We are not told whether any weight change occurred with treatment of acromegaly during the study or whether the patients, particularly those said to have abnormal glucose tolerance at the outset, were advised to make any prudent dietary changes. No specific information is given on individual relationships between glucose tolerance and growth hormone values and it is not therefore clear whether these would be expected to vary inversely or directly with SMS 201-995 treatment. Does better growth hormone suppression imply better insulin suppression?

This study addresses an important question in relation to a novel treatment which may find widespread clinical use in the management of acromegaly but does not present the information necessary to support the authors' favourable conclusion.

K C McHARDY

University Medical Buildings,
Aberdeen AB9 2ZD

D W M PEARSON

Diabetic Clinic,
Woolmanhill,
Aberdeen

AUTHORS' REPLY.—Drs McHardy and Pearson ask for additional information about our study (22 November, p 1327). Glucose tolerance measured by means of an individually standardised breakfast containing at least 75 g of carbohydrate, 50 g of fat, and 25 g of protein¹ formed the basis of the classification of patients into those with normal and those with impaired tolerance using the World Health Organisation's criteria.² In those patients in whom formal oral glucose tolerance tests were performed shortly before the start of the study an identical classification was reached as based on the breakfast test. No relation existed between an individual's glucose tolerance and height of growth hormone values. Suppression of growth hormone induced by SMS 201-995 was identical in both groups of patients and not correlated to the concomitant suppression of insulin.

As pointed out in the discussion, the overall effect of the somatostatin analogue on glucose tolerance in acromegaly is brought about by a balance between its effects on the digestive process itself, on insulin, and on growth hormone secretion. We feel that monitoring glucose tolerance under these circumstances by a standardised meal test procedure is practical and to be recommended.

L VERSCHOOR
S W J LAMBERTS
P UITTERLINDEN
E DEL POZO

Department of Medicine,
Division of Clinical Endocrinology,
Dijkzigt Hospital,
3015 GD Rotterdam, The Netherlands

- 1 Lamberts SWJ, Uitterlinden P, Verschoor L, van Dongen KJ, del Pozo E. Long term treatment of acromegaly with the somatostatin analogue SMS 201-995. *N Engl J Med* 1985;313:1576-80.
- 2 WHO Expert Committee on Diabetes Mellitus. Second report. *WHO Tech Rep Ser* 1980;No 646:1-80.

A limited role for manipulation?

SIR.—Professor Malcolm I V Jayson agrees that the evidence strongly supports the hypothesis that manipulation will cut short the time that a patient suffers from acute back pain.

Most studies that he quotes are based on hospital outpatient clinics and only one is based on general practice. Patients seen in hospital outpatient clinics are usually those with severe chronic back pain and represent only a very small proportion of those patients who suffer and lose work from this

symptom. If manipulation could reduce the period of time patients suffer from low back pain by, say, 25%, then they might be able to return to work more swiftly. In terms of a controlled clinical trial this is a relatively small treatment advantage, and one that is difficult to measure accurately without including a very large number of patients in a clinical study. However, in the context of the social and economic cost of back pain it could represent a 25% saving on a bill estimated at £250m in 1978. Such relatively small treatment advantages could in theory therefore subsidise a massive expansion of the rheumatological services that we now have available to us.

GEORGE LEWTH

Centre for the Study of Alternative Therapies,
Southampton SO1 2DG

SIR.—The three views of manual approaches to back trouble (6 December, p 1454, 1481, 1482) are a welcome improvement in the depth and breadth of the debate on this matter. However, methods of manipulation should be considered together with other aspects of management that practitioners apply; these may vary more widely than the manipulation itself.

As a representative of medically qualified osteopaths, I noted that, although Professor Jayson and Dr Grayson have taken part in academic meetings with our group, they remain unaware of the distinctive rationale of our practice on which the range of management options is based, manipulation being but one. Dr Grayson says that our course at the London College of Osteopathic Medicine aims at teaching "a whole new system of medicine." There is no basis for this divisive statement, and its repetition obstructs the benefits that might accrue from a synthesis of conventional and osteopathic views. Osteopathy addresses itself mainly to those musculoskeletal disorders in which symptoms and abnormal function cannot be causally related to structural disease, a notable example being most back pain presentations. The osteopathic working hypothesis is that these are mostly abnormalities of function induced by abnormal musculoskeletal stresses arising from intrinsic and extrinsic sources; it is not felt necessary to assume some covert structural disease of which muscle tension and other abnormalities are merely secondary effects. This concept of primary spinal dysfunction is not exclusive to osteopaths and has been proposed by eminent orthodox authorities.^{1,2}

It is not merely partisan pique for us to regret the neglect by orthodox authors of the concept of primary spinal dysfunction; patients are harmed thereby. Orthopaedic surgeons and rheumatologists, while admitting that a structural pathological basis cannot be substantiated for most back trouble, nevertheless apply some of the diagnoses (and treatments) that they find effective in the mainstream of their specialties. Thus non-steroidal anti-inflammatory drugs are often given to back pain sufferers on the assumption that inflammatory lesions are present; unfortunately the iatrogenic price is not offset by benefit above that obtainable with simple (and safer) analgesics.³ Surgery for structural lesions often fails to produce the expected benefit, especially when a causal link between lesion and symptoms has not been established. Clinicians would make these blunders less often if their conceptual repertoire included the possibility of primary spinal dysfunction—for which the management of a registered osteopath would be safer, including as it does the modification of the patient's body use, lifestyle, and perceptions, together with manipulative treatment where appropriate.

This therefore is not a "whole new system of medicine," but it could remedy a deficiency in contemporary medicine. When what is new arises within orthodoxy acceptance depends on merit, but incorporation of methods or ideas from outside may be delayed interminably by the problems of intergroup communication and credibility. Those doctors who have studied and practised osteopathy generally come to accept that its concept of primary symptomatic dysfunction is even more

important to medical progress than manipulation—useful though that is. Paradoxically their more orthodox colleagues may be prepared to accept the therapy "empirically" while refusing to examine its theoretical basis at all.

RODERIC MACDONALD

Honorary Secretary,
British Osteopathic Association

London College of Osteopathic Medicine,
London NW1 6QH

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- 2 Wood PHN. Understanding back pain. In: Jayson MIV, ed. *The lumbar spine and back pain*. 2nd ed. Tunbridge Wells: Pitman Medical, 1980.
- 3 Wiesel SW, Cuckler JM, Deluca F, Jones F, Zeide MS, Rothman RH. Acute low back pain. An objective analysis of conservative therapy. *Spine* 1980;5:324-30.

SIR.—Your three articles on spinal manipulation do not set out a very convincing case for benefit. Professor Malcolm I V Jayson alludes to the psychological benefit, and this is indeed important; patients equate strict bedrest with having nothing done and frequently will not accept that this may be best, insisting that something must be done. There is some magic in an x ray examination and much in the often dramatic manipulation.

It is partly because of this need to have something done and partly because rheumatology and orthopaedic waiting lists are so long that many patients find their way first to non-medical practitioners, and may there be both radiographed and manipulated, often under general anaesthetic. I and several of my colleagues here have seen people who have received such treatment for pain which has been shown later to be due to spinal metastases. Such cases undermine Mr Burton's contention that "these treatments seem likely to be safe in view of the practitioners' use of orthodox diagnostic procedures and of most patients' prior medical contact." Furthermore, it may be impossible for the victim of some catastrophic consequence of such a manipulation to claim damages, as there appears to be no requirement for non-medical practitioners to be insured.

It is therefore timely to remind doctors not only of the doubtful efficacy (Mr Burton's words) of manipulation but also of the potential for calamity. But who is warning the patients? Do they know of the risks? Manipulation may have a place in the medical management of back pain (and I ask our physiotherapists to manipulate now and then), but its place in the range of alternative medicine provided by non-medical practitioners is open to serious question. The treatments are often expensive. Should not the public be warned?

ANDREW BAMJI

Brook General Hospital,
London SE18 4LW

Prognosis for infants born at 23 to 28 weeks' gestation

SIR.—We welcome the article by Professor V Y H Yu and his colleagues (8 November, p 1200) on the prognosis of infants born at 23-28 weeks' gestation. As the expectations about the outcome of these extremely premature infants grow among both lay people and the medical profession the more important it becomes for perinatal centres to compile and report their results, looking at both the quantity and the quality of survival.

We have reviewed our own figures at the Glasgow Royal Maternity Hospital and find that during the three years 1983-5 45 neonates born at 23-28 weeks' gestation were admitted to the

neonatal unit; 18 of these infants had been born outside the hospital. While the overall survival rate was 47%, out of 17 normally formed infants born at 23-25 weeks' gestation only 2 (12%) survived. Both are so far neurodevelopmentally normal but one has severe bronchopulmonary dysplasia necessitating frequent admissions to hospital. The survival rate of 12% is in keeping with that of Professor Yu and his colleagues.

However, in Professor Yu's series half the survivors in the 23-25 weeks' gestation group were handicapped. There were no handicapped survivors in this group in our series, perhaps because of the small number of babies; but, even at 26 weeks' gestation, out of 13 normally formed infants admitted to our unit during the same period 9 survived, of whom 6 were handicapped.

We find these figures both worrying and disappointing. Intensive care of these extremely premature infants is demanding on resources and manpower and on the parents. However, the return is very poor, especially since the small number of survivors are at high risk of being handicapped.

We wonder whether the "routine" institution of intensive care is justified in babies born at 25 weeks' gestation or less. Caring for these babies is still very much at research level although many neonatal intensive care units offer it as a clinical service.

If intensive care is to be offered to these infants it should be on a research basis in properly funded units, thus avoiding the risk of precious resources being drained away from the needs of more mature infants, who have a much better prognosis given adequate treatment. Standardised long term follow up on a multicentre basis, as is happening in Scotland on a "one off basis" (Scottish perinatal study 1984), is essential if we are to determine whether our efforts in treating these babies are justified in this country.

C SKEOCH
P GALEA

Neonatal Department,
Glasgow Royal Maternity Hospital,
Glasgow G4 0NA

Acyclovir update

SIR,—Dr D J Jeffries states that this drug should not be prescribed when genital lesions have been established for several days (13 December, p 1523).

Primary genital herpetic infections, especially in women, are extremely unpredictable, and it has been my practice for some time to treat most primary infections in women with systemic therapy with acyclovir. Although it is difficult to prove, I am sure that treatment started even a few days after the onset of visible lesions often prevents the condition from progressing. The following examples illustrate some of the difficulties encountered.

A 23 year old woman presented with dysuria of four days' duration and was found to have a collection of about eight herpetic ulcers near the urethra and two or three at the fourchette. The cervix was normal and she had no systemic symptoms. It was decided to give her no antiviral treatment. Three days later she became ill with a headache, malaise, and fever and was admitted to hospital with a meningitis, which responded rapidly to treatment with intravenous acyclovir. At the same time she also had a great increase in the number of vulval lesions, though the cervix remained clinically normal.

A 19 year old girl presented with her first attack of genital herpes. Her symptoms were of mild dysuria, and examination showed four shallow vulval ulcers from which the virus was eventually grown. The cervix was entirely normal. It was decided not to give oral acyclovir. Four days later she also developed

a febrile illness with rigors, headache, and low abdominal pain. Examination showed mild neck stiffness but no clear signs suggesting meningeal disease. The vulval lesions were as before but the cervix was now severely ulcerated and covered with a thick white coagulum. Pelvic examination showed bilateral tenderness. Virus was cultured from the cervix. She made a rapid response to oral acyclovir, the cervix returning to normal within a week and all lesions having healed within two weeks.

It is this unpredictability of herpetic infection in women which I think should at least merit the consideration of systemic treatment with acyclovir even if the disease has been present for two or three days.

J K OATES

Department of Genitourinary Medicine,
Addenbrooke's Hospital,
Cambridge CB2 2QQ

SIR,—We were interested to read Dr D J Jeffries's leading article but were concerned about possible misinterpretation of the use of oral acyclovir in the ocular complications of ophthalmic zoster.

The paper cited¹ describes a decreased incidence of dendritic keratopathy, stromal keratitis, and anterior uveitis among those taking oral acyclovir over that in the placebo group. Cases of severe ocular inflammation at presentation were excluded from the trial, and those in the trial who subsequently acquired major disease were treated with topical or systemic steroids. The number excluded and the criteria for treatment were not given. On this evidence oral acyclovir may modify the incidence of ocular complications, but it cannot prevent and control them all. "Treatment in general practice" is unlikely to be safe.

In our experience acyclovir alone is not sufficient to handle such severe ocular complications as scleritis, disciform keratitis, and hypertensive uveitis. Indeed, many patients have presented at our clinic over the past two years with preventable corneal scarring and eye damage because acyclovir has been continued and topical steroids mistakenly withheld.

M COOPER
R J MARSH

Moorefields Eye Hospital,
London EC1V 2PD

1 Cobo LM, Foulks GN, Liesegang T. Oral acyclovir in the treatment of acute herpes zoster ophthalmicus. *Ophthalmology* 1986;93:763-70.

Doctors' double standards on alcohol

SIR,—Dr Fiona Adshead's and Professor Antony Clare's leading article on the alcohol problems of the profession will no doubt be read by many for whom the stated facts are individually appropriate.

I recently decided, as an exercise, to stop all alcohol for a month (ending, incidentally, just in time for the main Christmas festivities). This has been relatively easily achieved, certainly in comparison with stopping smoking, but the main problem has been to find a suitable substitute. Henries (orange juice and lemonade) and Clementines (bitter lemon and tonic) are all very well, but a delicious steak washed down with Chateau Gloucester Apple Juice or non-alcoholic wine is pretty hard to bear. This complete absence of equivalents in social life, combined with the pressure of TV and paper advertising, make the total abstainer's lot a trying one indeed at the outset—hence the wisdom of completely eliminating alcohol at lunchtime meetings and even a closed bar in postgraduate centres between 12 and 2 pm. However, until some socially accepted alternative range of soft drinks is found this is unlikely to happen.

The concept of "unit drinking" is an excellent one and this elimination of lunchtime units would make the weekly targets so much easier to achieve. It would be a kindness to try to help those attempting to overcome this addiction if these suggestions were tried.

G MATHERS

Taynton,
Gloucestershire

SIR,—Deans and most clinical students at least will agree with Dr Fiona Adshead and Professor Antony W Clare (20-27 December, p 1590) that students (not just medical students) drink too much; so also do housewives and many others. But attitudes are changing among medical students. Contrary to the impression your leader writers gained from the recent portrayal of selection (in which no beer swillers featured) and initiation into medical school life (in which beer did figure), the students themselves felt that the impression given was so unrepresentative and unfortunate with respect to drinking that they readily agreed to drop the freshers' week pub crawl on this and succeeding years. There is a bar in the medical school club for staff and students (as in most university colleges), but it is closed at lunch time.

I and the director of our occupational health service have for several years waged a steady if slow war against excessive, generally simply exuberant, drinking because it clearly can be the beginning of an unprofessional habit. We are glad that you are joining us but hope that this does not mean the end of invitations to the most hospitable *BMJ* Christmas party...

PETER RICHARDS
Dean

St Mary's Hospital Medical School,
London W2 1PG

** At which, in the spirit of our leading article, we "consistently and readily provide soft drinks." — ED, *BMJ*.

Doctors as nutrition educators?

SIR,—Efforts to foster the current upsurge in medical interest in nutrition are both timely and commendable. Well displayed and appropriately pitched, quizzes can provide an attractive and even compulsive means of increasing useful knowledge and interest in a subject.

We feel, however, that the recent series by Margaret B Clark, Elizabeth M Evans, and Margaret B Hamilton (11 October, p 928; 18 October, p 998; 6 December, p 1480; 13 December, p 1542) will have done little either to educate or to encourage those initially motivated to try these question and answer sets. Some topics are of questionable relevance and several answers are so brief as to be meaningless without further explanation. The descriptions of the recommendations of the National Advisory Committee on Nutrition Education and Committee on Medical Aspects of Food Policy are reasonable but one wonders how the doctor's ability to impart nutritional advice will be enhanced by the knowledge that walnut oil is a rich source of polyunsaturated fatty acids or that every cow should not carry a government health warning. Despite the suggestion at the end of part I that all those scoring less than 100% should discuss their failures with their dietitian or nutritionist, we cannot believe that more than a few dietitians with peculiarly restricted and destructively dogmatic viewpoints could be expected to concur with the answers of the authors.

Puffed wheat is said to be "a more effective" source of dietary fibre than Corn Flakes, Rice Crispies, or All-Bran without any hint of what is