as amphoterecin B and pentamidine can be toxic. Immunosuppressive drugs may have to be withdrawn.

Gastrointestinal complications may be extremely serious because of exsanguination and infection, and need prompt surgical intervention. Ureteric obstruction or leakage also demand prompt and expert surgical correction. Localised or systemic infections sometimes lead to rupture of the vascular anastomosis with consequent loss of the graft.

Further, though less dramatic, complications of treatment include Cushingoid features, hirsutism, diabetes mellitus, erythraemia, pelvic lymphocoeles, and steroid psychosis.

Later complications develop several months or years after successful grafting and include alopecia, thinning of the skin, recurrent infections, myopathies, hyperlipidaemia, osteoporosis, avascular necrosis of weight-bearing joints, cataracts, glaucoma, and neoplastic diseases.

Despite these many complications, a considerable number of patients benefit from successful renal transplantation. Although 40-50% of kidney transplants fail during the first six months, the rate of loss of function after the end of the first year is slow, and in our series 20-25% are still functioning at 10 years. Three of our women patients have had normal babies since transplantation and six of the men have successfully fathered normal children. As the combination of dialysis and transplant treatment has improved over the years, so has the survival of

patients. The long-term life expectancy from combined treatment of patients with chronic renal failure is currently above 70%.

To treat more patients economically in the future, home dialysis and transplantation units must continue working closely together with a greater emphasis on transplantation. More donor kidneys both from living relatives and cadavers are desperately needed. A change in the law regarding cadaver donation may well help to solve the problem of donor shortage. Immunosuppressive treatment has not improved for over 10 years, furthermore one must strive to improve immunological methods of selection since HLA matching as such has not contributed as much to graft acceptance as was originally hoped. Multicentre sharing of kidneys as practiced by the National Organ Matching and Distribution Service, Eurotransplant, etc, theoretically should help to ensure better HLA matching, but this has to be weighed carefully against the possible disadvantages of increasing ischaemic time intervals.

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Clinics in General Practice

A case for the gynaecologist?

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The trainee's problem

The patient is 31 and has two children aged 9 and 7. She was sterilised after the birth of the second child and has no regrets about this. Her husband is a foreman joiner and so far as we know there are no material family problems.

The problem is of deciding management of a three-year history of low bilateral abdominal pain that has occurred almost every day for periods of sometimes several hours at a time. The pain is constant, eased by paracetamol, and not apparently related to any specific event. It rarely but occasionally occurs through the night and when it does it prevents sleep. The patient has been investigated already at the surgical outpatient department, where the only abnormality noted was an enlarged uterus on ultrasound examination. The surgeon recommended her referral to a gynaecologist six months ago but the patient

did not come to see us over the summer when her children were at home.

She is back wanting help. She has heavy but regular periods and a periodic offensive vaginal discharge. (Vaginal swab grew a normal vaginal flora with some coliforms present.) She is "allergic" to penicillin, and a week's treatment with co-trimoxazole has succeeded only in adding nausea to her other symptoms. She is genuinely tender in both iliac fossae.

Last week she looked and admitted to being depressed. She says she is depressed because of the pain and not the other way round. I feel inclined to believe her and not start psychotropic drugs—which could easily become long-term treatment—but equally feel referral to a gynaecologist is passing the buck. I don't really see what he could do as the symptoms do not really suggest gynaecological disease to me. How much should I be influenced by the ultrasound findings (which don't seem reflected by much abnormality on clinical examination) and surgical advice (which appears to reflect lack of anything better to suggest).

General practitioner's comments

Some patients and their problems fill me with anxiety even when they are not in my care. Such a case has just been described. There is a feeling of despair in the doctor and despondency in the patient, with a pattern of chronicity that forbodes ill for the future. I wonder if this is the type of case

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that a trainee in a practice for a year or less should be allowed to take on, when the practice knows the potential problems that are likely to arise.

Possibly the trainee became enmeshed, unbeknown to the practice, in this entangled skein of physical, psychological, and social factors to which no obvious solution is evident. Certainly we need to know more of the patient. There is a lack of "feel" about her in the presentation. Why not, therefore, ask the other doctors in the practice their impressions and opinions, and if there is an astute team in reception their contribution could also be helpful.

Why was she sterilised? Why not her husband? Do we know who did the operation and what method was used? Would it be reasonable to contact the gynaecologist concerned and discuss the case with him? Were there any complications in such operations done seven years ago that have resulted in abdominal pain, and if so, what was the usual diagnosis? Would he in fact be prepared to see the patient again if it was thought desirable? Is he the sort of consultant whom the practice can turn to with confidence in such a case?

It would be interesting to look at her NHS medical record card and see how her demands for service have varied over the years, and then try to evaluate to what extent other problems have been diagnosed and treated. A glance at her children's and husband's record cards might also yield interesting information that will help us to fill in the background.

What, I wonder, led up to the surgical referral, and what investigations did he do and why? My feeling is to discount the ultrasound report and accept the trainee's physical findings, and that being so what are the indications for a gynaecological referral?

Heavy, but regular periods are normal unless she feels that the loss is "too heavy." The "periodic offensive vaginal discharge" seems to be normal bacteriologically, and I am not clear why co-trimoxazole was given unless "something had to be done," in which case I sympathise for I can feel the pressures without ever having met the patient.

At least last week she "admitted to being depressed" even though she blames the pain for this, and the trainee feels the tenderness is "genuine." Could I be wrong in thinking that all concerned (general practitioners, trainee, the surgeon, and the patient) prefer to stick with the physical and not touch the psyche? It is not easy, and often impossible to get through if the patient is not prepared to give a lead, but now at last there is a crack in the defences and the trainee has spotted it and has started to talk about this. How can the situation be shifted?

I would suggest that somebody in the practice has got to spend time with her at the next appropriate opportunity and then listen. Maybe the problem will at last become clearer. The doctor who did this would, if successful, inevitably have an on-going commitment. If the trainee is leaving shortly then he should not become further entrapped. Whoever takes on the problem would need to try and get to know (without didactic questioning or prejudging the illness) what was the quality of her life before the onset of the pain three years ago, and how it has changed since. Tactful talk should elicit whether she would have liked a third child about three to four years ago, and what has happened to her sexual life and feelings. It would be of value to know how she felt about the surgical outpatient referral, the actual visits, and her expectations or disappointments when discharged from this clinic. Does she now wish for a further opinion, and if so, does she like the gynaecologist suggested?

Who knows, but after such a long interview when confrontation is changed to co-operation the unexpected may happen and the pain may go. When it doesn't, or if further referral was agreed to at this time, the right consultant needs to be found: a paragon of sympathy, understanding, and clinical skill, who will devote time to a complex case and in relieving our anxieties not make us feel foolish with too simple a solution. Not the sort of case for a standard "Dear Sir, Please see and advise," letter.

Consultant's comments

This patient's problems present several intriguing features, and I would hope that her practitioner would refer her to a gynaecologist as he has the training and the diagnostic skills to give her the help that she needs. The fact that she has already been referred to a surgeon and been investigated without benefit does not necessarily mean that she was now being handed on to a gynaecologist because of a sense of desperation but rather that he felt that it was not really his field and wisely held his hand.

Girls and young women with lower abdominal pain have only too often, I am afraid, been admitted to general surgical wards and undergone exploratory, and in some cases unnecessary, surgery, sometimes including the removal or interference with healthy structures such as an ovary. While obviously the gynaecologist and the surgeon must have a basic knowledge and understanding of each other's specialty, I have found that when admitted to the surgical wards it is rare for a patient to have a detailed gynaecological history taken and an examination to have been performed before operation. The history in this case is all-important.

The first point that arises is that this patient underwent sterilisation after the birth of her second child seven years ago, apparently without regrets. At that time it would have been unusual for many gynaecologists to sterilise a woman of 24 after the birth of her second baby. It would have been extremely unlikely to have been performed merely at the patient's and husband's request, and I would imagine there would have been a strong medical or psychiatric indication at that time. If so, this information should be available, and further questioning might disclose that it was a step that was now regretted. Specifically, more of the timing and nature of her bilateral abdominal pain should be elucidated, if necessary by direct questioning. Is it related to the menstrual cycle, is there any dyspareunia, and apart from taking paracetamol, has she found anything that either exasperates or relieves it? Her discharge, which has been reported as periodic and offensive, calls for some further investigation. I am not particularly impressed by the fact that co-trimoxazole has not helped her, and I strongly suspect that the bacteriological findings may have been misleading.

Trichomonas vaginalis, especially, does not always present as the greenish, frothy, and offensive discharge described in the textbooks, and even when high vaginal swabs have been quickly taken and placed in the appropriate culture media and taken to the laboratory, the organism can be remarkably elusive and may well not be isolated. Often out of a natural and commendable fastidiousness, the patient has had a bath before the consultation and on examination there may be little or no discharge to be seen. Ideally, we should all have a microscope in the consulting room and examine the specimens ourselves when trichomonas would be much more likely to be seen. Unfortunately, this is not possible in most gynaecological clinics but if any bubbles can be seen in the discharge on the examining speculum the appropriate treatment should be offered to both the patient and her husband. As one rarely sees the patient's husband in the outpatient's department when dealing with this type of problem, it is advisable to enlist the aid of the family doctor so that he can explain the need for the double treatment. Many men resent being told by their wives that an unknown hospital doctor has prescribed a week's course of treatment for them and assume that doubts are being cast on their marital fidelity or personal hygiene or even worse that they have given her venereal disease. By neglecting this practice, I once nearly suffered physical assault by a very angry husband. Reassurance and explanation will be rewarded by co-operation.

Once the problem of discharge has been dealt with and a full history obtained, further investigation into the patient's pain is required. Clinical examination suggested an anatomically normal pelvis; this is much more likely to be correct than the

reported enlargement of the uterus after ultrasound examination. Ultrasound examination of the pelvis and abdomen may sometimes be extremely useful, especially when abnormalities of pregnancy or tumours are suspected. In the non-pregnant, I consider it to be of little or no value and am surprised that it was even attempted.

The gynaecologist does, however, have at his disposal the laparoscope and I hope now that every gynaecological unit in the country is equipped with this invaluable instrument, and that a uniformly high standard of skill in its use is being achieved. The financial stringencies and the competition for scarce resources in the NHS have made it a slow business but a unit without a laparoscope in 1977 should be considered inadequately equipped. Laparoscopy may be safely and easily performed as a day case procedure if necessary, although I think most patients appreciate the night in hospital after the operation. Its use and limitations must be explained to the patient, so that if surgery is indicated after laparoscopy she can have made plans for a longer stay. Careful inspection of the pelvis will either confirm its normality or show any disease that may be present.

In this patient's case one suspects either tubal disease after her sterilisation—such as adhesions, hydrosalpinx, or pelvic or ovarian endometriosis—or chronic pelvic inflammatory disease as the likely diagnoses. Except in the fairly advanced case, endometriosis is often not diagnosed until laparoscopy or laparotomy is performed. Small deposits in the pelvis or ovaries are not always detectable clinically, and it is not often that one obtains a clear history of the classic triad, dysmenorrhoea, dyspareunia, and menorrhagia. At the same time as laparoscopy, curettage should also be performed to exclude intrauterine disease. If laparoscopy shows the need for surgery it is wise not to be too radical, especially at this age. Hysterectomy should never be considered as a "cure-all" for unexplained pelvic pain and despite this patient's sterilisation the possession of an intact uterus may be important to her. Its removal could probably be a positive disservice leading to longstanding emotional and depressive problems, and when indicated the gynaecologist should take special care in his explanation and reassurances when he sees her postoperatively. If laparoscopy can exclude pelvic disease attention should then be focused again upon the emotional aspects of the patient's problem.

If it is apparent that she now regrets her early sterilisation and she wants another baby the possibility of tubal reanastomosis can be considered. In some centres good results have been

obtained from tubal repair after sterilisation, but this does depend upon the technique employed in the original operation. I suspect that with the increasing number of young women now being sterilised requests for repair will increase in the future.

The fact that it is now six months since the surgeon's investigations and suggestion that she should be referred to a gynaecologist is important. Six months is a long time for someone with pain, even when experienced intermittently. It is implied that it was because her children were home over the summer, and possibly their presence was giving her emotional support. Since their return to school she may have felt deprived, and their presence at home in the evenings and weekends is not enough for her. Further inquiries into her relations with her husband should be made, and despite there being no apparent family problems, psychosexual ones might exist. Many gynaecologists feel limited in their ability and the time available to them to deal with psychosexual disorders, although they are trained to suspect them and bring them out into the open. If the gynaecologist can have the opportunity of speaking to both husband and wife in a relaxed and informal way after his examination and investigations have been completed he may then be performing his greatest service to them.

Postscript to the problem

This problem appears to have several chapters still to run. A gynaecologist (of registrar grade and of different cultural background to the patient) saw the patient and sent a long review of the physical background that added little to the information we already had. He arranged admission for an examination under anaesthesia and laparoscopy. During the interval between the outpatient appointment and the admission a period of antidepressants produced temporary benefit, although the patient later returned to request more analgesics.

When the operation took place (ten days ago after a five-month delay), a different registrar carried out a dilatation and curettage but no laparoscopy "because the dilatation and curettage was normal." In the discharge summary he stated "no abnormality found" and recommended "analgesics as required." The summary promised that a "full report will follow." Is it too much to hope that this will advance our understanding of this final problem in the series?

Does tryptophan have any antirheumatic properties?

Tryptophan is not known to have any antirheumatic properties. Those patients in whom depression is a major symptom associated with their rheumatic diseases, however, may obtain physical benefits from using antidepressives. This has been shown on several occasions, and indeed imipramine has been shown to be considerably better than placebo in improving function in rheumatoid arthritis. It would seem reasonable to assume that those antidepressives that produce an increase in motor activity or which are euphoriant might be of some benefit to patients with rheumatoid arthritis, but I know of no evidence that tryptophan is of any specific value in rheumatic diseases.

Are there any medical hazards from the regular use of a solarium?

Solaria have been common in continental spas for many years and are now becoming popular in Britain. Strangely, there are few reports on them, which must imply that no important hazards have come to light when they are properly used, and strict precautions are normally enforced according to manufacturers' operating instructions. For practical purposes, the risks are similar to those resulting from excessive exposure to sunlight—for instance, erythema, accelerated skin aging, photosensitisation, and—after repeated exposure—skin

cancer. The cornea is also at risk and blindness can result. As in sunbathing, any therapeutic value is probably psychological. Concerning insurance cover, the user would be obliged to comply with instructions to which attention is drawn, and negligence would have to be proved in sustaining any claim for damages.

How is the watery secretion of allergic rhinitis—for example, in hay fever—produced? Are serous glands involved?

The watery secretion running from a hay-fever nose may be produced passively as a transudate or actively by secretion. Plasma transudation is probably of minor importance, as nasal-fluid albumin concentration in hay fever constitutes only 4% of the plasma level. The secretion is partly produced in the small seromucous glands of which there are about 80 000 in the nose, and partly in serous glands, which have large duct openings in the upper and front part of the nasal cavity. They are visible with a magnifying-glass and so are droplets of watery secretion, produced in the glands during hay fever. These serous glands of the nose are few, and their function is still a matter of debate. Their presence may explain why considerable volumes of watery secretion can be produced in the mucosa of the nose but not in those of the sinuses, the trachea, or the bronchi.