steroids, while others go into remission spontaneously after a few weeks. In the cases reported by Dr. Guardia and his colleagues there was only one clinical attack and A.M.A. disappeared, remaining absent on follow-up for 18 months. We have observed several cases of this syndrome and a 20-year follow-up is available in one.

The patient is a housewife born in 1909. She was well until 1954, when she presented at a rheumatology clinic with backache. One year later she developed erythema multiforme, pyrexia, arthralgias, and an E.S.R. of 70 mm in 1 hr. Penicillin caused a severe toxic purpura requiring steroids. Since then she has had repeated attacks occurring about three times a year, lasting one to four months, and consisting of arthralgias affecting mainly the hands, wrists, elbows, and knees with effusions and also the shoulders and back, without rheumatoid changes on x-ray. In 1957 and on several subsequent occasions there were pleural effusions. The most recent episode was in August 1974, lasting six weeks. The E.S.R. during attacks ranged between 30 and 95 mm in 1 h and returned to normal during remissions. L.E. cells have been looked for on numerous occasions in the past 20 years but have been persistently absent except once in 1970 when "very scanty L.E. cells" were reported. The W.R. became positive on one occasion in 1957 but this was considered to be a biological false positive reaction. A.N.A. were either absent or detected in trace amounts. Tests for rheumatoid factors remained equally negative. The leucocyte count was normal throughout, with occasional relative lymphopenia. Liver function tests were normal at all times. A.M.A. were first detected in 1964 and remained at low titres until 1969, when the complement fixation titre went up to more than 1/256. In 1970-2 these antibodies were barely detectable but in her last attack the titre rose again to 1/80. Past and family history showed that the patient, an uncle, and two cousins had Dupuytren's contractures and one son suffers from asthma.

Mitochondrial antibodies are best known for their diagnostic significance in primary biliary cirrhosis (P.B.C.) and allied liver disorders.^{3,4} The antigen has been characterized as a lipoprotein of the mitochondrial inner membranes, molecular weight 180 000 daltons, found at highest concentration in brown fat^{5,7} but also in tissue mitochondria of animal species down to insect flight muscles. Though the immunofluorescent pattern obtained with the pseudo-S.L.E. sera resembles that seen with P.B.C. antibodies, the antigen could be quite distinct in its location within the membranes and its chemical nature and have a different aetiological significance, especially as there are two other mitochondria-related human antibodies—the cardiolipin fluorescent antibody found mainly in active secondary syphilis⁸ and an A.M.A. reacting only with rat tissues, of unknown clinical significance and unassociated with either liver disease or collagen disorders.—We are, etc.,

ALEXIS FLORIN-CHRISTENSEN

A. C. BOYLE

MARY CORBETT

DEBORAH DONIACH

Departments of Rheumatology and Immunology,
Middlesex Hospital Medical School,
London W.1

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- 7 Bianchi, F. B., Penfold, P., and Roitt, I. M., *British Journal of Experimental Pathology*, 1973, 54, 652.
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Reorganization in Yorkshire

SIR,—I refer to the letter from Dr. W. R. M. Couper (8 February, p. 335) in connexion with the reorganization of the National Health Service in North Yorkshire.

In the first place the North Yorkshire Area Health Authority considered the recommendations from the Department of Health and Social Security in H.R.C.(72)5 and H.R.C.(73)13, along with recommendations which had been received from the joint liaison committee set up by the former authorities to give advice to the area health authority on matters in connexion with reorganization. After taking account of all the factors involved the area health authority unanimously decided to establish its headquarters in York and this was subsequently approved by both the Yorkshire Regional Health Authority and the Department of Health. It was also with the agreement and support of the North Yorkshire County Council, whose headquarters were in Northallerton.

So far as appointments to senior posts in North Yorkshire are concerned, these appointments were made by appointment panels properly constituted and set up in accordance with advice from the Department of Health, incorporating such outside assessors as the Department advised, and candidates were appointed strictly according to merit.—I am, etc.,

B. HAZELL

Chairman,

North Yorkshire Health Authority

York

Genitourinary Medicine

SIR,—With reference to the letters from Dr. A. S. Wigfield (8 February, p. 332) and Dr. W. Fowler (p. 333) in this department in 1974 the major sexually transmitted diseases syphilis and gonorrhoea accounted for 14% of diagnoses. Other genital infections, some of them not sexually transmitted, included non-specific genital infection, trichomoniasis, candidosis, genital warts, and genital herpes and constituted 51% of diagnoses. In 35% of patients no infective disease was present, though many of these patients had urogenital or other abnormalities which required treatment either in the hospital or from their general practitioners.

The title of the department was changed last year following a decision taken within the hospital, without pressure from the Department of Health and Social Security or the Royal College of Physicians. The new title does appear to reflect the work actually done; furthermore, being free from emotional overtones, it is hoped that it facilitates the use of the department's diagnostic facilities by colleagues within the hospital and in general practice and by patients themselves.—I am, etc.,

J. D. ORIEL

Department of Genitourinary Medicine,
University College Hospital,
London W.C.1

SIR,—I was surprised at the responses from Drs. A. S. Wigfield and W. Fowler (8 February, p. 332) to your leading article (11 January, p. 51).

I am a general practitioner and I know that my view is shared by many of my colleagues when I say that I welcome the change in nomenclature from V.D. clinic (or

even "special clinic") to that of genito-urinary medicine. If such departments are developing with a view to treating clinical problems much wider than those customarily regarded as "venereal" in origin, then it is time we recognized the fact and the change is worth supporting.

Certainly the department which serves my practice provides us with a good service over a considerable range of clinical problems, including particularly those very difficult syndromes of recurrent urinary tract infections and/or recurrent vaginal candidosis. These two problems alone are very well worth the attention of a specialist who is specifically interested and I dare say there will be a considerable number of general physicians and gynaecologists who will be very happy to be relieved of the burden by a colleague whose specific interest it is.

There is no question in my mind that a considerable number of patients (particularly those who are no longer in the first flush of youth) do find it easy to attend a department that is not specifically labelled as "venereal" in its interest. If the experience of general practitioners about the country reflects my opinion then I submit that that reason alone is sufficient to give the changed title our support.—I am, etc.,

DONALD GRANT

London N.W.5

Canine Smokers

SIR,—The recent furore over a mode of research which entails beagle dogs being forced to inhale smoke for long periods in the search to produce a safe cigarette is indicative of the views of the vast majority of ordinary citizens. Notwithstanding that many of the protesters are themselves smokers, they—together with non-smokers—are determined to ensure that scientists should not be allowed to exceed certain fundamental moral obligations to sentient creatures by subjecting them to prolonged suffering in an attempt solely to satisfy craving for whatever satisfaction smoking can offer.

At a time in history when science is leaping ahead in so many fields it becomes necessary to remind those engaged in scientific research that there is a right way and a wrong way to acquire knowledge. In the case of the smoking beagles the ends certainly cannot justify such means, and the methods employed in evaluating such products should be confined to alternative and ethically acceptable techniques.—I am, etc.,

NEVILLE BASSOUS

Parliamentary Officer,

National Anti-Vivisection Society

London W.1

Adverse Effects of Publicity

SIR,—I am wondering if it is possible for the B.M.A. to prevent two rather adverse types of publicity which have occurred during recent weeks.

Firstly, we have encountered a lot of problems as a result of the B.B.C. television programme on 3 February about induction of labour. I myself did not see this programme but several of my colleagues have asked me to associate myself with their protest over programmes like these. They make it very hard to treat patients in the

way one knows they should be treated. A similar sort of thing occurred with the publicity over social induction at Christmas. I think this sort of publicity is to be abhorred.

My second protest is that newspaper journalists are allowed access to information about research on new drugs, the results of which are published in lay papers before members of the medical profession have a chance to hear and know about the actions of these drugs. The particular article to which I refer appeared in the *Daily Mail* of 30 January (p. 11) and was headed "How we tested the new Happiness Pill." A patient came into my gynaecological clinic shortly afterwards, flung this piece of paper on my desk, and said, "I want these drugs," which I had not even heard of. I now understand that the "happiness pill" is an oestrogen at present under clinical trial for the treatment of menopausal symptoms.

I should be grateful if something could be done to prevent publicity such as we have experienced in the past few weeks.—I am, etc.,

MARGARET J. WITT

Department of Gynaecology and Obstetrics,
North Middlesex Hospital,
London N.18

Ouabain in Heart Failure

SIR,—Reading with interest your leading article "Problems with Digoxin" (11 January, p. 49), I was surprised not to find even a single mention of one of the drugs most favoured in Germany—namely, strophanthin-G or ouabain.

I remember well being taught in Britain that ouabain was out of date, offering generally less than intravenous digoxin, and even that its speed of action was no greater than that of the most rapidly acting digitalis preparations. But it is common clinical experience here that in acute congestive heart failure ouabain produces the most rapid increase in cardiac contractility and output and with the least risk of untoward (toxic) effects, though I am aware of the fact that it does, at least qualitatively, share the negative chronotropic and bathmotropic effects of its brother substances digoxin, etc.

There is another—however controversial—indication for the use of ouabain in Germany: in cases of reduced cerebral perfusion caused by decreased cardiac output due to degenerative heart and vascular disease. Here a single dose of 0.25–0.4 mg given daily or even only thrice weekly over a period of several weeks seems to restore cardiac energy and reserve for a much longer time than the period of actual treatment.

Thus I feel that even in our enlightened days this drug might still merit some thought and consideration.—I am, etc.,

J.-U. WALTHER

Munich, W. Germany

Essential Thrombocythaemia, Polycythaemia, and Peripheral Gangrene

SIR,—The paper by Dr. F. E. Preston and others (31 August 1974, p. 548) shows that it is important to look for thrombocythaemia in patients with peripheral vascular disease. Similar symptoms may be seen in

polycythaemia vera with an elevated platelet count,¹ and the distinction between the two conditions may depend on the criteria used and perhaps even on the effect of iron medication, as illustrated by the following case.

A man who, at the age of 40, had had one toe amputated because of gangrene, was two years later admitted to hospital on account of imminent gangrene of several toes. The peripheral pulses were palpable and blood examination revealed a hypochromic anaemia (haemoglobin 6.3 g/dl) leucocyte count $22.4 \times 10^9/l$ ($22\,400/mm^3$), and platelet count $1330 \times 10^9/l$ ($1\,330\,000/mm^3$). These findings should be virtually diagnostic of essential thrombocythaemia.² As the anaemia might be having an adverse effect on the ischaemic tissue iron was administered orally and the haemoglobin level reached normal values. Total red cell volume was then found to be 55 ml/kg and a diagnosis of polycythaemia was made. The platelets were morphologically normal, both by light and by electron microscopy (Dr. Skjorten, Ullevål Hospital). The platelets had a marked inhibitory effect on the intrinsic coagulation system. Biopsy from the posterior iliac spine showed a very hypercellular bone marrow with marked megakaryocytic hyperplasia (Dr. Marton, Aker Hospital). The patient was treated with ^{32}P and got rid of his symptoms within a few weeks. The platelet count decreased to $870 \times 10^9/l$ ($870\,000/mm^3$).

Some of the polycythaemia vera patients of Edwards and Cooley¹ could probably also have been classified as having essential thrombocythaemia. On the other hand we do not know if some of the patients described by Dr. Preston and his colleagues had iron deficiency and possibly might develop polycythaemia vera. In our patient the ischaemic symptoms were evidently due to the increased platelet count. The distinction between the two conditions is of some practical interest, for with a diagnosis of polycythaemia therapy against the enhanced platelet reactivity may not be instituted. As suggested by Dr. Preston and his colleagues, a therapeutic trial with aspirin is probably a useful diagnostic test of thrombocythaemia-induced gangrene, and it will be interesting to see this test performed in polycythaemia vera patients.—We are, etc.,

A. TEIEN
U. ABILDGAARD

Medical Department A,
Aker Hospital,
Oslo, Norway

¹ Edwards, E. A., and Cooley, M. H., *Journal of the American Medical Association*, 1970, 214, 1463.

² Gunz, F. W., in *Hematology*, ed. W. J. Williams, et al., p. 704. New York, McGraw-Hill, 1972.

Overseas Doctors in the U.K.

SIR,—The General Medical Council proposes shortly to introduce a test of the proficiency in the English language and the professional knowledge of those overseas doctors applying for temporary registration (7 December, p. 606). While this will give certain benefits to the N.H.S., how will the examination help the overseas doctors? I hope that the test will not prove just another hurdle and that passing the test will provide the foreign doctor with better job opportunities in the N.H.S.

Because of the unsatisfactory "training job" situation the foreign doctor often reluctantly has to prolong his stay in Britain. As a result of this he becomes accustomed to the British life style, may feel apprehensive of returning, and develops an apathetic outlook towards his own country. Therefore to achieve a symbiotic relationship, in addition to the proposed examination the

G.M.C. should permit the foreign medical graduate to work in Britain for only a set period of two or at the most three years. During this period the overseas doctor would be provided with programmed training in the N.H.S., and after the training period a "certificate of clinical training" would be issued. This procedure might rescue the overseas doctor from the frustrating experience of the completely uncertain outcome of the royal colleges' examinations, which, moreover, have a doubtful practical relevance in their own countries. At the end of this period the foreign doctor should be obliged to consider returning to his own country as a strong possibility. By this arrangement the foreign medical graduate would have a definite sense of purpose to keep his mental faculties alive and flexible towards his country of origin, and can carry back much "British goodwill."—I am, etc.,

T. A. REDDY

Glasgow

Kilopascals

SIR,—With reference to the letter from Professor J. H. Green (8 February, p. 333) I would like to enter a strong objection to the adoption of this particular SI unit. The trouble with the kilopascal is that it is simply far too large, and apart from its fortuitous numerical approximation to gas percentages at standard atmospheric pressure, has little to recommend it. This unit is being powerfully promoted by several bodies concerned with metrication, but surely should be discarded for clinical use in favour of the hectopascal, more familiarly known as the millibar. This, very closely approximating 1 cm H₂O, is of just the right size, both for gas tensions and for respiratory and blood pressures.

I am well aware of the recommendation of the 11th Conférence Générale des Poids et Mesures that prefixes should move up and down in steps of three powers, but the practical value of the litre and millilitre is so apparent that not even the dottiest purist of SI has yet attempted to constrain us to cubic metres and cubic millimetres. It seems likely that meteorologists will be as unwilling to discard the well-established millibar as we would be to discard the millilitre, so why should not we also use this convenient and accepted unit? By doing so, my blood pressure will certainly be likely to remain at 160/100 mbar and I trust that Professor Green's will not rise to 240/120 hPa.—I am, etc.,

R. B. ROE

Princess Margaret Hospital,
Swindon, Wilts

** Though the pascal is the official SI unit of pressure the bar, like the litre, is among those non-SI units whose use the 11th C.G.P.M. decided should be tolerated, though discouraged. The working party which drew up recommendations for the use of SI units in British hospital laboratories¹ advised that, for the time being, kPa should be used only for blood gas measurements. We have accepted this advice and shall await further developments before abandoning the use of mm Hg and cm H₂O in other contexts.—Ed., *B.M.J.*

¹ Baron, D. N., et al., *Journal of Clinical Pathology*, 1974, 27, 590.