CORRESPONDENCE

Correspondents are asked to be brief

Seat Belts and Head Rests

SIR,—Publications on the probable early legal enforcement of the wearing of seat belts, and your Legal Correspondent's suggestion (25 March, p. 810) that awards of damages for personal injuries sustained in motor accidents might be reduced in future on account of the plaintiff's negligent failure to use a belt, fail to take account of the many situations when the wearing of seat belts is positively dangerous unless supported by the presence of firmly-fitting or inbuilt head rests—already present in many cars from enlightened foreign firms.

I refer, from bitter personal experience, to the "whiplash" effect which occurs when a car parked by the roadside, stopped at traffic lights, or involved in one of our recurrent "motor-way fog madnesses," may be run into from behind by another vehicle travelling at speed. In such circumstances, the praiseworthy wearing of a seat belt, will, by preventing any significant forward thrust of the passenger, fail to absorb much of the energy engendered and, by that amount, the "whiplash" effect will be doubled or trebled with more disastrous effects on the cervical spine up to a total dislocation and quadriplegia, if not death—unless a head rest is there to prevent this.

The occasional fatal situations, raised by opponents of seat belts, of the outbreak of fire or of plunging into deep water, should not be allowed to prevent legal enforcement of their being worn, but the "set" should, by law, include stable head rests.—I am, etc.,

IAN W. CALDWELL

Southampton

Children's Testes

SIR,—In many ways I find myself in agreement with Professor J. P. Blandy's review of Scorer and Farrington's book *Congenital Deformities of the Testis and Epididymis* (11 March, p. 699). I cannot, however, agree that treatment with chorionic gonadotrophin is time-wasting and silly.

I do not intend to resuscitate the old controversy as to whether chorionic gonadotrophin is useful in the case of the truly ectopic testicle. I rather incline to the view that it is useful only when the testicle is on its proper line of descent. Nevertheless, in the latter type of patient there is no doubt whatever that chorionic gonadotrophin is very useful. In the first place retractile testicles do not invariably descend of their own accord before the danger point of seven years is reached. I have had successes with boys twice this age. It may be presumed that if the testicles remain high after the age of seven, absolute or relative infertility will be caused. In the second place a great deal of psychological trouble accrues in boys with undescended testicles. They are subjected to constant ragging by their companions.

Surely the sensible, not the silly, thing to do is to treat boys early with chorionic gonadotrophin. If the testicles come down much good is done and much worry by the patient and his parents is obviated. If the testicles do not come down after a six-months' course the boys should be referred for surgery before their seventh birthday.—I am, etc.,

RAYMOND GREENE

London W.1

Azathioprine in Ulcerative Colitis

SIR,—We were very interested to read the preliminary results of the first double-blind trial of azathioprine in ulcerative colitis (18 March, p. 709). In our view, the authors are right to recommend that at present the use of azathioprine should be reserved for those patients for whom conventional medical treatment is not proving successful. It may well be that the main use of azathioprine in colitis will be as a maintenance treatment to prevent relapse in certain patients or, as in connective tissue disorders (11 March, p. 645), to permit the use of smaller doses of corticosteroids than are necessary to control the disease when used alone.

Sulphasalazine, which has been shown significantly to reduce the relapse rate in ulcerative colitis in a double-blind trial lasting for one year,[1] should be regarded as the first line of treatment for a patient with colitis whose disease is in remission. This drug is relatively free of side effects when used in a dose of 2g daily, and no patient of ours who has taken the drug for several years has developed side effects at a late stage.—We are, etc.,

F. AVERY JONES
J. E. LENNARD-JONES
J. J. MISIEWICZ

St. Mark's Hospital,
London E.C.1

1 Misiewicz, J. J., *et al.*, *Lancet*, 1965, **1**, 185.

Costs of Antibiotics

SIR,—For some years the Department of Health and Social Security has been circulating leaflets with drug costs, and no one would belittle the necessity for keeping these costs as low as possible. However, the latest E.C.L. (106/69 serial 5/72) on the cost of

anti-infective agents is completely misleading, and surely it is time the system of presenting this information is changed. At the bottom of the leaflet there is a note concerning the cost of treatment in relation to dosage, but in this particular field of anti-infective drugs it is obvious that the impression which the Department *wishes* to present is for instance that ampicillin is cheaper than co-trimoxazole. It ignores two facts: that the weight of drug in a tablet of co-trimoxazole is twice that in a capsule of ampicillin, and that its two constituents are far longer-acting than ampicillin. Assuming an adult dosage of 500 mg six-hourly for ampicillin compared with two tablets 12-hourly for Septrin (co-trimoxazole) the cost effectiveness of Septrin is nearly twice that of ampicillin.

Would it not be better if the Department was to present its facts honestly and so increase the cost effectiveness of this quite expensive circulation of propaganda?—I am, etc.,

D. F. ELLISON NASH

London, W.1

G.M.C. Disciplinary Committee

SIR,—In Libman v G.M.C. [1972] 2W.L.R. 272 (see *B.M.J.*, 19 February, p. 519) the Lord Chancellor in delivering the decision of the Privy Council drew four general propositions. One is entitled with justification to take the view that these propositions are in effect criticisms of the procedure of the Disciplinary Committee and the appellate machinery. It is even arguable that these four propositions reveal the deplorable standard of justice exercised by the Disciplinary Committee over the profession.

Almost every aspect of Disciplinary Committee procedure was commented upon. In relation to appeals from the Disciplinary Committee, the Lord Chancellor drew attention to the fact that although the "Jurisdiction conferred by the statute (Medical Act 1956) is unlimited, the circumstances in which it is exercised in accordance with the rules approved by Parliament are such as to make it difficult for an appellant to displace a finding or order of the Committee. . . ."

It would now appear that the Disciplinary Committee (procedure) Rules [SI 1970 No. 596] and the Judicial Committee appeal procedure rules [SI 1971 No. 393] need considerable amendment. Furthermore, the profession is entitled to ask for an explanation from the G.M.C., or those members of the profession who were consulted at the time the instruments were drafted, as to why they had countenanced rules which partially negated the jurisdiction of the parent Medical Acts, especially after Lord Radcliffe's speech (Fox v G.M.C. 1960), in which he made reference to the subjects of appeals and the Legal Assessor's advices.—I am, etc.,

I. M. QUEST

Liverpool

Bone Disease after Gastrectomy

SIR,—In your leading article "Bone Disease after Gastrectomy" (19 February, p. 461) it was stated that osteomalacia had not been reported after vagotomy and drainage prior to the recent Australian study in which early bone changes were suspected in a few patients after vagotomy and pyloroplasty.[1]

We have reported osteomalacia, due to defective absorption of adequate dietary vitamin D, in a 79-year-old woman, five years after an anterior selective vagotomy and pyloroplasty.[2]

In February 1964, operation for a benign lesser curve gastric ulcer was performed by Mr. Harold Burge. Thereafter she developed diarrhoea and lost weight. Four years later she complained of spontaneous bone pain and tenderness first in the sacrum, then in a rib, and a little later in the left humerus in January 1969. The diagnosis of osteomalacia was confirmed biochemically and histologically. Further confirmation of the diagnosis, and the demonstration that this was due to simple vitamin D deficiency, was the biochemical response to a small dose of vitamin D, as suggested by Morgan *et al.*,[3] and the return of the bone histology to normal.

Dietary deficiency of vitamin D was thought to be unlikely in view of the daily intake of 115 I.U. vitamin D. as assessed retrospectively by dietary analysis. This is well above 70 I.U. daily, which Dent and Smith[4] regard as the minimum required to prevent the development of osteomalacia. Steatorrhoea, an abnormal small bowel radiological pattern, and postoperative weight loss despite an adequate caloric intake suggested that vitamin D deficiency was due to malabsorption following the operation. Steatorrhoea may follow vagotomy associated with pyloroplasty,[5] and there is no advantage in selective over truncal vagotomy in this respect.[6 7] We were unable to find another cause for the malabsorption.

In our report,[2] we reviewed the evolution of the recognition of postgastrectomy osteomalacia. We concluded, as did you, Sir, that similar problems are to be expected following vagotomy and pyloroplasty.—We are, etc.,

A. B. S. MITCHELL
D. GLASS
A. MORTON GILL

West London Hospital,
Charing Cross Group of Hospitals,
London W.6

1 Carrick, R., Ireland, A. W., and Posen, S., *Annals of Internal Medicine*, 1971, **75**, 221.
2 Mitchell, A. B. S., Glass, D., and Gill, A. M., *Postgraduate Medical Journal*, 1971, **47**, 233.
3 Morgan, D. B., Paterson, C. R., Woods, C. C., Pulvertaft, C. N., and Fourman, P., *Lancet*, 1965, **2**, 1089.
4 Dent, C. E., and Smith, R., *Quarterly Journal of Medicine*, 1969, **38**, 195.
5 Logan, H., *Gut*, 1964, **5**, 188.
6 Baldwin, J. W., Albo, R., Jaffe, B., and Silen, W., *Surgery, Gynecology and Obstetrics*, 1965, **120**, 777.
7 Kraft, R. O., Kirsh, M. M., Kittleson, A. C., Ernst, C. B., Pollard, H. M., and Ransom, H. K., *Surgery, Gynecology and Obstetrics*, 1965, **120**, 472.

Tumbu Fly

SIR,—I was very interested to read the short report on tumbu fly infection (1 April, p. 58), having suffered myself from this parasite when visiting my daughter in Nigeria last October. I can confirm that the lesions do not throb like furuncles, but they do itch, and any attempt to express the larvae may be exceedingly painful. In Lagos the lesions are treated with oxytetracycline ointment, and those which are liable to friction are covered with a suitable adhesive dressing. This effectively kills the larvae, which in time are shed naturally from the skin.

Your report makes no mention of prevention, and it is important to realize that all personal laundry, especially underclothes, socks, and shirts, and all towels should be ironed on *both* sides, and that drip-dry clothing should only be hung out indoors and with the windows closed. I believe that I caught my own infestation from a damp towel after bathing, which may have been in contact with the ground for a very short space of time.—I am, etc.,

WALTER RADCLIFFE

Colchester, Essex

Malnutrition and Body Temperature

SIR,—Drs. James and Margaret M. Lawless raise some interesting points about malnutrition and hypothermia (26 February, p. 566), and reaffirm their original proposal that in Rhodesia kwashiorkor is a cold injury syndrome. In Jamaica hypothermia is common in malnourished children but there is a much higher incidence in marasmus than in acute kwashiorkor, and reduced rectal temperatures are significantly related to lowered weight for height, in other words to the degree of wasting.[1] I have never seen acute oedema after hypothermia, and recovery is often quite rapid. An explanation for the less sinister significance of hypothermia in Jamaica may be its infrequent association with severe infection and multiple infestations, an association which, when accompanied by hypoglycaemia, has been regarded as a death warrant in Uganda.[2]—I am, etc.,

OLIVER BROOKE

Tropical Metabolism Research Unit,
University of the West Indies,
Kingston, Jamaica

1 Brooke, O. G., *Archives of Disease in Childhood*, in press.
2 Wharton, B. A., *Lancet*, 1970, **1**, 171.

Interstitial Cystitis

SIR,—Your readers might be forgiven if your excellent leading article (11 March, p. 645) on Hunner's ulcer convinced them that it existed. I wonder if it really does. Its clinical features are no different from those of other types of scarring in the bladder whose cause is known. Nor are its cystoscopic features specific, since the scarring in the bladder which follows tuberculosis or radiation also cracks and bleeds on overdistension. Biopsy of a so-called Hunner's ulcer will show loss of the urothelium with non-specific fibrosis and round cell infiltration in the deeper layers. Our only excuse for calling this condition after Hunner is that we do not know the cause of the scarring. This seems a poor reason.

The results of treatment are equally poor; diathermy coagulation and distension alleviate the symptoms temporarily and do no harm. Some patients are said to be improved with steroids (though reports are usually wanting in objective evidence or controls). Now that it has become fashionable to attribute any condition we cannot understand to autoimmunity, it will not be long before someone tries azathioprine. If so, please will he take a biopsy from time to time and use a placebo control. There really is no place for continuing to use the expression Hunner's