rise to any serious problems in Dr. Morrow Brown's hands, we would be extremely uneasy if his methods were adopted on a large scale in routine clinical practice.—We are, etc.,

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¹ Landon, J., Wynn, V., and James, V. H. T., *Journal of Endocrinology*, 1963, 27, 183.

² Wood, J. B., Frankland, A. W., James, V. H. T., and Landon, J., *Lancet*, 1963, 1, 243.

The Doctor in Conflict

SIR,—In your leading article "The Doctor in Conflict" (25 March, p. 761) you say "there is no reason to suppose, and no shred of evidence, that any doctor in the recent troubles has departed from the ethical traditions that guide the profession" and you advance the argument that the attention of a doctor before interrogation is more humane than his absence "for presumably if the doctor pronounces the person to be medically unfit for interrogation it would not be carried out." You do not say, however, whether the attention of those doctors who pronounced many persons *medically fit* (my italics) was in your opinion humane, when those persons were found to be fit to be submitted to methods of interrogation which (in the words of an editorial in *The Times*, 3 March) "clearly involved a degree of physical ill-treatment which it is hard to distinguish from brutality."—I am, etc.,

P. HORGAN

Limerick, Eire

SIR,—I was sadly amused by the irony of your leading article "The Doctor in Conflict" (25 March, p. 761). Glancing through the journal my eye caught the World Medical Association's Declaration of 1946 "I will maintain the utmost respect for human life from the time of conception," and I thought that the B.M.A. must be raising one of its periodic squeaks about the Abortion Act. However, on reading it, I fully agreed with your views on the doctor's ethical problems in regard to interrogation, however humanely conducted.

It is, however, blatantly hypocritical to quote such an authority in one context when in another the medical profession of this country is passively and actively allowing abortions to proceed at the rate of 150,000 per annum, so that the medical ethical standards of this country fall far below most other countries. This illogical stand is emphasized by the reasonable proposition that the interrogation of internees might have prevented many more life-long deformities from bombing of civilians than all these abortions have prevented the birth of deformed babies.

Surely, to quote again, "even under threat" this country's doctors have long ago abandoned the Declaration of Geneva. So please don't quote it in a rather minute ethical problem when, from anyone's viewpoint, we are faced with a major social problem.—I am, etc.,

F. DIFFORD

Bristol

"Sorcerers' Apprentices"

SIR,—In your leading article (12 February, p. 391) you discussed the issues raised by the letter of Dr. J. A. D. Anderson and others on "Doctors and Overpopulation" (8 January, p. 108). You then gave your readers a lot of advice, which most of us would accept as sound, concerning the role of the doctor in limiting population growth. Because of the great importance at this time of the allied threats of overpopulation and pollution, the correspondence goes on.

Is there not some message for us in the account of sextuplet pregnancy (25 March, p. 787)—iatrogenically produced. Of course the events described occurred more than two years ago, before our great concern was aroused, but the dangers of overpopulation have been recognized for a very long time.

No one would wish to deny the childless marriage a natural child, if this can be safely achieved. But surely until we can precisely control what we do, doctors must "encourage young parents to think responsibly about the size of their families" (12 February, p. 391).

Dr. Gillian Lachelin and her colleagues say "Gonadotrophin therapy . . . should be undertaken . . . in a special centre where precaution can be taken to minimize the likelihood of hyperstimulation." ". . . and even with careful monitoring . . . it is not always possible to avoid . . . multiple conception" (p. 790). What the lawyers would call, I think, *res ipse loquitur*. If in a modern special centre using all known means of monitoring and precaution it is—as this case seems to imply—a toss up as to how many ova are produced and fertilized should we not cease to behave like so many sorcerers' apprentices, and leave well alone till we know what we are at.—I am, etc.,

DAVID GULLICK

Stevenage, Herts

Payment by Colour

SIR,—I should like to comment on Dr. Sue Dowling's letter "Payment by Colour" (11 March, p. 689). There are many good things to be said about the standards of medical care in South Africa, but visitors to that country should not allow themselves to be seduced by these without asking several important questions: Why is there so much malnutrition in a country of such affluence? Why do black people have such high infant mortality rates and low life expectancies? Why aren't there more black doctors and medical students? Why do black doctors get 70% of the pay their white colleagues get for doing the same job? And, above all, what is the medical profession doing, collectively or individually, to redress these wrongs? Medical and scientific visitors to South Africa who express interest in these problems lend strength to the few South Africans who still care about the discrepancies in health between whites and blacks, and they can cause others to adopt new more critical attitudes. But if they fail to raise these and other questions, privately or publicly, their silence is construed as acceptance or even approval of the system and, I believe, they would have done better not to have gone at all.

Dr. Dowling brings up another important point in her last paragraph. Regularly, the

B.M.J. carries advertisements for medical posts in South Africa without stating that they are open to whites only, or, if not, that discriminatory rates of pay will apply, based solely on the skin colour of the applicant. One might reasonably ask whether these advertisements should be carried at all. If they are, surely it is less than honest to publish them without making these points clear. I would urge the B.M.J. to reconsider its policy on this. The journal should at least insist that the advertiser indicates what restrictions and discriminations apply to each post, and this information should be clearly stated in each advertisement.—I am, etc.,

R. HOFFENBERG

Hemel Hempstead,
Herts

Contaminated Drip Fluid

SIR,—Your leading article "Contaminated Drip Fluid" (18 March, p. 707) suggests that only one fatality due to such contamination has been reported in recent years.¹ The Medical Protection Society reported a similar tragedy in its *Annual Report* of 1969.²

This case concerned a 27-year-old woman in whom labour was induced with a Syntocinon drip. The patient suffered a rigor 20 minutes after the infusion was commenced. It was immediately discontinued but the patient died approximately two-and-a-half hours later, having meanwhile given birth to healthy twins.

It was established that the fatal septicaemia was due to bacterial contamination of the 5% glucose solution used for the infusion. Inspection of the bottle by daylight showed a minor degree of opalescence but this was not apparent to the house officer who set up the infusion by artificial light on a winter's evening. The manufacturers of the solution accepted full legal liability for this tragedy.

This case underlines the advice given by Drs. J. Guy and E. W. Jenkins (27 August 1966, p. 523) in which the need for visual examination of all perfusion fluids before use was stressed.—I am, etc.,

P. G. T. FORD

Regional Secretary,
Medical Protection Society

Leeds, Yorks

¹ *British Medical Journal*, 1966, 2, 597.

² Medical Protection Society, *Annual Report*, 1969, 77, 23. London.

Interstitial Cystitis

SIR,—We read your recent leading article (11 March, p. 644) and are in agreement with most of the points that were made, particularly in relation to the problems of diagnosis. We would like to make two observations.

Firstly, at the time of the initial symptoms, the diagnosis of interstitial cystitis is only one of many conditions in the differential diagnosis. Having excluded the imitators histologically, it is usually possible to prove it on a time-proven basis before secondary bladder contracture has proceeded to a point at which the bladder can no longer be distended to a useful capacity under anaesthetic. Early diagnosis is important because treatment at this stage, albeit empirical, may be effective. We have

had encouraging results with supratrigonal vesicolytic in the management of a carefully selected group of these hypersensitive bladders.

The longest follow-up is now nearly five years, but the immediate clinical result in most of them has been so striking that it seems probable that this relatively simple operative procedure offers a very fair chance of symptomatic relief, at least for a reasonable period. If this is so, it would certainly have a clear advantage over both long-term steroid therapy and repetitive bladder distension, and the details of our series will be presented to the British Urological Association meeting in July.

Secondly, we would like to express some degree of disagreement with the statement in your leader that the results of cystoplasty for patients with interstitial cystitis are disappointing. In our experience it has offered the great majority of patients a reasonably normal restoration of their bladder function.

With regard to cystoplasties in general, it is important to appreciate that bowel peristalsis is not an adequate replacement of the vesical detrusor. Selective relaxation of the sphincter mechanisms is not infrequently required to overcome the relative outflow obstruction that results from this iatrogenic voiding imbalance, and the complications of residual urine, infection, stone formation, and pyelonephritis are usually avoidable by a proper attention to postoperative supervision and outflow rebalancing. In our series, cystoplasty failure rate is about 10%; mostly patients in whom it proves impossible to establish a balance between voiding efficiency and continence. The great majority of the remaining 90% void at two to three hourly intervals with reasonably normal urinary control and bladder sensation.

When a cystoplasty is performed for interstitial cystitis it is particularly important to ensure that the hypertensive bladder is resected almost to the margins of the trigone, in order to reduce the chance of persistent bladder pain and hypersensitivity.—We are, etc.,

PETER WORTH
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SIR,—Your leading article on "Interstitial Cystitis" (11 March, p. 644) gives an excellent summary of its main features, but omits a method of treatment which I believe offers great promise. I refer to denervation of the bladder, a procedure which is of increasing interest to urologists.

Interstitial cystitis is rare; consequently I have myself had the opportunity of treating only one patient by denervation. This is a woman of 56 who presented three years ago with a classic Hunner's ulcer. Dilatation afforded increasingly less relief of her symptoms, and a course of prednisone had no effect. She reached a point where she agreed to urinary diversion, and as I thought that, theoretically at least, denervation should help her condition, I proposed this as an alternative, and pointed out to her the experimental nature of the procedure. Denervation was performed in August 1971. Within 24 hours of operation she declared herself symptomatically improved, and has

had no urinary symptoms of any sort since that time. At cystoscopy a fortnight ago—seven months postoperatively—her bladder capacity had increased from 160 ml pre-operatively to 500 ml. There is no residual urine. The ulcer has healed and the bladder looks normal.

The technique of denervation was briefly described by Turner-Warwick in another context.¹ My colleague Mr. W. Keith Yeates and I have used this operation now on a number of patients and we have developed a simple and satisfactory operative technique. Only one patient with interstitial cystitis has so far had a bladder denervation; the remainder have suffered from a variety of symptoms arising from hyperactivity of the detrusor presumably of neurological origin.

Our results so far have been excellent, and will be submitted for publication at a later date. The operation consists of circumferential supratrigonal division of the bladder with complete disruption between the two parts. Normal anatomy is restored by cysto-cystoplasty. This causes motor denervation of the supratrigonal detrusor. It is easy enough to formulate a hypothesis to explain the effect of this operation on Hunner's ulcer, but as yet there is no proof. So far as I am aware, supratrigonal motor denervation has not yet been described in the treatment of Hunner's ulcer.

Admittedly one patient is not conclusive evidence. In this instance, the result has been so impressive that I shall certainly consider denervation at an early stage in future patients suffering from interstitial cystitis.—I am, etc.,

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¹ Turner-Warwick, R. T., and Ashken, Handley M., *British Journal of Urology*, 1957, 39, 3.

Papillary Necrosis in a Transplanted Kidney

SIR,—Dr. R. P. S. Edmondson and others' report (26 February, p. 547) prompts us to record a similar case, in which the association between rejection and papillary necrosis was conspicuous.

A 26-year-old man, on our maintenance haemodialysis programme since 1969 for end-stage glomerulonephritis, received a kidney transplant on 22 October 1970. The donor was a man, aged 42, who died of brain damage. The recipient was not diabetic. Blood groups of donor and recipient were identical. HL-A compatibility studies disclosed two identities and two potential incompatibilities. There were no detectable preformed cytotoxic antibodies against the donor's lymphocytes in the recipient's serum. Total ischaemia time was 225 minutes (cooling with Collins's solution) and the surgical procedure was uneventful. Initial treatment consisted of prednisone 1/3 mg/kg and azathioprine 3 mg/kg. A brisk diuresis followed declamping (300 ml/min) but the urine output soon started to decline: 125 ml/hr at 24 hr, then 80 ml/hr at 48 hr. Pain and fever together with progressive anuria led us to increase the dosage of prednisone to 2 mg/kg without improvement. On the seventh day the patient passed a piece of soft tissue, without pain or haematuria. Histology disclosed the typical aspect of necrotic renal papilla. The following day the patient was anuric. Percutaneous

renal biopsy yielded a black piece of infarcted kidney tissue.

Nephrectomy was done. The renal vessels and the ureter were patent. The whole surface of the swollen kidney was mottled with black and reddish areas. Section disclosed scattered foci of necrosis in the cortex, predominating in the corticomedullary junctions. Most of the papillae were necrotic, and several had sloughed off.

Histology showed a necrotic cortex, invasion of the interstitium by erythrocytes and round cells, and tubular necrosis. Intrarenal vessels were mostly normal. The medulla was destroyed by interstitial haemorrhage. No fixation of antisera was detected on the glomeruli. Using immune fluorescent techniques, round cells fixed anti-IgM antiserum. Most of the peritubular capillaries fixed the antifibrinogen serum.

In our opinion, this case demonstrates that papillary necrosis can indeed be due to acute rejection.—We are, etc.,

C. LEROUX-ROBERT
A. MEYRIER
L. MOREL-MAROGER
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Paris, France

Suction Retractor

SIR,—Mixed parotid tumours may be difficult to enucleate, since conventional tissue-holding forceps tear out when any tension is exerted on them. Similar problems may also be encountered with branchial cysts or malignant nodes. It may not be possible to manipulate the tumour so that its under surface can be adequately visualized.

The suction retractors (Fig.) are made up in sets of three cup sizes. The cup is applied directly to the tumour, in place of tissue forceps. In practice the middle size of cup has been found adequate for most situations. The other end of the instrument is fitted into the sucker tubing. The amount of suction can be increased by covering the hole at the side of the adaptor fitting.

These retractors, known as "Burke's Trum-pets," may be obtained from Peacocks Surgical Medical Equipment Ltd., Newcastle upon Tyne.—I am, etc.,

MICHAEL BURKE
Newcastle upon Tyne

Islets of Munchausen

SIR,—In his article on spontaneous hypoglycaemia (12 February, p. 430) Professor Vincent Marks did not discuss self-induced hypoglycaemia—no doubt because this type is neither spontaneous nor common. A young man suffering—if this is the correct word—from this condition was admitted to the