public that we as a noble profession are dismayed by this verdict of the Disciplinary Committee of the G.M.C. and do not wish to be associated with its findings—I am, etc.,

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SIR,—It is remarkable that the G.M.C. Disciplinary Committee could not only find Dr. R. J. D. Browne not guilty of serious professional misconduct (*Supplement*, 20 March, p. 79), but that he should escape any official censure whatever for his high-handed action in deliberately betraying confidential information about a patient.

What practical results will Dr. Browne have achieved? Certainly he must have caused much distress and embarrassment to the family. Probably he has discouraged others from seeking contraceptive advice from an ethical source for fear of publicity. It may be that some cases of abortion or illegitimate birth may result. And what of communication between doctors? The Family Planning Association at present keeps us informed about our patients, and we must hope that they will continue this courteous and clinically valuable practice, but who could blame them if they ceased to do so in respect of all spinsters, widows, divorcees, and many others who might be encouraged by contraceptive knowledge to transgress "God's will".—I am, etc.,

R. S. SAXTON

Port Talbot, Glamorgan

Diphtheria Outbreak

SIR,—During the recent Manchester outbreak of diphtheria I came across a number of children in whom routine immunization had been withheld on grounds of diseases such as eczema, no doubt to avoid any untoward allergic reaction. Reactions of this nature are, however, rare following toxoid administration in young children, but unfortunately, if left unimmunized, these children run a very real risk of developing a severe hypersensitivity reaction from the use of horse serum antitoxin if they come to need them at a later date.

It cannot be stressed too strongly that children with an allergic disease such as eczema or hay fever should always be offered adequate protection against diphtheria and tetanus through active immunization, to obviate any future need for horse serum.—I am, etc.,

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Torsion of the Testicle

SIR,—I read with interest and sympathy Mr. R. G. Notley's letter on the sad consequences of the misdiagnosis of testicular torsion as epididymitis (27 March, p. 728).

I wholeheartedly agree with all that he has to say and would stress his point that epididymitis is very rare in young men in the absence of urinary tract disorder. It should be emphasized, however, that nowadays among the commonest genitourinary infections in this age-group are nonspecific and gonococcal urethritis (27 March, p. 734).

The former is notoriously often latent and in the latter discharge and any dysuria disappear some days before the development of epididymitis. (A fact first noted by John Hunter.) As these infections are acquired as a result of sexual intercourse patients, especially young teenagers, are often reticent about such activities unless directly and specifically questioned.

Any young man who develops testicular pain, swelling, and redness of the scrotal skin is probably statistically more likely to have epididymitis than torsion and therefore evidence to establish the presence of genitourinary infection in such patients should be very carefully sought. Accurate diagnosis is vital as surgery can prevent the tragedy of a gangrenous testis. A simple bedside "testicle-saving test" in such patients is to examine the first 50 ml or so of urine voided in a clear glass vessel. Provided that the patient has not passed urine within the last hour those suffering from urethritis will nearly always show shreds and flakes of pus. In *E. coli* urinary infections a haze of pus will often be visible. In patients with torsion the urine is normal in appearance.

Treatment for epididymitis should never be given in the absence of evidence of genitourinary infection, and any doubts should lead to immediate surgical intervention.—I am, etc.,

J. K. OATES

Westminster Hospital,
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Vaginitis and Tights

SIR,—Dr. J. T. Breen (13 March, p. 610) correctly draws attention to the association of vulval and vaginal infection sometimes associated with the wearing of tights. This appears to be due primarily to a local irritation to detergent remaining trapped in the fine mesh during washing of the garment.

Remedies available are the avoidance of detergent preparations for this purpose, careful and adequate rinsing after washing, the wearing (temporarily at least until the local condition has improved) of disposable paper pants, or the use of cotton or silk garments washed with soap and adequately rinsed.—I am, etc.,

JOHN STALLWORTHY

Churchill Hospital,
Oxford

Hospital's Duty to the Suicidal

SIR,—I write in support of the view expressed by Dr. Ian Oswald (20 March, p. 667). It is realistic—and not complacent—to recognize that some tragedies of self-injury in hospital, with or without a fatal outcome, are inevitable. Clearly the incidence of such occurrences must be minimized and when they happen they must be exploited for whatever clinical or administrative lessons they may hold for the advantage of other patients, but if they bring in their wake a blind regression to custodial conditions the sadness is redoubled.

Anxious and perhaps unconsciously guilt-ridden attempts to find a perfect solution risk just such a return to a surfeit of "security", which is not only ineffective in its intention but therapeutically suffocating, as those of us

who can compare practice before and after the liberalization of psychiatric hospitals can testify. Certainly if there is medical, nursing, or administrative negligence it must be recognized and rectified, but death or injury may often irrationally demand a scapegoat, and panic measures follow—open doors are once more locked, windows are shuttered, suicide caution cards are issued, meat is eaten with spoons, and various other degradations are imposed.

Our real safeguards lie in careful clinical assessment, energetic treatment, and the encouragement of an environment of mutual confidence and free communication between patients and staff.—I am, etc.,

K. S. JONES

Morgannwg Hospital,
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Idiopathic Hypercalciuria and Hyperparathyroidism

SIR,—We agree with Mr. W. M. Keynes and with Mr. D. R. Davies and others (9 January, p. 108) that more precise definition of the upper limit of normal for serum calcium might have obviated the need for provocative tests in some of our patients. But we do not share the belief of Mr. Davies and colleagues that significant hypercalcaemia will always be demonstrable in primary hyperparathyroidism even allowing that hospital laboratories in general should be able to achieve the degree of precision reached in some specialized units. We do not wish to imply that all patients with idiopathic hypercalciuria have primary hyperparathyroidism, nor do we advocate that all such patients should be subjected to exploration of the neck. Nevertheless, we suspect that among the 50 patients with idiopathic hypercalciuria referred to Mr. Davies and his colleagues following negative explorations elsewhere there may have been some in whom the procedure would have proved more rewarding if performed by Mr. Davies himself. Unless all four glands have been identified and biopsies made parathyroid disease cannot be excluded. Glands which are normal in size and appearance may yet be adenomatous or hyperplastic.^{1,2}

Our present policy is to carry out provocative tests in patients with fasting corrected serum calcium concentrations repeatedly between 9.9 and 10.6 mg/100 ml as determined in our laboratory. Exploration of the neck is advised in those who develop hypercalcaemia provided the clinical situation is felt to justify such intervention.

In reply to Dr. A. J. Richards (2 January, p. 47) our five patients with hypophosphataemia had normal potassium concentrations. Two of them developed hypercalcaemia with phosphate deprivation alone and a further one when chlorothiazide was added. Two patients with hypophosphataemia did not develop hypercalcaemia.—We are, etc.,

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¹ Adams, P., Chalmers, T. M., Hill, L. F., and Truscott, B. McN., *British Medical Journal*, 1970, 4, 582.

² Adams P., Chalmers, T. M., Peters, N., Rack, J. H. and Truscott, B. McN., *Annals of Internal Medicine*, 1965, 63, 454.