bolism, and coronary thrombosis as post-operative complications in this tropical country, in spite of the tendency of the Vietnamese to resist all encouragement to early mobilization. Australian surgeons who worked in the same environment over the years of the Australian commitment to the Vietnamese people confirmed these impressions. Unfortunately, the Doppler technique and radioactive isotope scanning were not available in that country and therefore no figures can be presented to be compared with the Queensland and Sudanese findings.

The role of diet and/or nutrition would appear to be excluded by the experience in Queensland, where the dietary habits and build of repatriation hospital patients would be little different from those in the southern states of Australia in which the incidence of deep vein thrombosis is nearer to that in Britain and the United States. It therefore seems that climate may well be the possible answer, and further investigations on these lines are awaited with interest.—I am ec.,

K. B. ORR

Kogarah, New South Wales

Serum Antitrypsin Levels in Acute Hepatic Necrosis

SIR,—α_1-Antitrypsin is a glycoprotein primarily synthesized by the liver.[1] Though severe hepatic disease does not usually result in low serum antitrypsin levels[2] acquired α_1-antitrypsin deficiency may occur in cases of massive liver necrosis.[3] To investigate this possibility we determined serum antitrypsin levels in a group of 14 patients with acute viral hepatic necrosis. Fifty-five blood donors and 35 patients with uncomplicated viral hepatitis were used as controls.

A single serum specimen only for α_1-antitrypsin determination was obtained from each control subject. Sequential serum specimens were obtained during the first two weeks of hospitalization in the 14 patients admitted with a diagnosis of massive liver necrosis. A radial immunodiffusion technique was used to measure serum α_1-antitrypsin concentration (normal levels: 212 ± 32 mg/100 ml).[4] We tried to correlate serum antitrypsin levels with the mental state and other relevant clinical and biochemical findings which are characteristic of fulminant hepatitis cases. The following observations were made.

In all 14 patients with massive liver necrosis one or more serum specimens early in the hepatic course showed normal or raised antitrypsin levels. Subsequently, however, a moderate to substantial lowering of antitrypsin levels to the range observed in subjects with inherited α_1-antitrypsin deficiency was noted in half the patients and four had severe α_1-antitrypsin deficiency (range 27-68 mg/100 ml)[5] at least transiently. No correlation between serum antitrypsin concentration and prognosis was observed. Thus, one case with persistently raised antitrypsin levels died and at necropsy diffuse submassive necrosis of the liver was found. Conversely, two patients who transiently developed severe "acquired" antitrypsin deficiency survived. In three patients who expired values were initially low but became normal before death. No correlation therefore exists between clinical outcome (death or survival) and a return to normal serum antitrypsin levels. In two patients, however, a pronounced drop of α_1-antitrypsin preceded an extreme depression of the prothrombin activity (less than 25% activity) and mental obtundation.

In patients with uncomplicated viral hepatitis serum α_1-antitrypsin levels are raised for an average of 4-6 weeks. By inference, we suggest that a pronounced drop in the serum concentration of α_1-antitrypsin, when it does occur, may be an early sign of massive liver necrosis.—We are, etc.,

JOSE CAMPRA
MARY ASHCAVAI
ROBERT L. PETERS
ALLAN REDEKER

Departments of Medicine and Pathology,
U.S.C.-John Wesley Hospital,
Los Angeles, California

1 Schultze, H. G., and Heremans, J. F., *Molecular Biology of Human Proteins*, vol. 1, p. 688. New York, Elsevir, 1968.
2 Sharp. H. L., Bridges, R. A., Krivitt, W., and Freier, E. F., *Journal of Laboratory and Clinical Medicine*, 1969, 73. 93.
3 Lieberman, J., and Mittman, C., *Annals of Internal Medicine*, 1970, 73, 9.
4 Kueppers, F., *Humangenetik*, 1967, 5, 54.
5 Lieberman, J., Gaidulis, L., Garoutte, B., and Mittman, C., *Chest*, 1972, 62, 557.

Odds on Getting a Coronary

SIR,—I do not write in criticism of your informative leader on coronary disease (19 May, p. 375), but clinical experience would suggest to me that heredity plays some part in the aetiology of the condition and that an old-fashioned family history is therefore important in assessing the likelihood of thrombosis. Has this been statistically disproved, or might this be the primary risk factor mentioned which has gone undetected?—I am, etc.,

W. E. SNELL

Hambleden, Henley-on-Thames, Oxon

Management Arrangements for the N.H.S.

SIR,—From time to time professional and lay opinion expresses alarm at the implications of management applied to the National Health Service. On the one hand, professional interests fear interference with their traditional clinical freedom, and on the other, informed members of the public fear that managerial efficiency in the Health Service will be undemocratic.

Discussions with members of joint liaison committees throughout the country indicate that these fears may well be unfounded in practice. The Department of Health and Social Security is issuing guidance to joint liaison committees. It would appear that this guidance is not merely being modified to suit local circumstances but that it is often being ditched completely in the face of local pressures. It would appear that circulars from time to time are mutually contradictory; a notable example is that HRC(73)10 is incompatible with the previous issue HRC(73)4.

In the end all guidance rules and directives are subject to interpretation and this in turn will depend on the personnel who do the interpreting. On the present evidence 1984 is not yet upon us and it would appear to be a long way off as for many years to come the new wine of managerial experience will be dispensed from well-worn bottles.—I am, etc.,

H. P. FERRER

Health Department,
County Hall, Kendal, Westmorland

Representation of Hospital Doctors

SIR,—I would not like Dr. R. M. Mayon-White's letter (19 May, p. 424) to pass without comment. His sense of frustration and disillusionment is understandable. Unfortunately hospital doctors on the whole have no sense of common identity, and one can see the increased fragmentation of specialists leading only to more difficulty in representing their diverse interests.

I do feel we should acknowledge our appreciation of the job that Dr. Mayon-White has done and the immense amount of time he has spent on our behalf. It is impossible to satisfy all the people all the time but he has certainly tried.—I am, etc.,

ALAN P. GRANT

Belfast

National Conference of Hospital Medical Staffs

SIR,—About 185 doctors, of whom approximately 60 were members of the Central Committee for Hospital Medical Services, accepted an invitation to attend the second National Conference of Hospital Medical Staffs on 19 May 1973. The agenda was received by the attending doctors only a few days before the conference and there was no time for Regional Hospital Medical Services Committees to discuss the motions which were to be debated. The doctors at the conference could therefore only express their own personal views with regard to many of the motions which were debated for the first time at the conference. During the final 30 minutes or so of the conference there were approximately 60 doctors in the audience, perhaps a quorum, but no more, yet motions were still voted upon.

I would suggest that it is difficult to interpret the conclusions which were made at the conference in view of the fact that there were only 175 doctors present, allegedly representing thousands of senior and junior medical staff, though they had no mandate from their constituents as to how they would vote. In particular I would refer to your report (*Supplement*, 26 May, p. 64) which states that "the conference reaffirmed its support—by 102 votes to 30—for the consultant contract proposals approved by the 1972 meeting."

If this conference is to continue and to be meaningful there should at least be time for the agenda to be discussed by regional committees. It would be even more meaningful if the agenda could be circulated to all hospital doctors so that they could advise their representatives on the regional committees. To implement this suggestion would be quite expensive and if the Defence Trust cannot meet this expense then perhaps the conference should be discontinued.—I am, etc.,

C. COHEN

Stracathro Hospital
Brechin, Angus

**A notice was sent on 11 January to all honorary secretaries of Regional Committees for Hospital Medical Services setting out the timetable of pre-conference arrangements for the National Conference of Hospital Medical Staffs. This stated that the conference agenda would be sent to representatives on 7 May, and it was in fact dispatched on 8 May.—ED., *B.M.J.*