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Extended Family

SIR,—Your leading article (4 May, p. 253), like a similar one some years ago,¹ raises several points for which satisfying solutions appear endlessly evasive. None can doubt the sincerity of the Pro-Chancellor of Ibadan University in urging that "Mankind should be an extended family in which no nation should be an island of poverty and misery in a sea of affluence and surfeit." The stark realities of the situation are less exhilarating.

As regards opportunities overseas for retired practitioners, it will be recalled you reported that a deputation from the Association's Committee on Overseas Affairs visited the Ministry of Overseas Development on 1 November last year, the outcome of which was said to have been a "useful meeting" (11 November 1967, *Supplement*, p. 50). The proceedings were subsequently reported to the Committee on Overseas Affairs earlier this year (10 February, *Supplement*, p. 34). Inasmuch as the Committee "decided it was impossible to devise any scheme at the moment which would allow retired doctors to do the type of work suggested in the A.R.M. resolution," it is hard to believe any conclusion was reached that could fairly be described as "useful." As at present conceived the idea seems little more than fanciful.

Furthermore, while it may be appropriate that the Ministry of Overseas Development should continue, alluringly, to recruit on behalf of overseas Governments doctors who "should normally be nationals of the United Kingdom or the Republic of Ireland," this type of recruitment must surely be seen against the background of our own acute shortage of medical manpower, against the recent enticement of United Kingdom nationals back from the New World, and also against our deep dependence upon immigrant postgraduates from the Commonwealth. Indeed, an onlooker might be reminded of the ass in Aesop's fables who "blew hot and cold on the same dish of porridge." Your most recent leading article,

like its predecessor, can do no more than define the needs and offer exhortative solutions. None could be more appealing than that "the work is surely the more worth while if it helps to ease the tensions that lead to racial conflict, a pressing evil of our time." The "hard facts" of these distressing reflections require a realistic approach. At local level in this country, on a regional basis, serious attempts to arrange more orderly secondment abroad seem merited. The Ministry of Overseas Development might well provide the necessary central administrative machinery and proper liaison with overseas Governments. Nor may it be overlooked that the supply of, almost all forms of technical aid to emergent countries is largely dependent upon their willingness to receive it.—I am, etc.,

Liverpool 1. H. VINCENT CORBETT.

REFERENCE

¹ *Brit. med. J.*, 1965, 1, 939.

Medical Examination of Immigrants

SIR,—In *The Times* of 6 May the Prime Minister is quoted as saying, "In 1967 over 20,000 Commonwealth immigrants were medically examined at our ports and airports, and only 58 had to be refused entry on medical grounds." I should like to ask what was the nature of the examination. A clinical examination is unlikely to discover helminths, amoebiasis, latent tuberculosis, or even early leprosy.

In 22 years' service in the R.A.M.C., and 14 years as a pathologist in the N.H.S., I have encountered a large amount of tropical disease, including some in this university town and seaport. It often takes a great deal of time and trouble to come to a diagnosis, including blood examinations and microscopy of urine and faeces, etc. Moreover, the incidence of disease varies greatly from one part of the tropics to another. Amoebiasis was very common in the soldiers in Assam

and North Burma in 1944–5. In the Western Desert in 1942 there was a great deal of infectious hepatitis and cutaneous diphtheria. A friend who used to travel often to the East to examine final-year medical students said that if they did not mention tuberculosis as a cause of intestinal obstruction they were liable to be failed on that question. And so on.

I think that if the 20,000 were given thorough laboratory investigation more than 58 would be found to have evidence of disease; but who has time to do it? Possibly one of the hospitals or schools of tropical medicine might do a pilot scheme on a few hundred.—I am, etc.,

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Swansea Hospital.

H. C. M. WALTON.

Hypothyroidism and ¹³¹I Therapy

SIR,—In agreement with a number of centres we have found that about 30% of thyrotoxic patients treated with ¹³¹I develop hypothyroidism after two years. Excessive radiation dosage has been blamed, and attempts have been made to reduce this by giving smaller amounts of ¹³¹I spread over a longer period. It has even been suggested that there may be a case for returning to external x-ray therapy.¹ However, it may be that the increased incidence of hypothyroidism has nothing to do with excessive radiation dosage.

About 30% of thyrotoxic patients treated with carbimazole revert to the euthyroid state within two years. At the end of this time carbimazole can often be withdrawn. This "cure" has nothing to do with the drug itself but seems to be part of the natural history of the disease. Carbimazole exerts no permanent effect on the thyroid gland. It acts by blocking the synthesis of thyroid hormone, and this action persists only while the patient is taking the drug. Thus we have a group of patients who spontaneously revert to euthyroidism after two years. Presumably

if ^{131}I therapy is used in these cases the thyroid gland will be permanently damaged and hypothyroidism will inevitably result. The problem then lies in identifying this group of patients beforehand rather than trying to reduce the dose of ^{131}I . Hence, although a correlation between high thyroid antibody titres and post-radiation hypothyroidism has yet to be shown, it would seem wise not to treat these cases with ^{131}I , since they are likely to "burn up" their own thyroid tissue. Further clues may be provided by an examination of serum levels of long-acting thyroid stimulator.

On the other hand, radiobiological studies might suggest a different explanation. Following radiation mitosis may be delayed. Furthermore, latent cell damage and death may not be seen until long after irradiation, when the cell has subsequently entered one or more mitotic divisions. As time progresses the feedback stimulus of the failing thyroid gland induces the pituitary to release more thyroid-stimulating hormone. Under this stimulus further thyroid cells enter division and die. This process could become a vicious circle, with increasing hypothyroidism causing increased cell destruction. This would correlate with the clinical findings of some workers who report² that the development of post-radiation hypothyroidism is a continuing process, progressing at a rate of about 3% per annum. Again, it has been shown³ that for rats, at any rate, a dose of radiation which results in a reduction of thyroid function inevitably interferes with the reproductive integrity of the gland.

Although this may be an insoluble problem, it has been pointed out⁴ that the irregular distribution of iodine in the thyroid gland may mean that some cells receive sublethal damage and are capable of recovery.—I am, etc.,

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Midgut Malrotation in Adults

SIR,—The article on midgut malrotation in adults (30 March, p. 803) clearly brings out the fact that such a gross abnormality can be missed on "routine" barium-meal examination. This examination normally includes evaluation of the oesophagus, stomach, and a variable portion of the duodenum, depending on the radiologist and/or the standard procedure in the particular department.

Because of the high incidence of ascariasis in the local population seen in Ibadan, Nigeria, one and a half years ago, we began including a delayed abdominal film on all barium-meal examinations (about 30 per week). This film is taken 30–60 minutes after the completion of screening, depending on the rate of gastric emptying observed during screening. Since beginning this routine we have picked up five cases of un-

suspected intestinal malrotation in adults, aged 16 to 69, as well as other small-bowel lesions. Three of these patients had symptoms in keeping with malrotation, none had an ulcer or other pathology demonstrated at the examination. One had had recurrent symptoms since childhood and was relieved of these following surgery for incomplete duodenal obstruction due to malrotation with bands.

After this experience, and considering the fact that these patients may be misdiagnosed for many years and sent from doctor to doctor, it seems reasonable to suggest that, when a barium meal is done for non-specific or vague abdominal symptoms of long duration and no cause is demonstrated after a routine study, a delayed film should be taken so that malrotation, if present, or other gross small-bowel lesions will not be missed.—I am, etc.,

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Ibadan, Nigeria.

Herpes Simplex Cervicitis

SIR,—Dr. R. R. Willcox (9 March, p. 610) is to be congratulated for his perception in detecting six cases of what appeared to be herpes simplex cervicitis.

In recent years a body of literature has developed in North America on the subject of herpes simplex cervicitis.^{1–3} This literature stresses that apart from any clinical signs or symptoms the most important finding, the one which enables the condition to be properly diagnosed, is the presence of "virocytes" in the cervical smears. These altered epithelial cells are often gigantic, and contain large multiloculated nuclei in which there may be inclusion bodies. Their appearance is striking (see Fig.).

Cervical smear. Herpes simplex virocyte. (Papanicolaou stain. $\times 600$.)

I was surprised, therefore, to read that in all of Dr. Willcox's cases the cytology of the cervical smears did not provide any assistance in making the diagnosis of viral cervicitis. I suggest the smears did contain virocytes, unobtrusive ones perhaps, but that they were not recognized for what they were.—I am, etc.,

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Cardiac Failure with Propranolol

SIR,—I would like to comment briefly on the observations of Dr. N. Conway and his colleagues (27 April, p. 213) on the production of cardiac failure in patients with chronic rheumatic heart disease receiving propranolol. It may be of some significance that Cases 1 and 4 (and possibly Case 3) suffered from aortic regurgitation, and Case 2 from mitral regurgitation. Such patients tend to require an increase in heart rate to maintain their cardiac output, and in my experience it is these patients who do badly with beta-receptor blockade, particularly if they have not been adequately digitalized. For this reason beta-receptor blockade should be used with extreme caution in patients with aortic and mitral regurgitation. As Dr. Conway and his colleagues point out, the slow heart rate produced by propranolol may well mask the need for an increase in digitalis therapy.—I am, etc.,

London S.W.20.

S. A. STEPHEN.

Measles and Panencephalitis

SIR,—Readers of your interesting leading article (27 April, p. 189) on measles virus and subacute sclerosing panencephalitis may imagine, from the way in which you refer to the work on immunofluorescence, that American contributors to the conference in Bethesda did not appreciate the small but important contribution by British members of our profession. Fortunately this was not so. Dr. J. M. Adams, who has believed for many years that measles virus is the principal aetiological factor in related conditions,¹ came here to express his pleasure and enthusiasm at seeing his beliefs so strongly supported by the immunofluorescent and other studies published by Dr. J. H. Connolly and his colleagues.² In addition, Dr. Connolly was invited to attend the conference, entirely at the expense of his American hosts, in order to present further observations.³

The justification for this interest and generosity appears in Table IV in Dr. Lennette's paper.⁴ Three of the six patients were from this side of the water.—I am, etc.,

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Retinal Changes and Chloroquine

SIR,—Following the observation that retinal changes can occur as a side-effect of chloroquine treatment¹ many animal investigations have been done to elucidate the changes involved.^{2,3} The fundal changes have been described as resulting from centripetal migration of uveal pigment and degeneration of the rods and cones. Changes in ganglion cells have been observed,⁴ but the exact nature of these changes has remained obscure.

In this laboratory ultrastructural examination of the retinae from albino and hooded rats treated chronically with chloroquine has