

that the first phase of any compulsive action which the doctors take must be mild but definite. I would advocate a graded strike commencing with refusal to sign all death certificates, sick notes, and Health Service prescription forms. I have no doubt that the Government has already plans in hand for lay officials to take over these duties, and some little time would elapse before their incompetence became fully evident. During this time doctors could achieve the cohesion that is required and the knowledge that all were taking part in the action.

The next step would be to close down all the non-emergency treatment—clinics, investigation, and diagnosis would continue. It is a dreadful thing to find myself, a doctor who willingly put life and freedom at the disposal of the R.A.M.C. in 1939 on behalf of my country, so disgusted by the treacherous and vote-grabbing manner in which politicians have handled the National Health Service that I am prepared to advocate the abandonment of this service in favour, once again, of total private medicine.

The present stage is climacteric and only a return of the Ministry to loyal and truthful adherence to the original conditions of service should persuade us to continue to deal with it. But it must be remembered that we can deal with it only from a position of strength which it will respect and indeed fear.—I am, etc.,

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Metaclopramide and Prolactin

SIR,—The report by Dr. A. S. McNeilly and others (29 June, p. 729) that metaclopramide is a potent stimulator of prolactin release may be a matter of serious consequence in the treatment of patients with breast cancer. It has been shown¹ that the growth of breast cancer is sometimes dependent upon the presence of prolactin. Metaclopramide is often used to treat the sickness induced by radiotherapy or cytotoxic chemotherapy in patients with breast cancer. It now appears that by releasing prolactin this drug could stimulate the growth of the cancer. I suggest that this drug should never be given to a patient with breast cancer. It has previously been reported² that prochlorperazine is equally effective in treating radiation sickness.—I am, etc.,

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¹ Salih, H., *et al.*, *Lancet*, 1972, 2, 1103.

² Ward, H. W. C., *British Medical Journal*, 1973, 2, 52.

Drugs for Gastric Ulceration

SIR,—Your leading article on the above subject (27 April, p. 186) leaves one with an impression that all currently available drugs for the treatment of gastric ulceration either suffer from side effects or are not very effective in accelerating ulcer healing. The reference to a "carefully conducted Scandinavian trial which showed no demonstrable effect at all" with carbenoxolone is interesting. A recent clinical trial with this compound carried out on Chinese subjects in

Singapore resulted in a similar conclusion.¹

It appears likely that once again the ubiquitous prostaglandins might fill the gap. The gastric antisecretory effect of naturally occurring prostaglandins E₁, E₂, and A₁ in man has been recognized for several years.^{2,3} However, these compounds are effective only when administered by continuous intravenous infusion and the gastric inhibitory effect is accompanied by unacceptable side effects. Of all the naturally occurring prostaglandins only PGA₂ is active by mouth, but inhibition of gastric secretion is transient.⁴ In laboratory animals some naturally occurring prostaglandins have an ulcer-sparing effect, but the drugs have to be given by subcutaneous infusion for many hours.⁵

The lack of effect of orally administered natural prostaglandins is most likely due to their rapid metabolism and inactivation. Results obtained with some synthetic analogues of prostaglandins are more encouraging; 15 (R) 15-methyl prostaglandin E₂ methyl ester, 15 (S) 15-methyl PGE₂ methyl ester, and 16, 16-dimethyl PGE₂ methyl ester and free acid are all potent inhibitors of gastric secretion in man⁶⁻¹⁰ when given by mouth. Of all these analogues 15 (R) 15-methyl PGE₂ methyl ester appears to be the most promising, and six-hourly oral doses of this compound for two weeks in normal volunteers are well tolerated. Repeated administration of the other analogues is associated with gastrointestinal side effects.¹¹

Some of the interesting and useful properties of 15 (R) 15-methyl PGE₂ methyl ester are: (1) A single oral dose of 150–200 µg of this compound results in complete inhibition of acid secretion in man. The volume of gastric juice does not alter significantly but there is a marked elevation in pH of gastric juice from around 2 to 7. (2) A similar inhibition of pepsin secretion has been observed.¹² (3) After a single dose the inhibitory effect on acid and pepsin secretion lasts for over three hours. (4) Given orally, it has a potent stimulant effect on mucus-secreting cells.¹³

Inhibition of pepsin and acid secretion and increase in mucus production could provide an ideal milieu for the healing of gastric ulcers. Two clinical studies with this compound in ulcer patients have been carried out so far. (a) In eight out of 10 subjects with gastric ulcers oral administration of a single dose of 150 µg 15 (R) 15-methyl PGE₂ methyl ester resulted in elevation of gastric pH from 1.5 to 7 accompanied by a reduction in epigastric pain and tenderness lasting for over three hours.¹⁴ (b) In another study the effect of this compound on the healing of gastric ulcers in 10 patients was evaluated and compared with that in a similar group prescribed an antacid and bed rest. It was given orally in doses of 150 µg every six hours for two weeks. Gastric ulcer healing in both groups was assessed endoscopically with a duodenofibrescope. In the prostaglandin group complete healing was seen in three cases, considerable healing in six cases, and slight healing in one case. In the control group complete healing was seen in none, considerable healing in two cases, slight healing in four cases, and no healing in three cases. The difference was statistically significant.¹⁵

These preliminary encouraging results warrant further clinical trials with 15 (R) 15-methyl PGE₂ methyl ester which may

provide a much-needed compound for the treatment of gastric ulceration.—I am, etc.,

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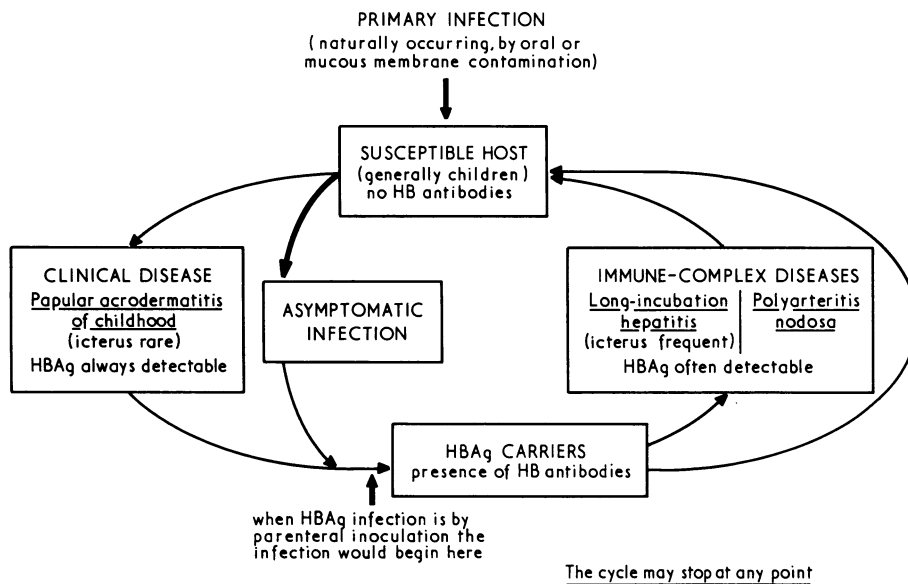
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- 14 Fung, W. P., and Karim, S. M. M., *International Research Communication Systems*, 1974, 2, 1001.
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Hepatitis B Antigen in Papular Acrodermatitis in Children

SIR,—In your leading article (9 March, p. 407) you suggested that there were alternative interpretations to my observations^{1,2} on the association of hepatitis B antigen (HBAG) with papular acrodermatitis in children (P.A.C.). From our 20 years' study of P.A.C. I must emphasize that diagnosis of the disease depends on the presence of (1) non-relapsing, non-itching erythematopapular dermatitis localized to the face and limbs and lasting 20–25 days; (2) a reactive reticulohistiocytic lymphadenitis; (3) an acute hepatitis, usually anicteric, which lasts for at least two months and may persist for several months or years; and (4) HBAG in the serum after the first few days of the dermatitis. These diagnostic criteria distinguish cases of P.A.C. from those of papular-vesicular-acrodermatitis syndrome.

HBAG can be shown in the serum of all cases of P.A.C. by immunodiffusion, electro-syneresis, or radioimmunoassay and may be seen on electron microscopy as pleomorphic spherical, tubular, and double-shelled particles identical with those found in the serum of patients with serum hepatitis or polyarteritis nodosa. We and others³ have seen some cases of P.A.C. where one or more members of the family were HBAG carriers. We and others³ have also seen cases where a few weeks before or after a child had developed P.A.C. another member of the family showed symptoms of icteric hepatitis.

We believe that P.A.C. is more common than it is thought to be. The diagnosis is often missed because neither the relatives nor the doctor pay much attention to the only symptom—the non-itching eruption without fever. Acute hepatitis, usually anicteric, is unsuspected, for there is little constitutional upset and only moderate hepatomegaly. We consider P.A.C. to be the clinical manifestation of the primary infection with HBAG (the causative virus of long incubation hepatitis) in childhood via the mouth or mucous membranes. It is true, as your leading article pointed out, that the characteristic rash and lymphadenopathy of



P.A.C. are not seen in serum hepatitis. But there are other examples of this. For instance, it is well known that herpes simplex infection affects almost everyone during childhood and adolescence but few present the cutaneous, mucosal, lymph-node, visceral, and general symptoms of the primary disease.

We suggest that the cycle of HBsAg infection (see fig.) is such that when it occurs in children it is asymptomatic in most cases but in others it causes P.A.C. When an infection is acquired by parenteral inoculation (blood transfusion or subcutaneous or intramuscular injections) the papular dermatitis and lymphadenopathy do not develop, either because the infection begins directly in the blood or because the subject has already experienced primary HBsAg infection. For these reasons HB antibody is not found in the serum of children with P.A.C., whereas HBsAg is always detectable in the dermatitis phase, while HBsAg is not always found in long-incubation hepatitis and polyarteritis nodosa, in which HB antibodies or immune complex are present. The rareness of icterus in P.A.C. and its frequent presence in long-incubation hepatitis should be noted.—I am, etc.,

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1 Gianotti, F., *Giornale Italiano di Dermatologia*, 1955, 96, 678.

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Doctors, Drivers, and Confidentiality

SIR,—I certainly had no wish to sadden Dr. R. McL. Archibald (22 June, p. 670), nor to cast any kind of slur on all who work in occupational medicine. But, yes, I have myself been approached by telephone by firms' medical officers asking for information about my patients without the patient himself having given his consent. I have never thought that these doctors were villains, but simply ordinary, honourable doctors doing a routine job and—like most of us—not considering the ethical implications of every little act.

Dr. Archibald invites me to examine my motivation in writing. One would have thought that this subject is worthy of discussion in your columns for two reasons. Firstly, doctors who seek information in this roundabout manner may welcome the chance to consider its ethical implications. Secondly, young general practitioners may wish to be forewarned and forearmed against this sort of irregular inquiry. Speaking—as Dr. Archibald would wish—from my own experience, I know how routine and normal such a request for information can sound when it comes from a genial, honoured, and senior medical colleague.

To end pedantically, the doctor *technically* in breach of our ethical code would be the one giving information without the patient's permission, and not the one seeking this information.—I am, etc.,

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Abdominal Decompression in Pregnancy

SIR,—I am pleased that Mr. D. D. Mathews (29 June, p. 725) agrees with many of the points which I made (1 June, p. 499). He then goes on to make two additional ones: (1) that observer bias still seems to offer a plausible interpretation of the difference in results which we obtained in our decompressed and control groups; (2) that the observed results in the decompressed patients may have been better because they received less bed rest.

I would concede that observer bias might conceivably have affected the cephalometry results, which were all measured by the same person who knew whether patients belonged to the test or control groups. However, it seems most unlikely to have affected the results of the urinary oestrogen assays, which were performed by two technicians unaware of which group patients belonged to. Furthermore, it seems frankly absurd even to consider the possibility that observer bias might have influenced the birth weights of the babies, who were weighed by midwives not involved in the project.

Turning to the matter of bed rest and exercise, since we were aware of the possible effects of these factors on fetal growth we

drew attention to the fact that the mean duration of bed rest was 1.5 days longer in the control group.¹ Our patients did not walk to the decompression suits; they were taken by wheelchair, and we know that the nursing staff did not allow them "considerably more freedom about the wards." Mr. Mathews implies that abdominal decompression involves patients in considerable exertion. I would disagree, while recognizing that we are both expressing opinions without any supporting ergonomic data. In short, I am not persuaded by his arguments that the better results in the decompressed groups of patients are likely to have been due to "the lesser amount of enforced bed rest to which they were subjected."—I am, etc.,

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¹ Varma, T. R., and Curzen, P., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1973, 80, 1086.

Infertility and Rubella Infection Prophylaxis

SIR,—The investigation and treatment of infertility are fraught with disappointments for both patient and doctor. Any pregnancy finally conceived brings both a sense of achievement and relief to all concerned.

Maternal rubella infection, even at a sub-clinical level, undoubtedly carries some risk of fetal malformation, enough perhaps to justify a couple to request and the doctor to grant termination of pregnancy. For this to occur in an infertile patient is an immense tragedy and waste. Two such infections in patients attending the infertility clinic at this hospital recently has brought this to our attention. We therefore suggest that, though as an ideal every woman of child-bearing age should have been tested for rubella infection and if necessary vaccinated, at the very least such measures should be carried out before referral to an infertility clinic. This would avoid any delay caused by the necessary tests and treatment having to be carried out later in the infertility clinic. A test for rubella antibodies should be available to all practitioners and will indicate if vaccination is required.

Vaccination will give the necessary protection, but contraceptive measures should be used to prevent pregnancy and possible teratogenesis for three months afterwards. Only by such prophylactic measures can our patients be best served and potential heart-break avoided.—We are, etc.,

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Vitamin A and the Teratogenic Risks of Oral Contraceptives

SIR,—Dr. Isabel Gal (8 June, p. 560) continues to warn that the high level of vitamin A (retinol) found in the serum or plasma of women taking oestrogen-containing oral contraceptives¹⁻³ may constitute a teratogenic hazard to women who become pregnant during, or shortly after stopping, treatment