possibility of updating it is also an added bonus. All forms of the media presentations (films, slides, and exhibitions) are expensive if produced commercially, but the N.H.S. already employs professional photographers and illustrators who, with encouragement and very modest expansion of their facilities, could provide most of its needs.—I am, etc.,

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Inquiry among Rheumatism Unit Outpatients

SIR,—As our outpatients sat patiently waiting in the rheumatism unit a few months ago at Westminster Hospital we asked them to fill in two questionnaires asking them (1) for details of their daily commuting to work and the effect it had on their arthritis, and (2) what forms of unofficial therapy they had had for this condition while attending our clinic or their general practitioners. This action was taken as we felt that, in the London area, if a patient was fit to get there she was probably fit for her work, and that patients with arthropathies, where cure is rare and treatment largely symptomatic, would in most cases try some unorthodox form of therapy. The results of our inquiry might be of interest.

Firstly, of 65 patients who completed the form as regards daily commuting to work 38 had arthritis, 12 ankylosing spondylitis, six gout, and nine osteoarthritis. They gave very different stories. For the 16 men and 22 women with arthritis travelling time averaged 67 minutes a day. Much the most popular form of transport was by private automobile, the least popular were walking and travelling by bus. A common complaint was of being jostled and pushed aside by hurrying commuters when walking. This often caused as much emotional as physical upset. For the spondylitics the least popular forms of transport were essentially those which entailed prolonged immobility. With them, unlike the patients with arthritis, travel on foot or by car were equally popular. For osteoarthrotics the most unpleasant feature was standing waiting at bus stops. In the whole group travelling time varied from six to 140 minutes daily, averaging 76 minutes.

The question about forms of unofficial therapy was answered by 184 patients. Rather to our surprise, 100 had not gone outside the treatment that their general practitioners and we had given them. Among the various unofficial forms of therapy were the wearing of copper bangles, faith healing, acupuncture, and manipulation. Though in individual cases benefit was seen on occasion, in all but one group therapeutic results were considered by the patients as unsatisfactory. The exception was manipulation. Of the 23 patients who had received it outside hospital and general practice, 11 had rheumatoid arthritis, six osteoarthritis, three ankylosing spondylitis, and three soft tissue lesions. Nine had lasting relief—five with osteoarthritis, three with rheumatoid arthritis, and one with soft tissue rheumatism. None of the three spondylitics improved, one being considerably aggravated. Eleven patients, seven with rheumatoid arthritis, had tried acupuncture. In none

was it considered helpful by the patient and in none did it produce remission or lasting relief. Faith healing was practised by 11 patients, six with rheumatoid arthritis. In two there was temporary and in one lasting improvement, the remainder reporting no benefit. Only two of 32 wearers of copper bangles thought that any benefit resulted.—We are, etc.,

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Hyperglucagonaemia in the Surgical Patient

SIR,—The article by Mr. R. C. G. Russell and others (4 January, p. 10) prompts us to record our own experience of this phenomenon in a two-year study in which changes in the plasma glucose level have been related to the plasma levels of immunoreactive glucagon (I.R.G.), insulin (I.R.I.), growth hormone, and cortisol, and the urinary excretion of adrenaline and noradrenaline in more than 50 patients.

Plasma glucose (hexokinase method) rose significantly above basal levels by the fifteenth minute of operation, from 5.08 ± 0.12 to 6.38 ± 0.20 mmol/l (91.6 ± 2.1 to 115 ± 3.6 mg/100 ml) (mean $\pm$ S.E.M., $P < 0.005$) and reached its peak of 7.71 ± 0.38 mmol/l (139 ± 6.8 mg/100 ml) by 30 min. I.R.G. values showed no change, being respectively 165 ± 25 , 164 ± 28 and 152 ± 34 ng/l, and no rise was seen during the remaining operation time. Values of I.R.I. fell during operation. On the first postoperative morning the plasma glucose had already declined to 6.44 ± 0.14 mmol/l (116 ± 2.5 mg/100 ml) and yet the I.R.G. (286 ± 36 ng/l, $P < 0.001$) and I.R.I. values were significantly greater than at any previous observation. During the next six days the plasma glucose fell steadily and there was a parallel fall in I.R.I., yet I.R.G. values remained elevated. We would thus agree that hyperglucagonaemia is a feature of the postoperative situation but have not found any rise during operation itself.

In the conduct of such studies a number of factors may introduce bias and we have therefore studied a stereotyped response in otherwise healthy adult males whose diet, activity, drugs, anaesthetic, operation, and convalescence could be precisely controlled. We have already shown that in this model situation changes in plasma glucose correlate precisely with the surgical injury and recovery¹ and that the relationship of insulin to glucagon is influenced by more than operation alone.² The use of heterogeneous groups of patients, some of whom have serious complications, detracts from the precision of an already difficult investigation. In addition, we are uncertain why Mr. Russell and his colleagues have used the mean of two basal observations as a comparison for a single highest value obtained during any one period of the operation. Their data do, however, show that overall the greatest increases in I.R.G. occurred not during operation itself but on the first postoperative day.

While supporting the evidence that hyperglucagonaemia occurs some 16 or more hours after operation, we do not think that glucagon can yet be implicated in the immediate surgical response. In our experience the

onset of hyperglucagonaemia occurs with that of hyperinsulinaemia and both are preceded by increases in plasma glucose.—We are, etc.,

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¹ Giddings, A. E. B., et al., *British Journal of Surgery*, 1974, 61, 920.

² Giddings, A. E. B., *British Journal of Surgery*, 1974, 61, 787.

Glucagon and Pseudogout

SIR,—I was interested to read the paper by Mr. R. C. G. Russell and his colleagues (4 January, p. 10) on hyperglucagonaemia in the surgical patient. Glucagon has been used in the treatment of Paget's disease of bone, one of the suggested mechanisms of action being that it plays a role in pyrophosphate metabolism.¹ Calcium pyrophosphate crystal deposition disease (pseudogout, articular chondrocalcinosis) has a clear-cut but little understood association with diabetes mellitus.²

It would be interesting to know if diabetic patients who develop pseudogout or chondrocalcinosis fall into the hyperglucagonaemic group and whether those patients who have postoperative attacks of pseudogout have very high levels of plasma glucagon.—I am, etc.,

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¹ Condon, J. R., *British Medical Journal*, 1971, 4, 719.

² McCarty, D. J., jun., in *Arthritis and Allied Conditions*, ed. J. L. Hollander and D. J. McCarty, jun., 8th edn., p. 1151. Philadelphia, Lea and Febiger, 1972.

Genitourinary Medicine

SIR,—The council of the British Association of Urological Surgeons has discussed the proposed change of name of the specialty of venereology to genitourinary medicine and has registered its disapproval of the change. Venereologists from various centres in Great Britain have also expressed concern at this proposed change.

In your leading article on this subject (11 January, p. 51) you state that the Royal College of Physicians has approved the change of name. This is not wholly accurate because at the time this was discussed by the council of the Royal College of Physicians it was noted that the proposed change of title was not acceptable to the Scottish Health and Home Department. Again, the problem of nomenclature was at this time still being considered by the Medical Society for the Study of Venereal Diseases, and no decision had then been reached. The council of the Royal College of Physicians felt that a compromise could be attained by allowing hospitals and clinics to use the title of genitourinary medicine instead of venereology if they so wished or any other designation of their choice.