Points

Effect of rubella vaccination programme in schools on rubella immunity in a general practice population

Dr G Ninane (Hôpital de Jolimont, 7161 Haine-Saint-Paul, Belgium) writes: In their paper about rubella vaccination Dr David Gilmore and others (27 February, p 628) write: "There are clear benefits from women having an early knowledge of both blood group and rubella immunity." I do not think that knowledge of her blood group is of any benefit to a woman before pregnancy but it is to her benefit to know of the presence of an immune antibody.

But when a practitioner has told a 15-year-old girl that she has a powerful anti-Kell antibody due to a previous transfusion what does she do? Do the authors think that . . . this young girl should be invited before maternity planning to choose a sexual partner who is homozygous Kell-negative and ABO incompatible?

Pleuritic pain: Fitz Hugh Curtis syndrome in a man

Dr G C Grice (Department of Genitourinary Medicine, Royal Infirmary, Sheffield S6 3DA) writes: The lesson of the week (13 March, p 808) regarding the Fitz Hugh Curtis syndrome as a cause of pleuritic pain in a man was a most interesting reminder of this rare occurrence. The article does mention the frequency with which multiple sexually transmitted infections may coexist, and yet several possible contributory pathogens in this case were not discussed—namely, cytomegalovirus, toxoplasma, mycoplasma, amoeba, chlamydia trachomatis, and, with special reference to the genital ulceration, herpes virus and *Haemophilus ducreyi*.

Many of these organisms have in the past been regarded as unlikely pathogens, but recent evidence suggests that we must ever be aware of their potential to cause disease concurrently with the traditionally accepted venereal diseases.

Missed injuries of the spinal cord

Dr R F Wynroe (Wendover, Aylesbury, Bucks HP22 6DH) writes: I would add to Mr G Ravichandran and Dr J R Silver's (27 March, p 953) six radiological causes for missed spinal injuries: (7) Inadequate, misleading, or undecipherable information on *x*-ray request forms; (8) The initial withholding from the *x*-ray department of the original radiographs and reports of patients transferred from other hospitals; (9) A singlehanded, registrarless consultant radiologist, overloaded with routine work, regularly absent visiting other hospitals, and consequently usually unable to supervise vital radiographic examinations; (10) Too much do-it-yourself radiology.

Auditory screening of school children: fact or fallacy?

Dr E S Kerr (Haywards Heath, West Sussex) writes: I have read with interest the article on auditory screening of school children, by Dr Olga Nietupaka and Mr Nick Harding (6 March, p 717). I am very concerned that this might be taken as a typical service. It is well known that screening techniques vary considerably, even in the same authority, but I should like to feel that in most areas auditory screening is far more effective. In West Sussex a routine pure tone audiometry screening test is not done until 7 years—but at the $4\frac{1}{2}$ preschool medical examination or 5-year entrant examination a hearing for speech test is given to all children. One would expect otoscopy to be as much a part of the examination as listening with a stethoscope. Any failure at either of these examinations is referred to an intermediary hearing clinic.

Roadside resuscitation in freezing weather

Dr A J Pim (Nettlebed, Henley-on-Thames, Oxon RG9 5AJ) writes: I have just noticed the letter by Dr A Inglis (6 March, p 748) relating to gelling of Haemaccel in cold weather. I have been very concerned at the temperature of an infusion under such conditions because many of us in accident schemes carry our infusion liquid in our cars all the time, and I cannot believe that it is really satisfactory to transfuse low temperature liquids. At the Peebles Basics Symposium last year I tried to interest one of the exhibitors in the idea of producing some sort of thermostatically controlled container. In the meantime one has to hope that a heated ambulance with warm Haemaccel is at the scene.

Removable subcuticular skin suture in acute appendicitis: a prospective comparative clinical trial

Sir Reginald Murley (London W1N 1DF) writes: I fully support Mr G B Hopkinson and Mr B R Bullen (20 March, p 869) in their advocacy of subcuticular sutures in potentially infected wounds. I started using subcuticular nylon for skin closure in patients with acute appendicitis in 1948 and have continued this practice ever since. As the authors of this short report aver, there is no difficulty in withdrawing part of such a suture should wound infection occur. I agree with them too that Prolene is now more suitable than nylon and that Dexon is unsatisfactory. One of my former registrars, Mr B J Britton (now a consultant surgeon in Oxford), undertook a trial of Dexon some years ago and expressed dissatisfaction because of the not infrequent inflammatory reaction to it.

It has been my custom to use removable subcuticular sutures for the abdominal skin and many other sites (including incisions for vein and arterial surgery) for many years past. I see no reason to revert to interrupted stitches other than at those sites on the face and neck when skin sutures are removed after two or three days.

Deferring parity in GP partnerships

Dr Graham M Hunter (Tamarisk Lodge Surgery, Bexhill on Sea, East Sussex) writes: I read Dr J D Wigdahl's letter (27 March, p 985) with interest, but parity in general practice is an ethereal concept. Indeed, I regard parity and even the laws governing medical partnership as archaic. Doctors can start working towards the goal of parity and maybe reach it only to find that parity in income does not equal parity in work load, and, though earning an equal share, he finds he is doing more than his share of the work.

I too have been through this treadmill and have found the process unsatisfactory. I resolved that when I was in charge a different system must prevail. Almost all practice disagreements are about money, so I evolved a plan that after the shared expenses of the practice had been paid each doctor should receive exactly what he earned.

After an initial few weeks to ensure compatability a new doctor would receive exactly what he earned; thus he could do as much as he wished and work as fast or as slow as he wanted and have as large a list as he required. Any extra money from hospital posts or factory work went to him alone. If he did the work he received the income.

Doctors' interests and, indeed, financial requirements vary over the years and this scheme allows flexibility. It has always seemed wrong to me that a senior doctor should live off his junior partners and particularly wrong that he should take advantage of the present scarcity of general practice posts.

Burst abdomen and incisional hernia

Mr Robin Burkitt (Farnham Common, Bucks) writes: I was interested to read your recent article from the Westminster Hospital (27 March, p 931). Very many years ago my then chief told me that he had recently met a surgeon from one of the South American republics who had an enormous experience of knife injuries. He was surprised to find that those who had their bellies slashed from side to side did very much better than those who were slashed from above down. This was quite contrary to general teaching in those days, but I was most impressed, and throughout my subsequent surgical career have always taken the greatest pains to avoid vertical abdominal incisions whenever possible.

As a result of this—I think as a result—burst abdomens and incisional hernias bothered me very little. Please do not think I am boasting. I probably made up for it by having far more of other complications, but I am just stating a fact. Shortly before retiring I reviewed 400 patients who had had biliary surgery on my unit and who had been explored through a subcostal incision. There was only one burst abdomen, and one incisional hernia—both in the same patient, who had had a massive postoperative haemorrhage into his abdominal wall. I have never been convinced that the type of suture material or the method of suturing makes all that difference. I may be wrong.

Consultants and their future

Dr V James (National Blood Transfusion Service, Regional Transfusion Centre, Sheffield S5 7JN) writes: Why do politicians write as they speak? What does "really takes the biscuit" (27 March, p 984) mean? Such emotional language should not be used even in letters in a scientific publication. What most of us would like to know is how much expert advice was rejected by the Select Committee. Perhaps Mrs Renée Short could enlighten us?

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