whether to begin long-term antituberculosis therapy.—I am, etc.,

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1 Mandal, B. K., et al., *British Medical Journal*, 1972, 4, 413.

2 Fallon, R. J., *British Medical Journal*, 1972, 4, 794.

Drug-precipitated Acute Attacks of Gout

SIR,—Though there has been little discussion about drug precipitation of acute attacks of gout, it is known that diuretics such as hydrochlorothiazide, ethacrynic acid, and frusemide induce hyperuricaemia and thus precipitate acute attacks.¹ Among the other drugs implicated are pyrazinamide, niacin, pempidine, alcohol, mecamlamine, and salicylates if the dose is less than 4 g per day.² It would be of interest, therefore, to add a little to this list, seeing that the incidence of gout in Asians is much higher than was formerly thought.²

A patient aged 40, of Chinese origin, who had been suffering from gout for the past five years with a serum urate level of 0.6 mmol/l (10 mg/100 ml) recently presented with an acute attack of gout after taking a hypnotic the night before. The patient was not stabilized on any drug, but had been relatively free from acute attacks and was familiar with the precipitating factors in his case. Regular estimations of the serum urate level once a week after this episode revealed fluctuations, depending upon his activities, from 0.32 to 0.74 mmol/l (5.4 to 12.5 mg/100 ml). The threshold for an acute attack was at about 0.54 mmol/l (9 mg/100 ml).

During the study period of three months the patient presented with an acute attack on five occasions after taking nitrazepam 10 mg and had a serum urate level of 0.6–0.7 mmol/l (10–12 mg/100 ml). Diazepam 5 mg and chlorthalidone 15 mg also precipitated acute attacks. His treatment was then changed to Mandrax (methaqualone 250 mg and diphenhydramine 25 mg) but he again suffered an acute attack with raised serum urate levels. All attacks were successfully controlled with colchicine 0.6 mg and niflumic acid 250 mg six-hourly.

It seems possible that hypnotic drugs can now be included into the list of medications which can precipitate acute attacks of gout, a list which physicians should be well aware of.—I am, etc.,

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1 Healey, L. A., Majid, G. J., and Decker, J. L., *New England Journal of Medicine*, 1959, 261, 1358.

2 Khaira, B. S., *Far East Medical Journal*, 1967, 3, 406.

Pseudocyanosis Neonatorum

SIR,—I should like to report a case of pseudocyanosis in the newborn—pseudocyanosis neonatorum.

The patient, a Caucasian male weighing 3.62 kg, was born to a 23-year-old primigravida of good health and barely adequate pelvis. At delivery the infant presented the appearance of gross cyanosis affecting the face and lips and this persisted despite a lusty and continuous cry.

The diagnosis of pseudocyanosis was apparent for reasons similar to the case of pseudocyanosis in an adult reported by Dr. N. G. Gold (13 July 1974, p. 119) in that there were no other features of cardio-respiratory disease and the simulated

cyanosis involved neither the limbs nor the mucous membranes within the mouth. The cause was thought to be facial contusion consequent to a degree of cephalopelvic disproportion, and this was subsequently confirmed by the characteristic evolution of colour which the face underwent.—I am, etc.,

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"Nasal FEV"

SIR,—Dr. J. Morrison-Smith and his colleagues (3 May, p. 255) state that "no completely satisfactory and simple measure of changes in nasal airway is available." Conscious of the need for a simple method of demonstrating changes we developed a "blockage index." This measurement correlates very well with nasal airways resistance as measured using more complex apparatus. The peak expiratory flow rate (PEFR_o) is measured in the usual way using a Wright peak flow meter, after which the mouthpiece is replaced by a semirigid rubber face-mask and the patient breathes out forcibly through his nose, keeping his mouth firmly closed. This measurement is the peak expiratory flow rate through the nose (PEFR_n). The blockage index is then: (PEFR_o—PEFR_n) ÷ PEFR_o.

Unlike the "nasal FEV" described by Dr. Morrison-Smith and his colleagues the blockage index is independent of variations in the lower airways and is therefore valid for use before and after allergen challenge.—We are, etc.,

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1 Taylor, G., MacNeil, A. R., and Freed, D. L. J., *Journal of Allergy and Clinical Immunology*, 1973, 52, 193.

Emigration of Doctors

SIR,—The truth of Dr. B. Senewiratne's two articles on medical emigration from developing countries (15 March, p. 618, and 22 March, p. 669) seemed so self-evident that I did not think of writing to endorse them until I read the dissenting letters from Drs. N. R. E. Fendall and A. J. R. Waterston (26 April, p. 190). Both dealt with the two important and interlinked questions of (1) tailoring the medical course in developing countries to the specific problems of those countries and (2) the use of paramedical workers to do routine tasks usually done in industrialized countries by doctors, so as to free the doctor in developing countries for vital educative and administrative work.

Over the past few years these two questions, or rather convening conferences on them and writing papers about them, have been one of the most remarkable growth-points in tropical medicine. There have been little in the way of tangible results because certain facts are always ignored. I would like to outline some of them, but for considerations of space I must be brief and dogmatic.

(1) Paralleling the decline in the morale, discipline, and output of our Health Service has been a similar falling-off in developing countries. This matter is never discussed.

As in our own Health Service, it is so much more acceptable to all parties to suggest "reorganization."

(2) It is accepted by the "reformers" that doctors are reluctant to go to rural areas. To replace the doctor they invent an Ideal—the paramedical worker who is only too delighted to do so. Unfortunately he does not exist. Having been a district medical officer myself I can attest that paramedical workers spend just as much of their time as doctors agitating to be posted back to the capital or sent on another course. Replacing sullen doctors by sullen paramedical workers achieves nothing.

(3) Anybody who has seen, or experienced himself, the extraordinary habits an isolated doctor can get into must appreciate how much more easily this can happen with a lesser-trained worker.

(4) "Adjusting" the medical course means lowering the standard (see George Orwell's *Animal Farm* and 1984). This could be argued about for hours. I do not believe the "reformers" consciously desire to lower the standards, but that is where their high-minded endeavours lead. For example, a professor of clinical sciences in a developing country recently told me he did not want his registrars taking even such a relatively trivial examination as the M.R.C.P.(U.K.) because it was "not relevant to the medicine they had to practise." All it tests, after all, is a basic competence in physical signs and a general knowledge of internal medicine.

The structure the "reformers" are searching for, as I understand it, is a pyramid with the doctor at the apex and his paramedical workers ranged below him, each doing his job to the best of his ability, reporting upwards the problems he cannot solve, and receiving in return a continuous flow of advice, encouragement, and education from those above him on the pyramid who know more than he does. I am happy to tell the "reformers" that their search is at an end. This very system was developed over a century by the Colonial Medical Service. There must be some survivors of the service still alive, though they would be well into their late thirties or even older by now. Could not some of them be invited to the next conference—or the next half-dozen—lest the secret die with them?—I am, etc.,

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Reversible Infertility in Male Coeliac Patients

SIR,—It was interesting to read of the two additional cases of reversible subfertility in male patients with coeliac disease after treatment with a gluten-free diet (10 May, p. 316), though the improvement in the seminal fluid analyses reported was hardly impressive. However, it was surprising that the authors had not checked previous publications on this subject.

In the *B.M.J.* as long ago as 1962¹ the case was reported of a youth of 18½ in 1952 with coeliac disease and infantilism, whose normal adult development was stimulated with androgens while on an ordinary diet until 1953. When fully virilized in 1954 he had azoospermia, and a previous testicular biopsy had shown only tubules containing Sertoli cells, with few spermatogonia and