Correspondence

Letters to the Editor should not exceed 500 words.

Chronic Haemodialysis

SIR,—Your leader on intermittent haemodialysis (11 June, p. 1433) was timely, but it is a pity that you did not consider the relationship of this procedure to renal transplantation, which also has an important part to play in the treatment of patients with severe irreversible renal failure.

Some people appear to think of these procedures as alternative, but in our view they should be regarded as complementary. There are admittedly some patients who are unsuitable for one but suitable for the other. As a general rule, however, we would suggest that a patient with irreversible renal failure, who cannot be treated adequately by conservative means, should be put on to chronic dialysis in the first instance, but when his condition is satisfactory he should be given a transplant from either a living volunteer donor or a cadaver when one is available. In this way space is created for another patient requiring dialysis, and the transplant recipient can look forward on average to about two years of freedom from dialysis. Unless the transplant was obtained from an identical twin donor, it is likely (although not certain) that it will sooner or later become impossible to prevent it from being rejected. When this time comes immunosuppressive treatment should be stopped, and the patient should be put back on to chronic dialysis until such time as a second transplant becomes available for him. It is worth pointing out that during the time when the transplant is functioning satisfactorily the patient is able to lead a much more normal life than a patient on chronic dialysis.

It should not be necessary, at any rate for the present, to have facilities for transplantation available in every hospital which practises chronic dialysis, but all dialysis units should be able to refer patients for transplantation to an appropriate unit.—We are, etc.,

M. F. A. WOODRUFF.
G. J. A. CLUNIE.
University of Edinburgh
Medical School,
Edinburgh 8.

Sterilization and the Law

SIR,—The Council of the Medical Defence Union, with the assistance of its legal advisers, has reviewed once again the legality of sterilizing a man or woman solely as a method of birth control. The council is advised that an operation for sterilization is lawful, whether it is performed on therapeutic or eugenic grounds or for any other reason, provided there is full and valid consent to the operation by the patient concerned. It must be emphasized, however, that this advice is not based on any statute or judicial authority, because the proposition has never been tested in the courts. Nevertheless, the council does not believe that a surgeon who complies with a patient's request that he or she be sterilized would be committing an offence.

In its 1961 annual report the Union expressed the view that sterilization of a husband or wife solely as a method of birth control might not be upheld by the court. The climate of public opinion has been changing, and the council feels that a more liberal attitude to sterilization would now be taken by the courts than might have been the case five years ago. In the case of a married patient the written consent of both the husband and wife should be obtained before the sterilization of either party is undertaken. The Union has prepared a model form of consent to an operation for primary sterilization, a copy of which will be sent on request to any member.

Members of the Union may rest assured that if, as the result of the performance of an operation for primary sterilization, they find themselves in any sort of medico-legal difficulty, they can count on the full support of the Union.—I am, etc.,

PHILIP H. ADDISON,
Secretary,
London W.C.1. The Medical Defence Union.

Treatment of Ulcerative Colitis

SIR,—Dr. F. Avery Jones and Professor B. N. Brooke write (28 May, p. 1356): "Surgical cure can only be achieved if the whole of the large intestine is removed—and that includes the rectum." This is completely at variance with my considerable experience, and with the results reported in my article (23 April, p. 1001). I doubt, therefore, whether their very lesser experience warrants them making such a statement with its implied reflection on the accuracy of that article.

Their reference to diarrhoea, precipitancy, and other complications is equally misleading and inexact. Had they chosen to visit even one of the follow-up clinics during the last 10 years, at which they know they would have been very welcome, and which are attended by physicians and surgeons from all parts of the world interested in ulcerative colitis, I do not think their letter would ever have been written.

They draw attention to three of my cases who developed carcinoma. It would have been less biased had they noted the reason why one developed it—she had a strictured rectum, but refused an ileostomy, though this was advised—and also the fact that in the second a definite and confessed error in selection for this type of operation was made. It is of interest that in the period over which I reviewed my cases 17 patients, mostly young, all of whom had been under physicians' care, were finally referred to me, and at the time of operation were found to have developed inoperable cancer. Medical care in this respect alone, apart from many others, would seem to carry its calculated risks, as indeed it does.

In addition those advising an ileostomy as a routine in the surgery of ulcerative colitis do not always appreciate the very real fear with which such a suggestion is regarded by the patient. As a result many refuse operation and continue with the disease and with medical treatment until they are overwhelmed by one of the numerous complications with which it is associated. Our records contain many such cases, and my own continued experience and the very recent one of Dr. Avery Jones and his colleagues reported in your correspondence columns (4 June, p. 1418) show that their numbers are being added to all the time. The operation of ileorectal anastomosis with total colectomy holds no such terrors for the patient, and he or she will accept operation when it is advised.

It was unfortunate that not long ago the journal of the Ileostomy Association refused to publish a letter from one of its former members. This patient is one of this country's leading violinists. After 18 months of an ileostomy life he came to the Gordon Hospital, where, as his rectum was still intact, continuity was re-established by ileo-rectal anastomosis. After several years, feeling he was no longer eligible for membership, he resigned, and included a letter for publication. In his letter he compared his abnormal life as an ileostomite with his completely normal one after restoration of continuity. Perhaps now Professor Brooke is president of the association controlling that journal he would arrange for the publication of that letter. This and similar letters are more likely to aid the general practitioner in his dilemma as to how best he can advise his patient than any article of mine or the letter to which it has given rise. It is difficult to believe that a violinist can cope with all the difficulties of a violin concerto when pestered by diarrhoea and precipitancy.

Total colectomy and ileo-rectal anastomosis, in spite of your correspondents' assertions to the contrary, cures the condition in the great majority of patients, provided a true ileo-rectal anastomosis and not an ileo-sigmoidostomy is carried out and provided certain technical details during operation and in the post-operative period are observed—provisos commonly ignored by those whose experience of the operation is an unhappy one. Dr. J. W. Todd's patients (14 May, p. 1233) are typical examples of what can be achieved.

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Of course the operation I advise carries certain risks, and indeed may be followed by grave complications. How could it be otherwise in dealing with patients often presented for surgical intervention in a near moribund condition? I am sure, too, that Dr. Avery Jones and Professor Brooke would not wish to suggest that the methods of treatment they advocate are free of similar difficulties and of mortality similar to my own. With co-operation and not antagonism I am certain that many more patients could be spared an ileostomy life.—I am, etc.,

London W.1. STANLEY AYLETT.

Steroids for Asthmatic Children

SIR,—When a doctor starts an asthmatic child on steroids he usually feels guilty about it. For example, he may say, "The child was so bad that I was forced to use steroids," but would he refer to being forced to give insulin for diabetes? Presumably at the back of his mind he harbours a picture of a puce, obese, stunted dwarf with a decalcified spine dying suddenly from an overwhelming infection. Temperance propaganda paints the same kind of picture for alcohol—once one drop passes his lips the recipient is on the slippery slope that leads downhill to a dreary death in the gutter, penniless, unloved, and cirrhotic.

The fact is that many people enjoy gin before dinner without becoming chronic alcoholics, and many asthmatics are relieved by very small doses of steroids that will prevent distress and improve the whole family's conception of the condition.

It is not usually necessary to start with high dosage and reduce it daily to nil—such a "course" usually results in a relapse. It is not true that once started steroids can never be stopped; many patients of mine who have taken prednisolone in the past have outgrown the need for it, or only require it in the pollen season. For years my practice has been to provide the mother of any child liable to awaken in the night with distressing asthma with a supply of 5 mg. prednisolone tablets, instructing her to give half to one tablet as required. Some mothers find they have to use fewer than 10 tablets a year (or season), whereas others need to give a dose at bedtime almost every night to avoid disturbance.

In severe cases the average daily intake may be high enough to inhibit growth, and in such cases it now seems beneficial to switch to A.C.T.H., but theirs is a special and more difficult problem.

My plea is that we should provide the mothers of mildly asthmatic children who sometimes awaken with a distressing attack in the middle of the night, or who cannot lead a full and active life by day, with a supply of prednisolone to be used in the way that ephedrine once was when it was the only available oral remedy. Its main advantages over ephedrine are that it is usually very much more effective, and that its action will last all through the night (and even up to 48 hours), compared with four hours for the older drug. Armed with such a potent remedy, the mother regains her confidence, and this is conveyed to the child, with the result that the emotional tension slackens and the liability to further attacks recedes. Anyone faced with a terrified child fighting for his breath at 2 a.m. would surely prefer to prevent it by giving 2½–5 mg. of prednisolone at bedtime; no doctor need feel guilty when he writes such a prescription, provided that he warns the mother against using it unnecessarily.—I am, etc.,

North Middlesex Hospital, London N.18. IAN G. WICKES.

Meningococci Resistant to Sulphonamides

SIR,—The observation that sulphonamide-resistant meningococci have been discovered not only in Servicemen but also in civilians in the U.S.A. must be of concern to those responsible for the treatment of meningococcal disease in this country. It is interesting to note that sulphonamide resistance appeared to be associated with group B strains, and this point has been emphasized by Feldman in a recent review,[1] where it was pointed out that group A strains seen in 1965 were not resistant. The interesting point which he makes is that sulphonamide-resistant strains of groups B and C may have existed for many years, and he was able to demonstrate sulphonamide resistance in a stock strain of group B meningococci first isolated some 20 years ago.

In view of the importance of knowing whether sulphonamide-resistant organisms occur in Britain we have examined nine strains of meningococci isolated in Glasgow in 1965 and one isolated in June of this year. Dilute suspensions of the organisms were made which gave 20–40 colonies per 0.02 ml. when dropped on Petri dishes of sulphonamide sensitivity test agar.[2] Plates of this medium containing various concentrations of sulphadiazine were inoculated with 0.02 ml. of suspension and incubated overnight at 37° C. The cultures were examined next day for growth. The results are shown in the Table:

Strain	Group	Concentration of Sulphadiazine (mg./100 ml.)		
		0·1	1	5
1	A	+	−	−
2	A	+	−	−
3	B	+	−	−
4	B	+	−	−
5	C	+	±	−
6	NT	+	−	−
7	NT	+	−	−
8	NT	+	−	−
9	NT	+	−	−
10	NT	+	−	−

+ = Growth. − = No growth. ± = Scanty growth. NT = Agglutinated with both groups A and B antisera. Did not agglutinate with antisera to serotypes[3 4] C, D, X, Y, Z, Z1.

All strains showed a good zone of inhibition on testing with discs containing 100 μg. of sulphafurazole. It is interesting, in view of Feldman's observations, to note that the only strain which seemed to show any increased resistance to sulphonamide was that belonging to group C.

These results suggest that resistant strains are not widespread in this area, but obviously many more strains will have to be examined before any final conclusion can be drawn. This work is now in progress.—We are, etc.,

R. J. FALLON.
W. BROWN.
Department of Pathology, Ruchill Hospital, Glasgow N.W.

REFERENCES

1 Feldman, H. A., *J. Amer. med. Ass.*, 1966, 196, 391.
2 Cruickshank, R., *Medical Microbiology*, 11th ed., 1965. Edinburgh.
3 Slaterus, K. W., *Antonie v. Leeuwenhoek*, 1961, 27, 305.
4 —— Ruys, A. C., and Sieberg, I. G., ibid., 1963, 29, 265.

Buccal Oxytocin

SIR,—I very much regret that in my letter to you (11 June, p. 1479), referring to Dr. H. C. Masheter's figures,[1] I stated that of 1,509 patients who had been given buccal oxytocin, pregnancy had to be terminated in 11% of them because of foetal distress. This was a careless slip and a serious mistake for which I alone am responsible, and I would like to offer my unreserved apologies to Dr. Masheter. To put the record straight: buccal oxytocin was given to 1,509 patients and in 1,283 of them to induce labour. Uterine "tetany" occurred in 28 of these women, rupture of the uterus in two, and foetal distress in 166 (11%). Caesarean section was done in 77 of them, but only on seven occasions was foetal distress the sole indication for it.

I am penitent for my error, but quite impenitent concerning my expressed attitude to buccal oxytocin.—I am, etc.,

G. W. THEOBALD.
University College Hospital Obstetric Hospital, London W.C.1.

REFERENCE

1 Masheter, H. C., in *Advances in Oxytocin Research*, ed. J. H. M. Pinkerton, 1965. Oxford.

Doctors in the Drug Industry

SIR,—I cannot allow some of the remarks of Mr. G. W. Theobald, under the heading "Induction of Labour with Buccal Oxytocin" (11 June, p. 1479), to pass without comment. Although unqualified to engage in obstetrical polemics, I strongly object to the remark that as "a paid servant of a commercial pharmaceutical house" any doctor is setting a very dangerous and undesirable precedent by commenting professionally on a medical subject or a drug of which he has knowledge. The implication is that his opinion or judgement is warped by the nature of his employment and that he is incapable of seeing that his prime allegiance is to the medical profession and the care of the patient. Such is not the case, and in this more enlightened age I would have thought that it was appreciated that doctors employed by commercial houses would have, and be given credit for having, expert knowledge of a particular drug because of their experience with its animal pharmacology, toxicity, and clinical usage.—I am, etc.,

Maidstone, Kent. E. L. HARRIS,
Chairman,
Association of Medical Advisers in the Pharmaceutical Industry.

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