Cardiac Failure and Folate Deficiency

SIR,—Your interesting leading article on cardiac failure and folate deficiency (24 January, p. 188) commented on the possible causes of this association, and factors like impaired dietary intake and gastrointestinal malabsorption were mentioned. A contributory cause could well be excessive folate loss in the urine. Urinary folate excretion has been poorly studied, but we recently reported an unexpected increase of urinary folate in association with congestive cardiac failure.¹ As much as 61.6 µg. folate was lost per day, while normal controls excreted 0.1–18.0 µg. folate per day.

Urinary folate loss is unlikely to be the sole cause of folate deficiency in these patients, but could well be an important contributory factor in a patient with prolonged anorexia. One could speculate that excessive urinary folate results from abnormal folate liberation secondary to the liver damage of chronic congestive failure. Urinary folate excretion is increased in cirrhosis and acute hepatitis¹ and also after surgical trauma.²—I am, etc.,

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Republic of South Africa.

REFERENCES

¹ Retief, F. P., and Huskisson, Y. J. *British Medical Journal*, 1969, 2, 150.

² Retief, F. P., Heydenrych, J. J., and Murphy, G. P., *South African Medical Journal*, 1968, 42, Suppl. 17 August, p. 13.

Computers for Transplantation

SIR,—It might be inferred from one of the signatories of the letter from Mr. J. P. Blandy and colleagues (31 January, p. 298) that the transplantation unit at St. James's Hospital, Leeds, participates in the scheme based on the London Hospital. This is, in fact, incorrect, since we are linked up with the scheme based on Newcastle, in which multiple centres from the north of England and southern Scotland participate, using sera provided from the National Tissue Typing Reference Laboratory at Bristol.

This decision provides the best solution for our transplantation service.—We are, etc.,

D. PRATT.
S. M. ROSEN.
P. H. SMITH.
G. WILSON.

Department of Renal Medicine,
St. James's Hospital,
Leeds, Yorks.

Sickle Cell Trait and Leg Ulceration

SIR,—After the early confusion surrounding the various genotypes containing Hb S, the sickle cell trait emerged as a benign condition compatible with a long healthy life.

The frequency of leg ulcers in sickle cell trait remains unclear. Diggs, Ahmann, and Bibb¹ found no increase in the trait in 46 negroes with previous leg ulceration. A case of recurrent leg ulceration in a negro girl with the sickle cell trait has been described² and Wolfort and Krizek³ reported healed ulcers in 6 of 232 negro patients with sickle cell trait admitted to John Hopkins Hospital,

but no control figures were available.

In the ulcer clinic of the University Hospital of the West Indies haemoglobin electrophoresis has been performed routinely. Patients are referred to this clinic on the basis of leg ulceration alone and not selected on any other criteria. The sickle cell trait was present in 49 out of 250 patients with leg ulcers compared with estimates of 10.8% in the negro population.^{4,5} The likelihood of such a result occurring by chance is extremely low ($p < 0.001$) and there would appear to be a definite relationship between leg ulceration and the sickle cell trait.—We are, etc.,

GRAHAM SERJEANT.
MIGUEL GUERI.

Department of Medicine and Preventive
Medicine,
University of the West Indies,
Kingston,
Jamaica.

REFERENCES

¹ Diggs, L. W., Ahmann, C. F., and Bibb, J., *Annals of Internal Medicine*, 1933, 7, 769.

² Dehann, C. R. and Saunders, D. F., *Plastic and Reconstructive Surgery*, 1963, 31, 467.

³ Wolfort, F. G., and Krizek, T. J., *Plastic and Reconstructive Surgery*, 1969, 43, 71.

⁴ Went, L. N., *Nature*, 1957, 180, 1131.

⁵ Miall, W. E., Milner, P. F., Lovell, H. G., and Standard, K. L., *British Journal of Preventive and Social Medicine*, 1967, 21, 45.

"Contributory Causes" of Death

SIR,—May I beg a small space in your columns to mention an aspect of death certification? I run an "Over 60's" club in this village, and from time to time assist bereaved members with the necessary formalities following death. Twice in the last year extra distress has been caused to two of our members by the entries on the certificate.

Both patients had died from carcinoma, but in one case a fractured femur occurred some eight weeks before death and this was given as a contributory cause. The sister of the deceased was greatly shocked when she was collected by the police and taken to the public mortuary to identify the body, and was told that a post-mortem examination and inquest would take place. In the second case cirrhosis of the liver was given as a contributory cause, and although the deceased was 82 a necropsy was essential in order to ascertain the extent of alcoholism—if any. In both these cases the funerals, previously arranged, had to be postponed. Could practitioners please warn relatives of the possible outcome of the causes of death entered on the certificate?—I am, etc.,

ANGELA STANTON.

Charlwood, Surrey.

Designated Areas Allowance

SIR,—This university is currently engaged on a research project on the geographical distribution of general practitioners in England and on the effect of the "designated areas" allowance. The project is supported by the Department of Health and Social Security, and we have received valuable help and co-operation at all stages of the research from the B.M.A.

One part of the project has involved a postal survey of about one in ten of all

general practitioners in England, and we are now in the concluding phases of the survey. More than four out of every five general practitioners who were approached have co-operated in the study, and this at a time when work-loads are in any case heavy and have been increased as a result of the influenza outbreak. May we through your columns express our sincere gratitude to all those doctors who have helped us? We are very conscious of the ever-increasing number of forms and questionnaires which general practitioners are asked to complete, and it was with some trepidation that we embarked upon this necessary part of the project. We hope that the very high response rate is a measure of the importance which doctors attach to the subject of the research, but we are in any case very appreciative of the interest which has been shown in our work.

Publication plans include a paper in one of the medical journals, and in addition a summary of the principal findings and conclusions will be made available to all the doctors who have participated.—We are, etc.,

J. M. BEVAN.
J. R. BUTLER.
R. C. TAYLOR.

Centre for Research in
the Social Sciences,
University of Kent at Canterbury.

Proteins and Insulin Release

SIR,—Drs. J. Dupré and D. J. Chisholm (14 February, p. 434), in commenting upon our article (6 December, p. 598), state that "the experiments show that exogenous secretin or pancreozymin enhances [*sic*] the increase in blood insulin in response to intravenous infusion of amino-acids in man, an effect which has already been amply demonstrated." I doubt whether this effect is yet amply demonstrated. The experiments to which we are referred¹ used a *single* amino-acid, arginine, which is very much a special case in relation to both insulin and growth hormone secretion. Also, it is arguable that Dr. Dupré and his colleagues demonstrated no more than a simply additive effect in the case of arginine plus secretin, the absence of the figures for appropriate control experiments making this point uncertain.

Regarding the role of secretin in the insulin response to oral glucose, I accept the demonstration by Dr. Chisholm and his colleagues² that levels of secretin, as measured by their immunoassay, rise following oral glucose, but regard the relevance of this as debatable. Thus, in their study, the mean peak level of secretin (12.5 µg./ml.) was reached five minutes after drinking the glucose, and by fifteen minutes the mean level had almost returned to the fasting value. The corresponding insulin levels, however, showed no rise until ten minutes after the glucose, by which time the blood sugar was also significantly elevated. Furthermore, this peak level of secretin reached after glucose contrasts with sustained levels of $> 20 \mu\text{g./ml.}$ during the infusions of exogenous secretin in amounts (1 unit/minute) which are modest when compared with those used in most studies of the effects of secretin in man. On the other hand, in the

two subjects given oral protein, the endogenous secretin reached levels similar to those observed in the infusion studies² and they were sustained, supporting our contention "that the augmenting effect of [these] intestinal hormones on insulin release occurs only in the presence of raised levels of plasma amino-acids," the protein meal providing not only the amino-acids but also a major stimulus to both secretin and pancreatic release.—I am, etc.,

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Department of Medicine,
Guy's Hospital Medical School,
London S.E.1.

REFERENCES

- 1 Dupré, J., Curtis, J. D., Unger, R. H., Waddell, R. W., and Beck, J. C., *Journal of Clinical Investigation*, 1969, 48, 745.
- 2 Chisholm, D. J., Young, J. D., and Lazarus, L., *Journal of Clinical Investigation*, 1969, 48, 1453.

Mass Radiography

SIR,—Drs. D. R. Wallace-Jones and M. Goldman (21 February, p. 495) appear to suggest that there is a significant radiation hazard to the individual undergoing a miniature film examination. The possibility of such a danger from mass radiography has been very carefully investigated by experts in radiological hazards and they found that there was no significant danger from this type of examination.¹⁻³

They also seem concerned about the expense to the taxpayer when certain examinations are carried out free by the mass radiography service. The vast majority of these are for persons in contact with children referred by local authorities. We believe that the taxpayer would infinitely prefer to meet the expense of six or seven shillings per examination by mass radiography of these cases rather than the three- or four-guinea fee per examination in a

hospital x-ray department which would fall upon him in his capacity as a ratepayer.—We are, etc.,

J. RIMINGTON,

J. I. CAPPER,

Medical Directors,
Mass Radiography Service,
Manchester Regional Hospital Board.

REFERENCES

- 1 *Radiological Hazards to Patients. Interim Report of the Committee.* (Chairman, Lord Adrian.) London, H.M.S.O., 1959.
- 2 *Radiological Hazards to Patients. 2nd Report of the Committee.* (Chairman, Lord Adrian.) London, H.M.S.O., 1960.
- 3 *Radiological Hazards to Patients. Final Report of the Committee.* (Chairman, Lord Adrian.) London, H.M.S.O., 1965.

Fire Risks for the Elderly

SIR,—We feel it necessary to express our concern about one feature of underpads for incontinent patients. Disposal is usually by burning, and even when very wet, underpads can be burned without great difficulty. This mode of disposal highlights an unfortunate feature of underpads, particularly before they have become wet through use. Recently a patient in a geriatric ward, who was in no way confused, was burned after hot ash from his pipe had fallen on an underpad on which he was sitting and set it alight.

Experiments on underpads used by the hospital and by the local health authority for home care patients revealed that they would burn promptly and fiercely. The danger to old and/or handicapped patients is clear.—We are, etc.,

MORAG INSLEY,

Consultant Geriatrician,
North Monmouthshire Hospital
Management Committee.

ANTONY J. ESSEX-CATER,
County Medical Officer,
Monmouthshire County Council.

Newport, Mon.

Financing Our Own Interests

SIR,—I am in receipt of a document entitled *The Hospital Medical Staffs Defence Trust*, which invites me to contribute £3 per annum (not allowable for tax purposes) to a Trust Fund "to provide money which can be used for the protection of the interests of hospital doctors." This document informs me that the purpose of the fund is three-fold, and here I abbreviate:

(a) To provide a fund exclusively under the control of hospital doctors which is not subject to control by bodies which represent all branches of the profession.

(b) To supply a channel through which all hospital doctors contribute to the very heavy costs of collecting and submitting evidence to the Review Body. The bulk of this expenditure is borne by the B.M.A., and it is unfair that the B.M.A. should bear the whole cost and that doctors who are not members of the B.M.A. should contribute nothing.

(c) To cover the working costs of the Joint Consultants Committee.

The document goes on to inform me that the B.M.A. "already pays the major share of the heavy costs of negotiation . . . but there is no reason why the B.M.A. should

be expected to pay for negotiations on behalf of non-members . . ."

I take the point. I was hitherto under the impression that the interests of my hospital colleagues who are members of the B.M.A. and myself were safeguarded by our annual subscriptions to the Association. The request for this further subscription suggests that this is no longer necessarily so. I am, I hope, a rational being, and clearly the logical thing for me to do now is to resign from the B.M.A. and covenant to pay the very much smaller subscription of £3 per annum to ensure that my interests continue to be taken care of. I wonder how many of my hospital colleagues agree with me?—I am, etc.,

G. R. FEARNLEY.

Gloucester Royal Infirmary,
Gloucester.

*The Secretary states: "Every prudent hospital doctor will join the B.M.A. in his own interests. The Hospital Medical Staffs Defence Trust is not a separate body which doctors can join. It is simply a legal instrument established to strengthen the powers of the profession in certain directions."—ED., *B.M.J.*

General Practitioner Obstetricians

SIR,—In recent years a great deal has been written and spoken about the alleged loss of status of general practice. This is thought by many to be due to the separation of the general practitioner from the work of consultants and specialists in hospital. It has even been suggested that general practice was rapidly becoming a form of glorified first-aid.

Many rural and semi-rural family doctors were anxious to keep cottage hospitals and other units which they entered of right—not on sufferance. However, it has been decided that in certain instances these small hospitals will be closed and general practitioner units will be established as part of the new district hospitals.

I have before me proposed conditions of contract for general practitioner obstetricians working in such a new unit. I trust that the General Medical Services Committee, and indeed the Council of the B.M.A., will study carefully these proposed conditions, with special reference to the status and independence of the general practitioner of the future.

May I quote from a memorandum entitled *Terms and Conditions of Service for attachment to Individual Contracts for G.P. Obstetricians working in Hospital Maternity Units?* "G.P. Obstetricians will NOT have access to antenatal beds, the use of which will be confined to consultant staff." "The G.P. Obstetrician shall not be able to make use of the routine services of junior medical staff of the Obstetric Unit."

I should add that the document from which I have quoted was presented by the senior administrative medical officer, who said that any suggested amendments to the terminology would be considered, but it was accepted that the sense of the document must remain unaltered by the local medical committee concerned. To avoid any misunderstanding, I should say that I am fully conscious of the value and importance of consultant opinion and help and of its availability.

Another quotation from the document—"the desirability of all patients being seen at a Consultant Clinic at least twice during their pregnancy." This apparently is to be accepted as a foregone conclusion.

I do ask again that the G.M.S.C. should scan such a document as the one from which I have quoted, with special reference to the status of the general practitioner in the district hospitals of the future.

In common with a great many of my colleagues, I think that it would be far better to depend on the good-will of consultants and general practitioners alike and on the sense of responsibility of the family doctor, rather than on a document with so many stipulations written in at the expense of the younger family doctors. How did general practitioners carry on their work with a full measure of success in the various cottage hospitals and certain general practitioner maternity hospitals without such binding agreements? As far as I know since 1948 these small units have been under the control of regional hospital boards.—I am, etc.,

CALEB WALLACE.

West Clendon,
Surrey.