14 years of age. She was admitted to this hospital at 38 weeks' gestation (before the onset of labour) with signs and symptoms suggestive of intra-abdominal haemorrhage. At laparotomy the upper end of the "classical" hysterotomy scar had ruptured completely and a portion of the underlying placenta was protruding through it. There was about 2½ l. of fluid and clotted blood in the peritoneal cavity. Caesarian supravaginal hysterectomy was performed and both mother and child survived, but the former required blood transfusions totalling 3 l.

While fully agreeing with the authors' suggestion that hysterotomy should in general be eschewed unless sterilization is also performed, there may be circumstances in which hysterotomy is urgently indicated but sterilization is undesirable. In such cases, if the operation is performed after the 18th-20th week, the lower uterine segment is often sufficiently developed to permit evacuation through a transverse incision at this level. It would seem likely by analogy with classical and lower segment caesarean section incisions that the risk of uterine rupture in a subsequent pregnancy will be considerably reduced by this technique, which I now use whenever possible instead of the vertical upper segment incision usually employed for hysterotomy.—I am, etc.,

R. F. HEYS

Halifax General Hospital,
Halifax

Loin Percussion in Acute Pyelonephritis

SIR,—I wish to draw attention to the value of loin percussion in the diagnosis of acute pyelonephritis in general practice. Indirect percussion with a clenched fist is begun over the scapula and is continued downwards, with reduced force, over the loin. The demonstration of loin tenderness, and by implication tenderness of the kidney, is readily performed without requiring the patient to undress or lie down. Percussion is used on patients either with symptoms of urinary infection or with abdominal pain and nausea. This is often the only positive clinical sign in acute pyelonephritis, since fever is often intermittent and may be absent at the time of examination.

During a three-year study of women with bacteriuria in general practice loin tenderness was found in 18 out of 102 women with symptomatic urinary infection. A diagnosis of acute pyelonephritis was made in these 18 women, all of whom gave a history suggestive of fever and had loin pain. Fever at the time of examination was found in only eight women. The other 84 were diagnosed as cystitis. When the patients were investigated at least one month after diagnosis renal function was impaired in women with acute pyelonephritis when compared with the cystitis group. Urine concentrating ability was tested by 15 hours' overnight fluid deprivation. Abnormalities, including minor faults of the pelvis and calyces, were seen in 75% of 16 intravenous pyelograms in women with acute pyelonephritis and in 4% of 23 women with recurrent bacterial cystitis.

Hence the presence of loin tenderness in patients with bacterial urinary infection delineates a group of acute pyelonephritics who are likely to have abnormalities of renal function and structure. This sign can be rapidly elicited even in the often hurried

atmosphere of routine general practice.—I am, etc.,

B. T. B. MANNERS

Addlestone,
Surrey

Earnings of General Practitioners

SIR,—If Dr. D. J. Anderson and his colleagues (3 March, p. 554) care to flick over the pages to the advertisement section of the *B.M.J.* they will see under the heading "Partnerships Available" column numerous offers quoting incomes "at parity" in the range £7,000-£10,000 per annum. If they make inquiries of the B.M.A. Personal Services Bureau they will learn that these figures refer to the income available to the incoming partner after deduction of practice expenses. They will also note that this sum is achieved generally before the age of 30, whereas the top whole-time basic consultant salary of £7,350 is not reached until the age of 45. The general practitioner will have further personal professional expenses (motor car, telephone, etc.) for which he can whereas the top whole-time basic consultant also has these expenses, but does not receive tax relief. The figure of £5,500 per annum quoted in their letter is the projected average income which the Review Body considered the general practitioner should receive in 1972. We in the Regional Hospitals' Consultants and Specialists Association are in wholehearted agreement when they suggest that it is difficult to believe that income tax reliefs "could increase a family doctor's income by £1,500" or that "it would be possible to earn £3,000 per annum outside the N.H.S." Maybe this income comes from within the N.H.S. Unless the doctors from Teesside wish to challenge the advertised figures, perhaps they will agree that the Review Body has in fact done its sums wrong and by quoting "projected" and "average" earnings has under-estimated the real earnings by some £2-3,000 per annum. They will, of course, have noted the impressive increase in the numbers of general practitioner principals in the last two years and they will be dismayed to learn that this has been matched by the numbers of unfilled consultant posts rising from about 500 in 1970 to 800 in 1971 and probably to over 1,000 today. In our view this movement in medical manpower is related directly to remuneration prospects.

The main concern of the R.H.C.S.A. in this particular field is not only to ensure a fair rate of remuneration for the basic grade regional consultants, but we hope that by so doing we will also ensure that senior hospital posts continue to be filled by suitably qualified doctors. We applaud the general practitioner's 150% increase in income since 1965. But we hope the Teesside doctors will not begrudge the efforts of the R.H.C.S.A. in our attempts to match that success. After all, our interests are also very much their interests.—I am, etc.,

JOHN WINTER

Regional Hospital' Consultants and Specialists
Association,
Ascot, Berks.

SIR,—Dr. D. J. Anderson and others (3 March, p. 554) must be very naive to think that the regional consultants will express any

sympathy for his letter. He and his colleagues have only to read the advertisements in the same issue of the *B.M.J.* (pp. xxii and xxiii) to realize that nearly every practice offers more than the salary of a full-time consultant to start with, and much more at parity. The parity offered by 11 practices well exceeds the salary of a full-time consultant with maximum increments.

Who is telling the truth?—I am, etc.,

E. PLATTS

Thornton-in-Cleveland,
Teesside

Management of the N.H.S.

SIR,—It is to be hoped that Dr. D. G. Ferriman's concept (24 February, p. 492) of the district management team in the re-organized Health Service proves to be false. He describes it as consisting of four administrators and two clinicians, the implications being that the attitudes and objectives of these two groups are different and hence the composition of the team should be adjusted to redress the balance between "them" and "us."

The team could with equal accuracy be described as consisting of four members of the caring professions (three doctors and one nurse) and two others, but this distinction is equally invidious. All six will in fact be administrators with the shared objective of endeavouring to ensure that available resources are used in such a way as to achieve the best possible outcome in terms of patient care. Each member will contribute his or her particular knowledge and experience to this end, and decisions will be reached by consensus. Those which affect the clinical care of patients will surely be made largely on the advice of the clinical members of the team.

Whether or not the new administration at district level is successful will depend on the way in which the management team functions. If it meets in a spirit of constructive co-operation, then the prognosis is good. The N.H.S., and hence patient care, will not be served by the perpetuation of out-dated interprofessional distrust.—I am, etc.,

PETER N. DIXON

Department of Public Health,
University of Bristol

London Pride?

SIR,—I was disturbed to read an advertisement in the *B.M.J.* (10 February, p. xlvii) asking for applicants for the post of surgeon in Aden, required by the British Petroleum Company. Part of this advertisement states that candidates' experience should include "time spent [as a senior registrar] in a London teaching hospital." This surely negates not only the efforts of the Joint Committee on Higher Surgical Training, the Royal Colleges of Surgeons, and the Association of Professors of Surgery, but also your own past policy. In the *B.M.J.* of 5 June 1971, at page 543, you stated in a leading article: "The sooner we have a unified system of [surgical] training throughout the British Isles the better."—I am, etc.,

R. BUCHAN

Royal Infirmary,
Edinburgh