being necessary only in the presence of severe stenosis.

A new hypothesis is important because it may lead to a new action. The hypothesis may be entirely or partially wrong (hypotheses often are) but the action resulting from it may be right. Accepting the retention hypothesis based on benign gastric outlet disease, I have used vagotomy in one form or another for every gastric ulcer patient since 1962. The results have been carefully studied and reported.⁴ Not one of the 142 patients has needed gastric resection for persistent or recurrent ulceration. A few (about 5%) with persistent or recurrent gastric ulcer after vagotomy and pyloroplasty have later needed a gastrojejunostomy to overcome retention and to cure the ulcer. There has been no recurrence in the 32 patients treated by proximal gastric vagotomy without drainage. Our results of this operation for gastric ulcer are the same as those reported by Johnston and his colleagues in Leeds.⁵ Proximal gastric vagotomy preserves the motor function of the stomach and is the most logical and, in practice, the best operation for gastric ulcer. Incomplete nerve section is the only cause of recurrent duodenal ulceration after vagotomy and may be important too in gastric ulceration. A peroperative test for completeness of nerve section may, therefore, be as desirable when the operation is done for gastric ulcer as it is for duodenal.—I am, etc.,

HAROLD BURGE

West London Hospital,
London W.6

- 1 McNeil, A. D., McAdam, W. A. F., and Hutchison, J. S. F., *Surgery, Gynecology and Obstetrics*, 1969, 128, 91.
- 2 Burge, H., *Vagotomy*. London, Arnold, 1964.
- 3 Serck-Hanzen, F., *Brunns' Beiträge zur Klinischen Chirurgie*, 1933, 157, 464.
- 4 Burge, H., *Archives Françaises des Maladies de L'Appareil Digestif*, 9th Congres International De Gastro-Enterologie, Paris, 5-12 July 1972, p. 209.
- 5 Johnston, D., Humphrey, C. S., Smith, R. B., and Wilkinson, A. R., *British Journal of Surgery*, 1972, 59, 787.

SIR,—In view of the recent spate of letters concerning the relationship of duodeno-gastric reflux of bile and gastric ulceration (Mr. J. O. Kilby, 22 July, p. 235; Dr. W. B. James and others, 16 September, p. 699; Dr. C. D. T. MacLean, 14 October, p. 113; and Mr. H. Burge, 11 November, p. 360), it is relevant to refer to some animal experiments that are currently in progress. We are studying gastric function and in particular gastric ulceration in the pig, which is a unique animal in that it has a natural incidence of gastric ulceration which has been variously reported as 18%¹ and 26%² in different centres.

Owing to the anatomical proximity of the pig's common bile duct to the pylorus, marked biliary reflux occurs in all pigs. Initially, it was thought that bile reflux and gastric ulceration might be causally related, so it was of considerable interest to find that when reflux of bile was avoided by various surgical manoeuvres the rate of ulceration increased to between 56% and 100%. The latter figure is associated with ligation of the common bile duct, which involves the added factor of hepatic disease,³ while the former figure was seen in a group of 10 animals in which the bile was deviated farther down the small bowel by means of a Roux-en-Y procedure.

It thus appears that in the pig duodeno-gastric reflux of bile has a protective action in the stomach, interference with which results in a high incidence of gastric ulceration.—I am, etc.,

RICHARD S. ARNOT

Groote Schuur Hospital,
Cape Town, South Africa

- 1 Penny, R. H. C., Edwards, M. J., and Mulley, R., *British Veterinary Journal*, 1972, 128, 43.
- 2 O'Brien, J. J., *Veterinary Record*, 1968, 83, 245.
- 3 Sherlock, S., *Gastroenterology*, 1959, 37, 574.

Clinical Assistants in Anaesthetics

SIR,—Dr. M. M. Burrows (23 December, p. 736) thinks that I do "less than justice to the . . . new hospital practitioner grade." I have three objections to this grade.

(1) It is unnecessary. The clinical assistant grade provides a flexible system for the employment of those whose work in the hospital service is short-term or intermittent. The medical assistant grade is in my view under-used, and many present clinical assistants should actually be medical assistants. For those appropriately qualified and who are prepared to give the appropriate degree of commitment, part-time consultant contracts would be suitable. With an increasing number of trainee anaesthetists with the F.F.A. opting for general practice—stepping, not falling, off the consultant ladder—candidates for such appointments should become increasingly available.

(2) Attempting to limit entry to the grade to principals in general practice seems to me quite wrong. A person's status and rewards in the hospital service should depend solely upon the skills and time he is able to devote to that service. What he does outside the hospital is irrelevant.

(3) Limiting the contract to five sessions seems quite unreasonable. If the hospital practitioner is useful for five sessions he will be even more useful for six.

I think we should fully exploit the existing structure before innovating further categories of employment.—I am, etc.,

MERLIN MARSHALL

General Hospital,
Newcastle upon Tyne

Cogwheel and the Medical Social Worker

SIR,—We feel that your Special Correspondent (2 December, p. 543) may have been incompletely informed and we suspect that perhaps unwittingly he is grinding a political axe. Medical and psychiatric social workers have stated as a group that they wish to remain in the N.H.S.¹ It is becoming increasingly obvious that the policy of the British Association of Social Workers is not only to promote a local authority hegemony in social work, but also to render ineffectual or to destroy specialist and minority groups. The means of achieving these ends are the usual ones of using a vast majority membership to swamp the views of a minority.

It is ironic that your own Special Correspondent alludes to a recent meeting of the B.A.S.W. at which a majority showed by their votes that they agreed with the proposal to transfer hospital social workers to the local authority. Although your correspondent makes no precise reference we think he must be referring to the meeting at Scarborough, and the vote to which he alludes was a rejection of the following very

significant motion: "In situations where clearly defined groups of social workers face far-reaching changes in their employment, the views of such workers should be sought by referendum in order to guide the Council in the formulation of recommendations to official bodies." The defeat of this motion cannot do other than signify that there is a majority in the B.A.S.W. which is anxious that the voice of clearly defined minority groups should not be heard.

Your readers may find it disappointing, even significant, that an organization dedicated in principle to the defence of minorities in the community, should have so little regard for its own minority groups. Many hospital social workers, far from sharing the paranoia of the majority group, who are employed largely in local authority social work, look to doctors, and the B.M.A. in particular, for support in their fight against absorption by the local authority.—We are, etc.,

D. LINDSAY WALKER
J. A. MORPHEW

Coney Hill Hospital,
Gloucester

1 *The Guardian*, 16 October 1972.

Afternoon Surgeries

SIR,—My partner and I are endeavouring to change our evening surgery to an afternoon surgery to fall in line with the working hours of all the other branches of medical service. However, the local executive council has refused our request despite the existence of a precedent within our area.

We would be grateful to hear from doctors in other practices who have been working in the afternoons only instead of evenings so that we can quote their experience in support of our case.—I am, etc.,

R. B. SMITH

568 Whitmore Way,
Basildon, Essex

De Quervain's Disease

SIR,—I would like to write in strong support of the article by Miss Jean M. M. McKenzie (16 December, p. 659) on the conservative treatment of de Quervain's disease. Her findings agree with my own experience in the treatment of this condition. During the past few years all patients sent to me have been treated primarily by an injection of prednisolone with local anaesthetic into the common synovial sheath. Since I adopted this as a routine several years ago operative treatment of de Quervain's disease has almost ceased to figure on my operating lists.—I am, etc.,

H. D. W. POWELL

High Wycombe, Bucks

Fenfluramine and Haemolytic Anaemia

SIR,—It is possible that yet another drug may have to be added to the growing list of preparations capable of causing haemolytic anaemia.

A 46-year-old woman presented on 7 June 1972 with a haemoglobin level of 5.1 g/100 ml, 8.6% reticulocytes, W.B.C. 17,100/mm³, and 22 nucleated R.B.C.s per 100 W.B.C.s. Her R.B.C.s

gave a strongly positive direct Coombs test, and her serum contained autoantibodies of the IgG type, falling into the rhesus blood group system—namely, anti-e (stronger) and anti-rl (weaker). The patient, who was obese, was given fenfluramine for a period of five months in 1970 and for one month in 1971 without ill effect, and it was only after she resumed this treatment for a further two months at the beginning of 1972 that she began to feel ill. She had no infection before becoming anaemic and, unlike the two patients mentioned by Mr. A. M. Walshe (30 September, p. 821), who in addition to fenfluramine also had propranolol, she had received no other drugs. She was transfused with four pints (2.3 l.) of blood and given a course of prednisolone. She made a full recovery and her Coombs test became negative.

No similar case was found in the literature, apart from the two mentioned above, and if fenfluramine is indeed capable of inducing haemolytic anaemia, further examples may come to light.—I am, etc.,

A. M. NUSSEY

Solihull Hospital,
Solihull, Warwicks

Transient Cranial Mononeuropathy

SIR,—I was surprised to read that Dr. J. N. Blau and Mr. R. Kapadia (4 November, p. 259) "conclude that it is reasonable to accept the entity of the cranial mononeuropathies," but still more so to find that they state that "it would clearly be sensible to tackle the aetiology of Bell's palsy because it is the most common of these neuropathies"—in order "to incriminate or dismiss a viral cause for transient cranial nerve lesions."

They seem to base their conclusion on the facts that of a series of 21 selected patients with unilateral vocal cord palsy 10 recovered more or less completely and 11 did not recover, but no serious diseases had developed after a follow-up period ranging from three months to eight years. This may be true, though I do not understand how one can be sure that a case of disseminated sclerosis could not have remained undiscovered over a period of one year or less (six patients in this series). Examination of the cerebrospinal fluid is not mentioned. Not mentioned either is examination of the passive mobility of the cricoarytenoid joint; in a case of arthritis its immobility is so often overlooked because, on inspection only, it is indistinguishable from a palsy of the recurrent laryngeal nerve.

If I nevertheless accept the truth of this conclusion and if I do not criticize the statistics—15 patients who declined to attend were excluded—I still do not see the reasonableness of the conclusion about the entity of the cranial mononeuropathies. There is simply no reason for it; on the contrary, there are reasons to doubt it. The acute and permanent loss of hearing complicating mumps, the usually transient abducens paresis, the zoster paralysis of the facial nerve showing histological changes up into the nuclei of this nerve, the ischaemic (Bell's) palsy with, histologically, oedema and never a trace of inflammation,¹ the severe but short-lived influenza vertigo—certainly a very impressive entity of diversities. If this diversity of reactions is here proposed as an argument for the existence of viral infections, it can only be because in any symptom of uncertain origin the virus seems to be the modern magic prince,

Beelzebub revived, who explains the problems away.

If one seeks an entity, take Bell's palsies—they are all the same, "like peas in a pod."²—I am, etc.,

L. B. W. JONGKEES

Wilhelmina Gasthuis,
Amsterdam, Netherlands

- 1 Jongkees, L. B. W., *Acta Otolaryngologica*, 1954, **44**, 336.
- 2 Taverner, D., *Archives of Otolaryngology*, 1965, **81**, 536.

Acute Polyarthritis

SIR,—We would like to congratulate Drs. S. S. Bedi and G. N. Marsh on their article on acute polyarthritis (30 December, p. 779). They have, however, omitted to discuss, under differential diagnosis and investigations, the possibility of the patient having gonococcal arthritis, a condition which would, of course, present in exactly this manner in a young female. We have personally seen 10 cases in the past three years, several of which presented as an acute sero-negative polyarthropathy unresponsive to anti-inflammatory drug therapy.

In view of the recent dramatic increase in the incidence of gonorrhoea in this country it would seem important that a diagnosis of gonococcal septicaemia with arthritis should be considered in cases such as this.—We are, etc.,

J. R. W. HARRIS
R. S. MORTON

Royal Infirmary,
Sheffield

SIR,—I was sorry to read in the article by Drs. S. S. Bedi and G. N. Marsh (30 December, p. 779), one of whom is a Fellow of the Royal College of General Practitioners, the following statements: "A clinical diagnosis of acute rheumatism was made by the general practitioner and she was advised rest at home and 3 g of soluble aspirin per day. Her husband was instructed to bring her to the surgery the next morning, for an appointment with the attached local authority nursing sister" (to take throat swabs and blood samples and do an electrocardiogram).

Where is the end to the present-day notion that a general practitioner should do as few visits as possible and should delegate those tasks which do not require his diagnostic prowess? Are we really too busy to visit and undertake investigative procedures on patients whom we have told to rest at home—or is it that we like everyone else to think that we are?—I am, etc.,

NIGEL W. S. HESTER

Albrighton,
nr. Wolverhampton

C.C.H.M.S. and Consultant Contract

SIR,—The Chairman of the Central Committee for Hospital Medical Services in his reply (9 December, p. 614) to the letter on this theme from Mr. J. A. Fleming (2 December, p. 553) seems not to appreciate the disquiet felt by many hospital consultants about the competence of the C.C.H.M.S. to

represent their views on conditions of service. It is evident that the essential fault in the structure and functioning of the C.C.H.M.S. needs to be spelled out.

The organization of the C.C.H.M.S. appears to stop short at regional level. Thus, although hospital medical staff appoint group representatives to regional committees, there is no formal national organization within hospitals for regular meetings or for election of officers or group representatives. The result is a woolly arrangement, the details of which presumably vary between hospitals. If the representative is deeply interested in the affairs of the C.C.H.M.S. (as is our representative), then there is a reasonable chance that the views of hospital medical staff on conditions of service will be obtained and that the gist of discussions, proposals, etc. at meetings of the C.C.H.M.S. will reach the periphery both effectively and in good time. If, however, the representative is not experienced in policy-forming and communication, the lack of organization at hospital level will result in an ineffectual and possibly misleading dialogue between the centre and the periphery. It appears that the only way to avoid such confusion is for the C.C.H.M.S. (or any committee which may replace the C.C.H.M.S.) to expand its organization to include all medical staff in hospitals in the N.H.S.

The present furore about a new consultant contract exemplifies the consequences of the poor organization of consultants in hospitals for dealing with matters affecting their conditions of service and the inadequacy of communication at sub-regional levels. The National Hospital Staffs Conference and C.C.H.M.S. decided on the need for, and the proposed conditions of, a new contract without first having consulted hospital consultants at large by referendum. The failure to ascertain the views of hospital consultants has shaken their trust in the C.C.H.M.S. This trust will be restored only if the C.C.H.M.S. arranges for a referendum to obtain the views of all hospital consultants on possible changes in the terms of their contracts. In our view a referendum on this matter is essential.—We are, etc.,

R. A. DALE
P. D. ROBERTS
N. F. COGHILL
J. S. STEWART

West Middlesex Hospital,
Isleworth

The Chambers Principles

SIR,—The "fundamental principles" of the Chambers Report (*Supplement*, 25 November, p. 55) have been listed by the Organization Committee and reported by you (*Supplement*, 6 January, p. 7).

The most important principle of all appears to have been left out. It appears in section V, paragraph 3, and reads: "... there must be an assumption that the Association intends to co-operate wholeheartedly with the Government in the task of making the National Health Service successful."

Sir Paul Chambers has adduced ample evidence in his masterly report showing this to be something new. Will someone please see that this essential and novel principle is included?—I am, etc.,

T. McL. GALLOWAY

Chichester, Sussex