Correspondence

Correspondents are asked to be brief.

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Bacteriological Checks on Food Handlers

SIR,—Bacteriologists are sometimes asked to make routine examinations of the faeces of food handlers with the object of detecting carriers of such intestinal pathogens as typhoid or paratyphoid bacilli, food-poisoning salmonellas, and dysentery bacilli. I am often asked for advice about the value of the proposed routine examinations and your readers may care to know my views.¹

Examination of the faeces of individual food handlers should be carried out whenever there is any question of their having suffered an intestinal illness or been put at risk by close contact with a known infected patient—for example by eating food prepared by such a patient. Likewise, if any circumstances suggest that food handlers have been involved in an outbreak of food-poisoning or dysentery, such examinations will normally be carried out as part of the investigation at the request of the local health department.

But if purely routine laboratory checks on the faeces of food handlers are asked for, I think that this work should not be undertaken. The potential benefit to the public health is not likely to be proportional to the effort and resources that would be required, even if these were available. Pre-employment clinical assessment, on the other hand, is extremely important. Employees who have recently been abroad or come from abroad should also have their medical

history very carefully checked before beginning work or returning to work. Any with a history suggestive of intestinal disease should have their faeces carefully examined; but this is a different matter from undertaking regular routine laboratory examinations. The public health must be protected, of course, in every practicable way, but strict application of the rules of hygiene in the handling and preparation of food will do much more to that end than will routine examinations of faeces.

When laboratory examinations are found to be necessary, their timing and planning should always be discussed with the bacteriologist concerned. Such consultation is particularly desirable when any considerable number of specimens must be examined, but it should always be undertaken because it is the best means of ensuring a wise selection of cases, use of the best methods for collection and transmission of specimens, and the right interpretation of reports. Also by ensuring a discriminating use of the laboratory resources available, the consultation is likely to guarantee increased efficiency in the carrying out of any tests agreed upon as necessary.—I am, etc.,

JAMES HOWIE,
Director,
Public Health Laboratory Service.
London W.1.

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Routine Laboratory Screening

SIR,—Dr. M. H. B. Carmalt and his colleagues have demonstrated, as have many others, that routine laboratory screening with a multiple analyzer may occasionally bring to light certain previously undiagnosed diseases and a variety of haematological and biochemical abnormalities (7 March, p. 620). What they have not done is to show that prognosis of any of the conditions diagnosed has been in any way influenced by their efforts. To detect a biochemical abnormality is one thing; to change the course of the disease is another.

Although the World Health Organization has arbitrarily defined a haemoglobin level of below 12 g./100 ml. as abnormal, the evidence for saying that a woman who has a value of 11 g./100 ml. is anaemic is flimsy in the extreme. What is needed is a

correlation between haemoglobin level and a realistic index of disability. Cochrane and Elwood¹ have clearly pointed out that this is not available. Moreover, in a community study they were unable to show an improvement in symptoms following iron therapy, though the haemoglobin level subsequently reached a standard approved by the W.H.O. In short the administration of iron under these circumstances might well be described as relieving symptoms in an asymptomatic patient. The example cited by the authors of the usefulness of routine normal tests is that of an anaemic patient who showed a normal blood urea, thereby excluding uraemia as the cause of his anaemia. I cannot but recall doing just this some years back when I was Sir Edward Wayne's house physician. He good-naturedly pointed

to the results of the routine urine analysis that I had done myself and asked me how often I had renal failure of sufficient severity to cause anaemia without there being albuminuria. I am looking yet. As for the detection of early diabetes, no one has yet shown that its ultimate prognosis has been influenced one jot or tittle by early diagnosis. The same applies to most of the other entities likely to be brought to light by multiphasic screening.

Living in a country where routine multiphasic screening is indeed routine, I would point out that it is nothing like as helpful as many would have us believe. In those hospitals where this service has been available for some time, it has been shown that around 40% of the abnormalities detected by routine screening are ignored by the physicians in attendance, despite the fact that various methods have been employed to designate the abnormal values—for example, denoting them with an asterisk. Routine screening becomes a form of "biochemical bingo" and inevitably leads to short cuts in history taking. To those who advocate the concept of routine biochemical and haematological screening, the monograph *Presymptomatic Detection and Early Diagnosis*² is recommended as an unbiased review of its limitations. Many more randomized controlled trials need to be done before it is going to be possible to say that the routine performance of a specific biochemical or haematological test (the W.R. excluded) is a worthwhile procedure.—I am, etc.,

WILLIAM KEITH C. MORGAN.
Department of Medicine,
West Virginia University,
West Virginia, U.S.A.

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- Cochrane, A. L., and Elwood, P. C., *Medical Scientists Look at Screening. In Presymptomatic Detection and Early Diagnosis*, ed. C. L. E. H. Sharp and H. Keen, p. 359. London, Pitman, 1968.
- Presymptomatic Detection and Early Diagnosis*, ed. C. L. E. H. Sharp and H. Keen. London, Pitman, 1968.

Epidemic Malaise

SIR,—The articles of Dr. C. P. McEvedy and A. W. Beard (3 January, pp. 7 and 11) are of considerable concern because of the authors' contention that benign myalgic encephalomyelitis (epidemic neuromyesthesia) is a psychosocial phenomenon related to mass