understood way utilising words already available to anyone educated to the literacy of "O"-level English. He calls upon foreign tongues—"angst" and "manqué"—when they are not only inappropriate but in any case have perfectly acceptable and more subtle English counterparts. He uses the words "apposite" and "sacerdotal" when he obviously does not understand what they mean. He makes arrogant statements regarding the social and intellectual behaviour of baboons, subjects which have recently been thoroughly and lucidly documented and found to be of a remarkably advanced kind. His references to "mental masturbation" and "corporate self-abuse," while extraordinarily offensive, are also entirely baffling in the context in which he uses them.

I can understand his attack only on the assumption that it was written after the author had been gazing into a mirror. Let us hope that the Personal View column will quickly recover from this sorry lapse and return to its established standards of discrimination, scholarship, and interest.

PAUL BUISSETER

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Small thymus in anaemia

SIR,—I was most interested to read the article by Drs J Ellis and H G Kohler (20 March, p 694) in which they report low thymic weight in the human fetus following fetal trans-placental blood loss. Dr Kohler has also found that the thymus weighs less than expected in many cases of perinatal death caused by various forms of anaemia.

During studies of the lymphoid organs in severely anaemic guinea-pigs¹ we found a 50% reduction in thymic weight. The histological structure was remarkable. The cortex was markedly reduced and in some specimens there appeared to be a massive migration of small lymphocytes into the interlobular septa and around the interlobular vessels, including the lymphatics, some of which were full of lymphocytes. There was no evidence of cellular pyknosis. In fact numerous mitoses and DNA-synthesising cells were present in the cortex. Accompanying these thymic changes there was a marked lymphocytosis in the peripheral blood and this was almost completely abolished by previous thymectomy.

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¹ Harris, P F, and Kugler, J H, *Journal of Anatomy*, 1970, 107, 389.

Observer error in blood pressure recording

SIR,—The article by Dr S Concerção and others on defects in sphygmomanometers (10 April, p 886) omits one important source of error—the user. The accompanying chart illustrates the readings given by 24 of our midwives from the film produced by Miss Jane Wilcox¹ showing a column of mercury slowly falling in a manometer tube accompanied by a recording of the Korotkoff sounds. Most of the readings give a systolic value of between 200 and 210 mm Hg but three read 260 mm Hg.

There is more agreement concerning diastolic values, which were mainly 100-110 mm Hg, but they vary between 80 and 190 mm Hg.

It is essential to discover whether personnel using sphygmomanometers are good or bad readers and this can be done by checking their performance with a double stethoscope.

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¹ Wilcox, J, *Nursing Research*, 1961, 10, 4.

Coeliac disease and farmers' lung

SIR,—We were interested in Dr T J Robinson's report of two cases of coeliac disease with farmers' lung (27 March, p 745). However, it is now generally accepted that the term "coeliac disease" should be used only when gluten withdrawal has resulted in a significant improvement in jejunal mucosal histology¹ and is not therefore necessarily appropriate to the two cases described.

There is, in fact, circumstantial evidence of gluten sensitivity in most of the cases of extrinsic allergic alveolitis with villous atrophy described, confirmed by repeat jejunal biopsy in one patient.² Also, an increased prevalence of the HLA-B8 antigen has been noted in both conditions.^{3 4} Nevertheless, we feel that future studies of this association should pay close attention to the effect of gluten withdrawal on the jejunal mucosa. The possibility of other antigens causing the intestinal lesion should also be considered, in particular the agent responsible for the alveolitis, and it was in view of this that we were careful to use the term "villous atrophy" rather than "coeliac disease" in our paper.

O E EADE
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¹ Booth, C C, *British Medical Journal*, 1970, 3, 725.

² Berrill, W T, et al, *Lancet*, 1975, 2, 1006.

³ Stokes, P J, et al, *Lancet*, 1972, 2, 162.

⁴ Flaherty, D K, et al, *Lancet*, 1975, 2, 507.

The bran-wagon

SIR,—A bran-wagon effect for the treatment of diverticular disease has been produced by a clever hypothesis,¹ suggestive epidemiological evidence,² and uncontrolled clinical trials.^{3 4} Now Mr A J M Brodribb and Dr Daphne M Humphreys (21 February, p 425) have given us another uncontrolled treatment trial. Granted they collected some objective data—transit times, colonic pressures—and granted

they sound a note of caution—"a positive placebo effect may have resulted." Nevertheless, they go on to conclude that a high-fibre diet does relieve symptoms of diverticular disease. They even state that "a low-residue diet . . . was accepted without any real proof of its therapeutic value," while they provide no proof that bran had anything to do with relief of 60% of symptoms in their patients. All parameters assessed were subjective and there were no control patients.

"It was not feasible to carry out a double-blind controlled trial," the authors state. If an uncontrolled trial with purely subjective end points is useless (as the authors seem to tacitly agree) why did they not just omit it? Or why did not the Editor of the *BMJ* winnow out the invalid parts of a good study? High-fibre diets may indeed benefit patients with diverticulitis. Let's see an article from the British bran-wagon that proves it.

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¹ Cleave, T L, Campbell, G D, and Painter, N S, *Diabetes, Coronary Thrombosis and the Saccharine Disease*, 2nd edn. Bristol, Wright, 1969.

² Painter, N S, and Burkitt, D P, *British Medical Journal*, 1971, 2, 450.

³ Painter, N S, Almeida, A Z, and Colebourne, K W, *British Medical Journal*, 1972, 2, 139.

⁴ Plumley, P F, and Frances, B, *Journal of the American Dietetic Association*, 1973, 63, 527.

Bacteraemia following rectal biopsy

SIR,—I was interested to read your leading article entitled "Bacteraemia from the bowel" (16 August 1975, p 396) and I wish to report an episode of significant bacteraemia which followed sigmoidoscopy and rectal biopsy.

A 69-year-old woman was admitted to hospital with a deep venous thrombosis, pulmonary embolus, and previously undiagnosed ulcerative colitis which had manifested itself by bloody diarrhoea for six months. Sigmoidoscopy was undertaken soon after admission, and an intensely hyperaemic and haemorrhagic mucosa was seen. A forceps biopsy was taken which showed the changes of severe proctitis. Treatment was started with an immediate dose of prednisolone 15 mg by mouth and intravenous heparin 10 000 units.

Four hours after the sigmoidoscopy and rectal biopsy the patient felt and looked less well. Her temperature had risen from 37.6°C to 38.7°C, but there were no other specific changes in her signs or symptoms. Blood, sputum, and urine cultures were taken. It was thought possible that her pulmonary infarct had become infected, and she was started on treatment with benzyl penicillin, one mega unit intramuscularly six hourly. The patient's temperature fell to normal within 12 hours and she made an uneventful recovery.

On the fifth day the blood culture grew anaerobic streptococci, and a rectal swab taken after the course of penicillin had been completed also yielded anaerobic streptococci. Transient bacteraemia has been shown to occur quite frequently after sigmoidoscopy¹ and barium enema.² However, in these studies the patients remained symptom-free and all positive blood cultures were obtained within 30 minutes of the examination and cultures thereafter were sterile.

This patient underwent a definite deterioration in clinical state four hours after sigmoidoscopy and rectal biopsy. A bacteraemia was demonstrated at this time, and anaerobic streptococci were isolated both in the blood and later from the rectum. In the reported

cases of significant bacteraemia following proctoscopic biopsy of a rectal polyp³ and barium enema⁴ both patients had a significantly altered immune state.

The risk of significant bacteraemia following rectal mucosal biopsy is probably small, as no cases have previously been reported. However, it should be borne in mind, particularly in a patient with an altered immune state or in a patient at risk from bacterial endocarditis.

I would like to thank Dr J D Kinloch for permission to report details of this patient, who was under his care.

NICHOLAS BUCKELL

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¹ Le Frock, J L, *et al*, *New England Journal of Medicine*, 1973, **289**, 467.

² Le Frock, J L, *et al*, *Archives of Internal Medicine*, 1975, **135**, 835.

³ Lal, D, and Levitan, R, *Archives of Internal Medicine*, 1972, **130**, 127.

⁴ Richman, L S, *et al*, *Journal of the American Medical Association*, 1973, **226**, 62.

Spare parts for anaesthetic machines

SIR,—It has been brought to our notice that British Oxygen Company have decided to stop supplying spare parts, and maintenance to, anaesthetic machines manufactured prior to 1957. My colleagues and I quite understand that the manufacture of spare components might be uneconomical and we would be prepared to replace our machines gradually over a matter of years, but for a firm to decide to say they will not maintain what are perfectly good machines is completely unacceptable.

In our small group this will amount to some £16 500 at present-day prices and it must amount to millions over the country as a whole. I would urge all consultants through your columns to write, as I have done, to the Department of Health asking them to put a stop to this nonsense.

D EYRE-WALKER
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Stafford

Sociological realities

SIR,—Your leading article on the role of the social worker working as part of an integrated community team in order to promote links between the health and social services is welcome and timely (3 April, p 790). The Paddington Centre for Psychotherapy is currently putting into practice a multidisciplinary approach within the centre itself and in relation to the needs of the community. Social workers form part of an integrated team which has the aim of furthering the skills of all those in the "caring professions"—general practitioners, health visitors, nurses, social workers, teachers, probation officers, police, and youth workers. This work is promoted in two ways. One is by exploring the network of relationships between workers in different professions in relation to each other and to the patients/clients. The other is by the provision of a 20-week course of multidisciplinary seminars for these workers in the community. Using case material drawn from the community and brought by individual participants, theory and practice are integrated.

In our experience the stagnation, sense of depression and frustration described by your review is avoided, and a sense of purpose,

clarity of role, and enjoyment of the work is furthered.

ISMOND ROSEN
Chairman, Professional Staff Committee

CHRISTOPHER PERRY
Senior Psychiatric Social Worker

GEOFFREY ELKAN
Senior Clinical Psychologist

LIONEL KREEGER
Consultant Psychiatrist

Paddington Centre for Psychotherapy,
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Trade unions and private practice

SIR,—A patient of mine is seeking a consultant opinion concerning his ability to continue his work as an ambulance driver. The local authority medical officer has turned him down on the grounds of bronchial asthma. I agreed to have him seen by a local chest physician whose routine waiting list is three weeks at the moment.

My patient has just telephoned me and told me that the local secretary of his trades union has suggested he have a private appointment "to save time."

Any comments?

KEITH FAWCETT

Gillingham, Dorset

BMA and HCMA

SIR,—Dr N A Simmons's letter (17 April, p 963) deserves prompt reply and refutation. I write as a CCHMS representative and as one who agrees broadly with the political policy of the HCMA. What I do not agree with is their claim to negotiating rights. My reasons are these:

(1) Through HMS machinery all hospital doctors have a right to representation, not only BMA members. This is not true of the HCMA.

(2) The right place for any doctor to make his views known is at local level. For example, if he does not agree with CCHMS policy, then he should say so; and if enough people are of the same mind his views will be transmitted by their representation.

(3) To give the HCMA a voice at the negotiating table would result in unfair weight being given to HCMA views. Other minority pressure groups with different views (for example, the Socialist Medical Association) would then have a right to representation, and the result would be Babel. The Department of Health also holds these views, presumably, as the past attempt by the HCMA to obtain negotiating rights was rejected.

(4) Short-circuiting the existing plenary machinery by a sectional interest is undemocratic and grossly unfair to the CCHMS representatives, who attempt to transmit the opinions of all senior hospital doctors.

Yes, the BMA and HCMA should and must agree on policy. But, I repeat, the right place for this is at district level. The duplication of representative machinery is wasteful and divisive and has severely weakened the profession. For the HCMA to ask for a seat at the negotiating table is like the CBI asking for a seat in the Cabinet.

HARRY HALL

Chairman, South-west Committee
Hospital Medical Services

Exeter

Payment of wives

SIR,—My wife has just received her long awaited reply from Dr David Owen regarding payment to related ancillary staff. Undoubtedly other wives have received similar replies. On reading it I can only say that it is a load of clap-trap. Dr Owen states that wives who work as ancillary staff in their husband's surgeries cannot be reimbursed because this would in some way infringe the present incomes policy. Perhaps Dr Owen could explain how an incomes policy can be infringed when no payment has ever been made at all.

Secondly—and Dr Owen thinks this is important—he states that related staff cannot be paid because of abuse by the profession. Surely the BMA, if it had any guts at all, would take this point up directly with Dr Owen as he is suggesting that his own professional colleagues are dishonourable and not to be trusted. He is, in fact, imputing possible infamous conduct of the profession as a whole. If the Government is so afraid of abuse, why is payment to MPs' wives who act as their husbands' secretaries paid without question? Why are they so much more virtuous? Dr Owen represents a Government which believes in equality for all; and what about the workers? Are related staff who work in GP surgeries not workers? They work without stinting themselves in packed surgeries, for free in the NHS.

I would remind Dr Owen that in Red China and Russia workers are paid for working. Our wives are denied the right to work for whom they wish. They have all the qualifications yet are refused employment because they cannot be paid the rate for the job. What union would stand for this for any of their workers? Dr Owen attempts to smooth things over by suggesting discussions with the GMSC. Is he blind to the fact that discussions have been going on for the last 10 years? Each side blames the other for the failure to agree, and the poor wives are political footballs.

At least two wives have asked on more than one occasion to meet Dr Owen to discuss the question of reimbursement. They have neither of them had the courtesy of an acknowledgement of their quite reasonable requests. Dr Owen's PPS has not replied either. A telephone call to the DHSS at the Elephant and Castle meets with a polite answer that the matter is being looked into; they will ring back. But nothing happens.

MICHAEL GLANVILL

Chard

*.*The Secretary writes: "It is true that the Department of Health is claiming that the introduction of direct reimbursement would infringe the present incomes policy. The Department has been informed that its view is unacceptable. For several years the negotiators have been putting forward proposals containing limitations which would virtually eliminate the possibility of any abuse, and Dr Owen cannot therefore rely on this excuse. The issue of the rate for the job for wives is at present before the Equal Opportunities Commission. At the last meeting with the negotiators departmental officials stated that Dr Owen had instructed them to prepare a 'limited scheme' for discussion with us. For some time, and in spite of the criticisms of the Review Body, the Department has refused to put forward any proposals, and this therefore represents some advance."—ED, *BMJ*