is still

debatable, but this case seems to show that rheumatoid arthritis and the Australia antigen can coexist.—We are, etc.,

S. DESCHE-LABARTHE
R. CAQUET
CL. LAROCHE

Hopital Cochin,
Paris

SIR,—Dr. C. J. Burrell and others (7 October, p. 23) stressed the occurrence in rheumatoid arthritis of false-positive results in tests for Australia or hepatitis-associated antigen (H.A.A.) using latex agglutination techniques. They suggested that the false-positive results were due to rheumatoid factor in the serum.

Our experience with the search for H.A.A. (using countercurrent immunoelectro-osmophoresis) in the serum of 152 patients suffering from rheumatoid arthritis (84 of whom were positive for the rheumatoid factor) confirms the observation of Burrell *et al.* that there is no evidence of a relation between rheumatoid arthritis and a significant incidence of H.A.A. detectable by countercurrent immunoelectro-osmophoresis. The H.A.A. test was positive only in one rheumatoid-factor-negative patient with polyarthritis, who developed hepatitis two weeks after the serum was obtained.

Although we found in our series of 152 rheumatoid arthritis patients a significant incidence of positive tests for antinuclear factor (22.6% of those positive and 8.8% of those negative for rheumatoid factor), the absence of H.A.A. in rheumatoid arthritis is in contrast to the high incidence of H.A.A. (by countercurrent immunoelectro-osmophoresis) reported in systemic lupus erythematosus.¹⁻³—We are, etc.,

A. BURSENS
J. DEQUEKER
W. ODEURS

Rheumatology Unit,
Academic Hospitals Pellenberg and Leuven,
Belgium

- 1 Alarcón-Segovia, D. and Fishbein E., *New England Journal of Medicine*, 1971 284, 448.
- 2 Alarcón-Segovia, D., Fishbein E., and Diaz-Jouanen, *Clinical and Experimental Immunology* 1972 12, 9.
- 3 Ziegenfuss J. F., Byrne E. B., Stollhoff I. L. and Burka E. R. *Lancet* 1972 1, 800.

Intestinal Parasites and Au Antigen Transmission

SIR,—Dr. M. Barbotin and Mr. J. L. Ondart (10 June, p. 653) suggested a possible association between hookworm and strongyloides infestation and the presence of Australia antigen in the blood. We have examined stool and blood samples from 300 randomly selected patients aged 10 years or over attending the University College Hospital, Ibadan, for the presence of hookworm ova or strongyloides larvae in the stool and for Au antigen in the blood (see Table). The overall incidence of Au antigenaemia is 2.3%, and this is significantly lower than the incidence of 6.05% ($P < 0.05$) found among 8,000 blood donors in Ibadan.¹ However, these donors were all young adult males, and when comparable age and sex groups in the present series are compared the antigenaemia rate of 5% is found not to differ significantly from that found in the earlier blood donor series. Our sample of patients is therefore probably representative of the population at large.

Age (Years)	Number of Patients		Hookworm Positive		Strongyloides Positive		Au Antigen Positive	
	Male	Female	Male	Female	Male	Female	Male	Female
0-10	0	1	0	0	0	0	0	0
11-20	18	13	9	3	7	1	1	0
21-30	28	29	4	12	0	2	1	0
31-40	31	21	5	3	5	1	2	1
41-50	24	20	6	2	1	1	1	0
51-60	18	14	7	2	5	1	0	0
61-70	7	6	2	1	1	0	0	0
71 and over	3	2	2	0	0	0	0	0
No age recorded	37	18	8	5	4	1	0	1
Total	166	124	43	28	23	7	5	2
No age or sex recorded ..	10		1		0		0	
Total	300		72 (24%)		30 (10%)		7	

We found a substantially higher incidence of hookworm and strongyloides infestation than was found in Senegal. Our rate of 24% for hookworm was similar to that reported by Cowper from Ibadan,² though the incidence of strongyloides infestation in the present series (10%) seems to be significantly higher ($P < 0.01$). Among the seven patients carrying Au antigen in their blood three were excreting hookworm ova and one was excreting strongyloides larvae, an incidence of 42.8% and 14.2% respectively. Chi-square analysis of the incidence of hookworm or strongyloides infestation and Au antigenaemia shows no evidence of a relationship between these two conditions ($P > 0.3$).

While there is little doubt that the incidence of Au antigenaemia is higher in the tropics than in temperate areas, and transmission by insects has been shown to be possible,³ we feel that the present evidence is insufficient to implicate hookworm or strongyloides as being concerned in the transmission of Au antigen, at least in the Ibadan environment.—We are, etc.,

E. A. LEWIS
D. MONTEFIORE
J. A. SMITH
A. O. SOGBETUN

University College Hospital,
Ibadan, Nigeria

- 1 Francis, T. I., and Smith, J. A., *British Medical Journal*, 1971, 4, 683.
- 2 Cowper, S. G., *West African Medical Journal*, 1966, 15, 203.
- 3 Smith, J. A., Ogunba, E. O., and Francis, T. I., *Nature*, 1972, 237, 231.

Trichuris Infestations and Difetarsone

SIR,—Monoinfestations with *Trichuris trichiura* were rare until anthelmintics selectively active against *Ascaris lumbricoides*, hookworms, and *Strongyloides stercoralis* made evident the presence of *T. trichiura*. Difetarsone (14 October, p. 73) is specifically effective against *T. trichiura*, like piperazine against *A. lumbricoides* and bephenium against *A. duodenale*. Polyparasitosis, with its multiple clinical manifestations, is increasingly encountered in temperate regions. Several broad-spectrum anthelmintics have been developed, but few completely remove the *Ancylostoma* and *Trichuris* burden.

Mebendazole (methyl (5-benzoylbenzimidazol-2-yl) carbamate) has been studied in children and adults with mono- and polyparasitosis in Africa,^{1,2} Asia,³ Europe,^{4,5} and North,⁶ Central,⁸ and South America.^{9,10} A single 100-mg tablet radically cures infestation with *Enterobius vermicularis* and *A. lumbricoides*. A standard 100-mg dose given twice daily for three consecutive days is

virtually 100% effective against *Necator americanus*, *A. duodenale*, and *T. trichiura*, and shows high promise against *Taenia solium* and *T. saginata*. Activity against *S. stercoralis*, though significant, is less regular. Because of its potency and its broad spectrum of anthelmintic action, coupled with total absence of side effects and standard dosage, irrespective of the patient's age or weight, mebendazole is of special value in all patients with single or multiple helminth infestations.—We are, etc.,

J. VANDEPITTE

Department of Microbiology,
University of Leuven,
Belgium

D. THIENPONT

Institute of Tropical Medicine,
Antwerp, Belgium

- 1 Vandepitte, J., Gatti, F., Lontie M., Krubwa, F., Nguete, M., and Thienpont, D., *Bulletin de la Société de Pathologie Exotique*. In press.
- 2 Gatti, F., Krubwa, F., Lontie, M., Vandepitte, J., and Thienpont, D., *Proceedings of the VIIth International Congress of Chemotherapy, Prague (Czechoslovakia)*, 23-28 August 1971.
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- 5 Fierlaftin, E., *Bruxelles-Médical*, 1971, 51, 605.
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- 9 Chaia, G., Métené, F., Chiari, L., de Moura Araújo, S., and Barbosa de Abreu, I., *Folha Médica*, 1972, 64, 139.
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Myxoedema and Retention of Urine

SIR,—Renal function is often moderately affected in hypothyroidism,¹ probably owing to interstitial infiltration, enlargement of the basal tubular membrane,² and the low renal perfusion brought about by the illness.³ So far as we know there have been no reports of hypothyroidism presenting as renal failure resulting from urinary obstruction due to vesical paresis caused probably by myxoedematous hypotonia of the smooth musculature. We report here a case of this kind.

Six months before being admitted to hospital a 67-year-old woman developed character changes and urinary retention. Daily catheterization was required. Later constipation, a changed tone of voice, mental confusion, and deafness also developed and became progressively worse. On admission the patient was typically myxoedematous. The bladder could be palpated in the abdomen, the Achilles tendon reflex was slow, the E.C.G. presented low voltages, and the E.E.G. slow, diffuse, predominantly frontal waves. Neurological examination was otherwise normal. Blood examination showed: haemoglobin 7.2 g/100 ml, leucocytes 9,200/mm³, protein-bound iodine 0.4 µg/100 ml,