lapping of sigmoid and other bowel loops often made interpretation difficult. This patient was remarkable for the relatively small size of his colon.

Dr Calder indicates that the rural Kenyan is less likely to undergo barium enema investigation. One need not conclude that the elderly countryfolk suffer from undiagnosed diverticular disease. It may be that the urban Kenyan's diet and way of life are more Western than is apparent, and that the diverticular disease observed is consequential on a changed lifestyle.

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Amyl nitrite as a sexual stimulant

SIR,—I was interested in your expert's reply to the question about amyl nitrite as a sexual stimulant (14 July, p 117). As a venereologist practising in London from 1969 to 1975 I saw many male homosexuals who admitted to the use of amyl nitrite ("poppers") in sex play. It tended to be used by the more sophisticated members of that group, especially those into the "leather scene." Some stated that orgasm was not so good if amyl nitrite was not used. It was also inhaled by the recipient in the practice of inserting the clenched fist into the recipient's rectum (fist fucking)—presumably the sphincter relaxing at the time of inhalation.

Several pharmacies in London sold amyl nitrite vitrellae *BPC* freely to members of the public without prescription at the time. I understand that since about 1976 this has no longer been allowed. Certainly, practising in Yorkshire one hears very little of this use of a volatile nitrite being used as a social drug. However, as Cohen mentioned,[1] the practice of some "adult bookshops" aimed at homosexuals in the London area persists, where "street" varieties of amyl nitrite are sold very profitably to clients.

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[1] Cohen, S, *Journal of the American Medical Association*, 1979, **242**, 2077.

Tuberculosis

SIR,—I read Dr Neville Oswald's article on tuberculosis ("In My Own Time," 21 July, p 188) with much nostalgia.

Although never attaining his eminence or indeed ever being on the staff of the Brompton I did also work with all forms of tuberculosis in outlying sanatoria and clinics for 30 years from 1930 onwards. How well one recalls the struggle of those early days—the persuading of patients to accept months of complete bed rest, including the children with bone and joint disease, who had to bear with various forms of plaster or, even worse, the total immobility of being strapped to a Robert Jones frame. Despite this came the problem of infected sinuses, followed all too often by the invariably fatal amyloid disease. Then back to the pulmonary cases with the induction of artificial pneumothoresis or pneumoperitoneum and the difficulties of torn adhesions, plural effusions, and empyemas. I well remember, as does Dr Oswald, the large refill clinics with the weekly or fortnightly *x*-ray screening of patients before the refill. How much radiation, I wonder, did those patients (and ourselves) absorb?

And so on to 1950 and the excitement of the arrival of streptomycin, to be allayed all too soon by the bitter disappointment of finding that by itself it rapidly produced bacillary resistance—this excitement to be renewed about a year later by the discovery of two further drugs, para-aminosalicylic acid, and isoniazid and the almost miraculous coincidence of the fact that when given separately resistance occurred, but when given together or with streptomycin this did not occur. And so the happy 10 years from 1950 onwards when we learnt how to use these new drugs and so cure many early cases or to render many of the older, chronic cases fit for curative surgery—for example, limited thoracoplasty or localised excisions which had not previously been possible.

It is surely not too much to call this the conquest of tuberculosis and it is surprising that the public at large and even the profession itself does not seem to have realised the vast importance of the change that occurred—I feel privileged to have been able to play even a small part in it.

Finally, the one important lesson to come from this story, which was never more true than in the management of tuberculosis, is that in medicine one is never simply treating a disease—one is treating a person suffering from that disease and this is by no means the same thing.

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The "Radcliffe" hospitals, Oxford

SIR,—Mr Malcolm H Gough is to be congratulated for his historical review of the Radcliffe Hospitals (7 July, p 33). His assertion that few would leave the old Radcliffe Infirmary without a sense of regret is not echoed by myself and other junior doctors, who leave with an immense sense of relief. It is sad that such a famous institution should have become the most inefficient and uncaring, with appalling facilities for staff and patients, severely deficient pathological services, and understaffing of the telephone exchange (GPs regularly took over an hour to get the switchboard to answer). Staff accommodation, which in my case probably contravened both public health and fire regulations at the old hospital, is excellent in the new one, and urgent blood tests are possible too.

It is most heartening to hear a senior consultant such as Mr Gough concerned about the absence of a residents' mess in the new John Radcliffe Hospital. Although it is easy to blame the incompetence and ignorance of administrators (which are rife), doctors themselves must take their share of responsibility for the decline in standards to a disgraceful level at old hospitals, such as the Radcliffe Infirmary, and the inadequate provision in new ones. It is a question not just of financial resources but of priorities, which all grades of medical staff must reiterate incessantly to preserve the standards of patient care and staff provision which are essential. Every hospital doctor in this country should read Jurg Schifferli's Personal View (16 June, p 1623), in which he comments about the strike of porters and catering staff: "What amazes me is how people react. They think it is a pity but no one protests, no one expostulates or demonstrates his or her annoyance."

Sir James Cameron was reported (30 June, p 1803) as saying that the BMA's reputation "rested largely on the respect built up in the public's mind by the thousands of doctors who quietly practised their profession irrespective of the problems of the day." Sir, there comes a point when to practise quietly serves the interests of patients and profession less than to protest loudly. Some of us consider that that point has been passed, and deplore the apathy and disinterest which our colleagues show in the working of our health services.

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Motor neurone disease associated with bronchial carcinoma?

SIR,—In their case report of a syndrome indistinguishable from motor neurone disease (21 July, p 176) Drs D M Mitchell and S A Olczak base much of their case on the pattern of electrophysiological abnormality. However, this was far from typical of motor neurone disease.

Firstly, motor conduction velocity was normal in their case but it is usually possible to demonstrate a differential slowing of motor as opposed to sensory conduction. Secondly, in motor neurone disease it is usual to find fasciculation potentials and discrete motor unit activity on voluntary contraction. Thirdly, although prolonged polyphasic potentials can be an indication of reinnervation,[1] polyphasic potentials are more common in myopathies. In motor neurone disease giant motor units of 10-15 mV can occur. None were seen in the case reported.

One must consider their case as not proved on electromyographic grounds. They may have witnessed the reversal of another carcinomatous neuromyopathy.

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[1] Buchthal, F, *Acta Neurologica Scandinavia*, 1970, **43**, suppl p 129.

SIR,—The association of motor neurone disease with carcinoma remains the subject of considerable controversy. The short report by Drs D M Mitchell and S A Olczak (21 July, p 176), suggesting a causal relationship between carcinoma of the bronchus and a neurological syndrome indistinguishable from motor neurone disease in one of their patients, prompts us to raise some of the problems of making such an association and to describe one of our own cases in which, we believe, that association exists.

The first difficulty is to verify the diagnosis of motor neurone disease. The clinical picture should be complemented by neurophysiological and neuropathological evidence to make the diagnosis as certain as possible. Thus a picture of progressive onset of combined upper and lower motor neurone weakness without sensory loss should be confirmed by the following objective findings. (1) An electromyographical demonstration of lower motor neurone denervation, the surviving motor units being of long duration and very large in amplitude. "Malignant fasciculation" may be