CORRESPONDENCE

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Tuberculous Peritonitis and Laparotomy

SIR,—Your leading article (3 March, p. 502) discusses the differential diagnosis of abdominal swelling, fever, and ascites in the weeks after abdominal operations. Surprisingly you omit mention of starch peritonitis as a cause, in spite of the considerable correspondence in the *B.M.J.*¹⁻⁵ which followed the description of five cases by Neely and Davies.⁶ Though clinically apparent reactions to glove-powder contamination of the peritoneum are infrequent, they are likely to prove a commoner, if less serious, cause of this syndrome in Britain than tuberculous peritonitis.

You recommend needle biopsy or "other form of peritoneal investigation" when there is a possibility of tuberculous peritonitis. In the case of starch peritonitis the appropriate "peritoneal investigation" is paracentesis. Microscopical examination of ascitic fluid using polarized light may reveal spherical granules showing "Maltese-cross" birefringence characteristic of the condition.⁷ A diagnosis of starch peritonitis should also be considered by pathologists examining material from the abdomen of patients who have previously undergone laparotomy. The

histological picture of a follicular, granulomatous reaction including multinucleate giant cells with occasional foci of necrosis may easily be misdiagnosed as tuberculosis if the specimen is not examined under polarized light.

Starch peritonitis is frequently overlooked because of lack of awareness of the condition. Your leading article unfortunately missed an opportunity to remind clinicians and pathologists of this important complication of laparotomy.—We are, etc.,

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- 1 Colin, J. F., and Wastell, C., *British Medical Journal*, 1971, 4, 47.
- 2 Swingle, G. R., *British Medical Journal*, 1971, 4, 116.
- 3 Nicholls, J. C., *British Medical Journal*, 1971, 4, 426.
- 4 Macpherson, G. H., and Barrie, W. W., *British Medical Journal*, 1971, 4, 747.
- 5 Nash, D. F. E., *British Medical Journal*, 1973, 1, 485.
- 6 Neely, J., and Davies, J. D., *British Medical Journal*, 1971, 3, 625.
- 7 Warshaw, A. L., *Lancet*, 1972, 2, 1054.

Hospital Advisory Service

SIR,—It was interesting to read Dr. A. A. Baker's report to the General Medical Services Committee and the ensuing discussion (*Supplement*, 13 January, p. 11).

He rightly points out that it would be a mistake to look at the hospital service as if it were an encapsulated part of a total service. As general practitioners are key participants in the overall professional care of patients it is extremely difficult to understand why a G.P. is not included in all the

teams of the Hospital Advisory Service. Dr. Baker makes the point that a larger team means longer time in discussion of problems but states in his report that more recently a physiotherapist and an occupational therapist have been included, while a G.P. has not. None of us would doubt the importance of these disciplines, but with an integrated National Health Service in view, in which G.P.s will be represented at district level in the management team as well as at area and

regional levels, it seems self-evident that the Hospital Advisory Service should always have the advantage of G.P. opinion.

Having served for a short time on one of the teams in 1971 I am convinced that the family doctor has an angle on the care of patients complementary to that of consultants, nursing staff, and social workers. The G.P. member would be in a key position to arrange for the team to meet the local medical committee at one of its regular meetings. In dealing with other matters such as ambulance services and open access to hospital departments, we have found this method of communication extremely useful—far more so than by calling a special meeting of G.P.s. I hope that the valuable work of the Hospital Advisory Service will be enhanced by the inclusion of a G.P. on every team.—I am, etc.,

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Rh Immunization in Ruptured Tubal Pregnancy

SIR,—The reply of Drs. J. Katz and R. G. Marcus (3 February, p. 290) to my criticism (4 November, p. 295) of their original article (16 September, p. 667) demands further comment.

In order to derive, as the authors do, the volume of fetal blood in the maternal circulation one must know the circulating blood volume of the mother and her red cell count as well as the red cell count of the fetus and the "fetal cell score" in the mother. The first two items of information are not given by the authors. Haemoglobin concentration in peritoneal blood is lower