is in the vicinity of 5,000 blood donations annually, apart from the cost of the associated equipment for the preparation of platelet concentrates and the salary of a technologist over and above the salaries of the blood collection staff necessary.

In this country we have available a "mini-exchange" set,³ comprising a needle and tubing connected to one limb of a Y-piece which has a free length of tubing from another limb, and the third limb fits the needle adaptor on the standard giving set. This enables the whole manoeuvre of mini-exchange and transfusion to be carried out with a single venepuncture.—I am, etc.,

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¹ Shaw, A. E., *Medical Journal of Australia*, 1969, 2, 529.

² *Lancet*, 1969, 2, 1176.

³ Obtainable from Tuta Laboratories, Lane Cove, Sydney, N.S.W., Australia.

Tuberculous Meningitis in Children

SIR,—May I comment on one point in your recent leading article on this subject (2 January, p. 1)? "An intradermal tuberculin test (Mantoux 1:1,000) should be carried out at once, but in advanced cases a negative result does not rule out tuberculous meningitis." Surely a negative result does not rule out an early case either? This warning is particularly needed in view of the higher incidence of the disease in underdeveloped countries where tuberculin reactions are often suppressed.^{1,2}—I am, etc.,

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¹ Lloyd, A. V. C., *British Medical Journal*, 1968, 3, 529.

² Bhattacharyya, A. K., *British Medical Journal*, 1968, 4, 580.

Low Molecular Weight Dextran in Systemic Sclerosis

SIR,—Dr. Peter Lane's paper (12 December, p. 657) calls for comments on at least two major points. He implies in his introduction that he attempted to repeat my findings by using identical methods and treatments but my paper¹, as its title indicates, dealt with the "effect of intermittent low molecular weight dextran infusions upon the digital circulation in systemic sclerosis." In fairness, Dr. Lane states at the end of his paper that final conclusions cannot be drawn from his own series of patients since each patient received only one infusion of low molecular weight dextran. I have more recently² emphasized that patients who have not previously been treated with this regimen may require infusions of 2 litres of low molecular weight dextran, given over 48 hours, initially at intervals of three to four weeks on three or four occasions, before the peripheral blood-flow is improved. Subsequently intervals between infusions have been extended and my first 3 patients, treated since 1964, have not required dextran infusions for the past 14 months because of their maintained satisfactory digital bloodflow. Each has

received 15 infusions so far. Others have confirmed the efficacy of this regimen.^{3,6}

It is important to ensure that the kidneys are protected against unduly high concentrations of dextran. Our nursing staff has instructions to slow down the rate of infusions (normally 2 l. over 48 hours) if the specific gravity of urine exceeds 1045. During the past 6 years I have treated 35 patients suffering from systemic sclerosis and 98 affected by other disorders associated with obliterative disorders of small blood vessels with a total of 1,121 dextran infusions without adverse renal side effects in a single patient. Dr. Lane rightly states that systemic sclerosis is an intractable condition for which there is no specific treatment. Ischaemic digital changes, with or without intractable ulceration, can make the life of these patients utterly miserable. I hope that Dr. Lane's paper will not dissuade any physician from using a treatment which, in my experience, is beneficial as well as safe provided simple precautions are observed.—I am, etc.,

G. HOLTI

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Royal Victoria Infirmary,
Newcastle upon Tyne

¹ Holti, G., *British Journal of Dermatology*, 1965, 77, 560.

² Holti, G., *Practitioner*, 1970, 204, 644.

³ *Year Book of Dermatology*, 1966-67, p. 94. Year Book Medical Publishers, Chicago.

⁴ Korting, G. W., and Holzmänn, H., *Die Sklerodermie und ihre nahestehende Bindegewebsprobleme*, p. 293. Stuttgart, Thieme.

⁵ Alani, M. D., 1970, *Acta Dermato-Venerologica*, 50, 137.

⁶ Burrows, D., Shanks, R. G., and Stevenson, C. J., *British Journal of Dermatology*, 1968, 80, 767.

Problems in Quebec

SIR,—“No man is an Island, entire of itself.”

I am writing to draw your attention to recent events affecting our medical colleagues in the Province of Quebec. The source of my information is friends and colleagues working there, and also the *Canadian Medical Journal*.^{1,2} In June last, the Quebec Government passed Bill 8 creating a compulsory Medicare Scheme with a very low fee schedule for specialists, at the same time denying to the latter or to the public the right to opt out of the scheme. The specialists refused to take part and limited their services to a hospital emergency cover scheme. In response the Government, in October, passed the notorious Bill 41; the salient features of this were:

(1) All doctors were ordered back to work under threat of imprisonment or heavy fine.

(2) Similarly it disallowed their freedom to move their practice or place of work and equally forbade them “even to speak against the order.”

(3) It made it an offence, liable to a gigantic fine, for any association or group to encourage a medical specialist to defy the order, and allowed for the imprisonment of its individual officers “without even prosecution or conviction.”

The equivalent in this country of this selective withdrawal of civil rights would be if you sir, in speaking against the government order, were liable to imprisonment without trial or conviction. As the president of the C.M.A. rightly stated, the medical specialists have been “conscripted, muzzled and threatened with gaol terms.” This

vicious deprivation of civil rights and threat to our colleagues, however far removed geographically, must be our own direct concern.

“Any man's death diminishes me, because I am involved in Mankind; And therefore never send to know for whom the bell tolls; it tolls for thee.”—I am, etc.,

GEOFFREY STEEL

London S.W.15

¹ *Canadian Medical Journal*, 1970, 103, 1106.

² *Canadian Medical Journal*, 1970, 103, 1308.

Prostatic Acid Phosphatase

SIR,—I have read with interest the report of Mr. D. Dow and Mr. R. H. Whitaker (21 November, p. 470) with regard to the prostate and level of acid phosphatase. In this study, the authors state that “there is no justification for referring to the tartrate-labile serum acid phosphatase as ‘prostatic acid phosphatase.’” With reference to the prostate gland in man, I should like to point out that in our immunological studies of normal human prostatic tissue¹ we have identified two tissue- and species-specific antigens, one of which, through the specific immunochemical staining of the gel-precipitation pattern by a modification of the Gomori histochemical procedure, was identified as prostatic acid phosphatase. Furthermore, we have recently concluded an investigation in which specifically absorbed heteroimmune sera to saline extracts of benign and malignant human prostatic tissue were employed in an attempt to compare the antigenic composition of these tissues with that of normal human prostatic tissue through the utilization of the adjunct specificity of antigen-antibody interaction in gel diffusion precipitation and enzymatic analysis.² Results suggest that benign and malignant prostatic tissue are, in comparison with normal prostatic tissue, antigenically deficient. The possible deficiency of normal prostate-specific antigens, particularly prostatic tissue-specific acid phosphatase antigens, in extract preparations of malignant prostatic tissue has been particularly interesting in view of previous chemical and histochemical reports of diminished quantities of acid phosphatase in patients with advanced carcinoma of the prostate.^{3,6}

The possible prognostic and therapeutic utilization of the detection of the antigenic deficiency of specific prostatic tissue-specific acid phosphatase antigens looms as a possibility pending the demonstration of a definitive correlation between the presence or absence of specific prostatic tissue-specific acid phosphatase antigens and the histological confirmation of the stage of prostatic carcinoma.—I am, etc.,

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Memorial Hospital of Springfield,
Springfield, Ill., U.S.A.

¹ Ablin, R. J., Bronson, P., Soanes, W. A., and Witelsky, E., *Journal of Immunology*, 1970, 104, 1329.

² Ablin, R. J., Witelsky, E., Bronson, P., and Soanes, W. A., in press.

³ Woodard, H. Q., and Dean, A. L., *Journal of Urology*, 1947, 57, 158.

⁴ Kirchheim, D., Györkey, F., Brandes, D., and Scott, W. W., *Investigative Urology*, 1964, 1, 403.

⁵ Parkin, L., Bylsma, G., Torre, A. V., Drew, D., and Madden R. J., *Journal of Histochemistry and Cytochemistry*, 1964, 12, 288.

⁶ Kent, J. R., Hill, M., and Bischoff, A., *Cancer (Philadelphia)*, 1970, 25, 858.