junction.¹ The serum ferritin concentration in the remaining eight patients ranged from 19 to 251 µg/l and they had not received any abnormal amounts of blood transfusion. Large joints were not affected in these patients. Six of the 10 patients had evidence of renal osteodystrophy and underwent parathyroidectomy.

We concur with Dr N R Cary and coworkers (29 November, p 1392) that amyloid deposits are a feature of carpal tunnel syndrome in patients undergoing regular haemodialysis treatment and are related to β_2 microglobulin accumulation. However, we did not observe iron overload in these patients. We wonder whether the haemosiderin deposits they found in the synovial tissue of joints could result from minor haemorrhages for mechanical reasons in these susceptible patients.

R AHMAD
T HELLIWELL
F H BEDDOW
A DAVENPORT

Renal Unit,
Royal Liverpool Hospital,
Liverpool L7 8XP

1 Ahmad R, Ackrill P, Day JP, et al. Reversal of osteomalacia in chronic dialysis patients with heavy iron and aluminium loading. *Mineral Electrolyte Metabolism* 1985;11:1.

Day surgery: does it add to or replace inpatient surgery?

SIR,—To answer Dr E A Howarth's and Dr R Balarajan's question (10 January, p 133), it is self evident that if day surgery is set up as a unit in addition to the existing facilities then it will add to them. Should a day unit be set up with a calculated removal of inpatient facilities then it will replace them.

The Kingston day unit was set up in addition to existing facilities so it was bound to result in a greater total volume of work. This reflects only the huge unmet need, which is pressing at all times. Surgeons live with this every day. Although the authors say "The critical or irreducible surgical rate for a given population is not known," it would seem to many of us that we live with a basic critical level all the time. They go on to show that the New York level of provision is over twice that in England and Wales. Even if New York is over-provided by 10%, 20%, or even 30% that still leaves us significantly underprovided, whatever the politicians may claim. We do not seek over-provision of facilities and surgeons but just ask that they be adequate.

Of course we could, and should, change to treating more patients in day case units but even if these facilities are additional they will barely get us above the present disgraceful level of provision in surgery.

BRIAN HOGGIN

Brighton General Hospital,
Brighton BN2 3EW

Macrocytic anaemia in patients treated with sulphasalazine for rheumatoid arthritis

SIR,—We note that the seven patients of Dr P J Prowse and colleagues who developed macrocytosis were from a group of 50 receiving sulphasalazine for progressive erosive rheumatoid disease. The authors infer from the data presented that the development of macrocytic anaemia due to sulphasalazine therapy in this situation is therefore quite common. We do not, however, think that this conclusion is entirely justified from their data.

Of the seven cases described, four had an important potential cause of folate deficiency quite

separate from sulphasalazine therapy. Thus one had malabsorption with bacterial overgrowth, a second coeliac disease, a third a "poor diet," and a fourth chronic haemolysis. In none of these patients can sulphasalazine be concluded to be the cause of macrocytosis. Of the other three patients reported, none appeared to have undergone bone marrow examination, and therefore megaloblastic anaemia was not confirmed. Also the increase in mean corpuscular volume while taking sulphasalazine was at most modest in one of the subjects (case 7). In all three cases the red cell folate value was below the lower limit of normal, but no data were given on red cell folate before sulphasalazine therapy. Modest increases in mean cell volume in the absence of folate deficiency have been reported in patients with rheumatoid arthritis taking sulphasalazine¹ and we have seen a number of cases in which a modest increase in mean cell volume occurred during sulphasalazine therapy, with a subsequent spontaneous fall and no evidence of folate deficiency or haemolysis.

The data presented are not adequate to justify a diagnosis of sulphasalazine induced folate deficiency in most of these patients. Indeed our own experience in 350 patients would suggest that this is an uncommon complication of sulphasalazine treatment in rheumatoid arthritis. The authors correctly point out that sulphasalazine need not be discontinued if anaemia occurs, but we would suggest from their data that a more reasonable conclusion would be that macrocytic anaemia occurring during sulphasalazine therapy should trigger a search for some other cause of folate deficiency.

M GREAVES

Department of Haematology,
Royal Hallamshire Hospital,
Sheffield S10 2JF

R S AMOS
DEBORAH BAX

Department of Rheumatology,
Nether Edge Hospital,
Sheffield S11 9EL

1 Grindulis KA, McConkey B. Does sulphasalazine cause folate deficiency in rheumatoid arthritis? *Scand J Rheum* 1985;14: 265-70.

The debasing of medicine in the Soviet Union

SIR,—Dr Stewart Britten may be sincere when he says he is against sin (17 January, p 180) but unlike the Royal College of Psychiatrists he does not see it when it occurs. He insinuates that the royal college has been guilty of "coercing" the Russian people, and his intellectual gymnastics complete a 180° turn by complaining that we should not fête released dissidents because this would serve as a "disincentive" in granting exit visas to other dissidents.

No doubt Dr Britten would not occupy his present post as honorary secretary of the UK/USSR Medical Exchange Programme if he did not, on occasion, release a defensive smoke screen about the situation in the Soviet Union. Psychiatric detention as a means of political repression is a proved fact quite irrespective of whether the "patient" is mentally completely normal or whether he shows mental abnormalities: even in the latter case the decisive factor is the expression of views unacceptable to the Soviet establishment.

The views of ordinary Soviet psychiatrists are totally immaterial as far as the practice of this type of abuse is concerned. They have no voice in formulating psychiatric policies let alone policies entailing political decisions. Their views probably encompass the whole range from strong secret disapproval to uncritical acceptance of these

practices. What is relevant is that we cannot meet ordinary Soviet psychiatrists unless they are chosen by the staff of the Soviet embassy in London. This was made very clear to the royal college when this question was discussed with a representative of the Soviet embassy.

I hope Mr Britten's sanguine view of better times to come is based on something more relevant than the publication of infant mortality figures. What concerns us psychiatrists and, I am sure, many other doctors is, for instance, the continued detention of Dr Anatoly Koryagin in conditions of the utmost severity in a labour camp for no reason other than his insistence on drawing attention to the existence of psychiatric abuse as a means of political repression. His psychiatric reports on specific cases are in the possession of the Royal College of Psychiatrists and show a perversion of a humane discipline that was surpassed only by the fascist dictatorship in Germany. Dr Britten's letter would have carried at least a grain of conviction if he had, for instance, joined the royal college in its insistent demands for Dr Koryagin's immediate release.

G A LOW-BEER

Horton Hospital,
Epsom, Surrey KT19 8PZ

The increase in molluscum contagiosum

SIR,—Dr J D Oriel brings to our attention the increase in the incidence of molluscum contagiosum (10 January, p 74). I would like to add a few points about its management.

Identification of the lesions is not as easy as it may seem, and they are often mistaken for condylomata acuminata. When a patient presents with lesions of molluscum contagiosum in a busy clinic their removal will probably be time consuming, each one needing to be removed individually.

The standard descriptions mention phenol, but this might be considered unsafe, especially if the operator's hands are unsteady. Tincture of iodine introduced into the tumour with the pointed end of a wooden stick is probably safer.¹ The removal of the lesions is usually done in the outpatient department with the operator having to press on the lesion with his thumb nail, usually ungloved (in fact they are not easy to remove in gloves). There is usually some oozing of blood. In homosexuals molluscum contagiosum is often found on the face and around the natal cleft. The lesions are often worse and more widespread in individuals who are infected with the human immunodeficiency virus,² who are often also positive for hepatitis B surface antigen. Is it not about time that physicians' standard procedures in the treatment of this condition were reconsidered?

M A WAUGH

Department of Genitourinary Medicine,
The General Infirmary,
Leeds LS1 3EX

1 Radcliffe-Crocker H. *Molluscum contagiosum in disease of the skin*. London: H K Lewis, 1903:674-82.

2 Farthing CF, Brown SE, Staughton RCD, Cream JJ, Mühlemann M. *A Colour atlas of AIDS*. London: Wolfe Medical Publications, 1986:66.

Prognosis for infants born at 23 to 28 weeks' gestation

SIR,—The question raised by Drs C Skeoh and P Galea (17 January, p 178) is obviously relevant in these straitened times. I must, however, confess to some unease at the recent debates concerning what amounts to selective non-treatment of extremely low birthweight infants.

My main concern is that the human reality represented in the bald figures sometimes escapes our notice in such debates. That it is better to be dead than handicapped is not obvious. It is, however, a necessary assumption if one is to justify not treating infants because some of the survivors will have varying degrees of handicap. If this assumption is to underlie public policy—for example, in a weight or gestation limit for the initiation of neonatal intensive care—many infants will die who would have survived intact and many will die who would have survived with varying degrees of handicap. Using the figures of Professor V Y H Yu and others (8 November, p 1200), to avoid each additional handicapped survivor in the 23-25 week group we would allow one infant who would otherwise have survived without handicap to die (assuming a 42% handicap rate in survivors and 100% mortality in those not treated). As the accurate assessment of gestation in such infants is difficult, many errors will be made, especially as such decisions are often made by junior obstetric and paediatric staff. There are always those infants who do not oblige by dying quickly and who are then either subjected to a prolonged period of distress until death or changed to aggressive management after a period of suboptimal care.

The definition of handicap used by Professor Yu and his colleagues is conventional and covers a wide range of disability, from those with mild cerebral palsy attending normal school to those with profound mental and physical handicap and little prospect of meaningful human contact. At which point on this continuum is one better off dead? As medical practitioners we are morally obliged to act in the best interest of our patients, in this case the child. We must surely then attempt to make such a judgment in each individual case and use this in deciding when we have reached the point at which we are "striving officiously..."

It is not possible to predict outcome on day 1 in the individual infant. The picture becomes clearer in the next day or so, as shown by Professor Yu and colleagues. It is a more difficult decision to withdraw established treatment, but this policy has many advantages. One has the advantage of a far better relationship with parents and a clearer understanding of the outlook for the infant. The practice of not initiating treatment results in these decisions being made at delivery by junior staff, at a time when the family have had no real opportunity to grasp the issues, as is surely their right. Senior staff with an established relationship can provide far better support for the family, both at the time and after the death of the infant, should this be the decision.

There is no reason to believe that the prognosis for these infants will not further improve. It will not improve if we do not treat them. Medical resources are not infinite, but it is clear that in Britain we are entitled to expect more than is currently provided. Let us at least consider the human impact of our decisions.

ANDREW WATKINS

Regional Neonatal Intensive Care Unit,
Liverpool Maternity Hospital,
Liverpool L7 7BN

A new health region for London?

SIR,—Dr A K Thould's letter on the possibility of a new health region for London (17 January, p 181) offers a tantalising solution to the constant problems which beset the outer parts of the Thames regions. There can be no doubt that the division of the city and home counties into the four Thames regions has been a disaster for both parties.

The peripheral parts of the regions continue to

be drained of resources because of the way that RAWP has been applied to the London districts, while these same districts maintain a centripetal myopia. The boundary between South East and South West Thames regions provides an entirely artificial barrier between parts of Sussex. The logical provision of services on either side of this boundary is constantly hindered.

Dr Thould's suggestion should be taken most seriously. The South East Thames Regional Health Authority has already signalled the logic of a south coast regional health authority by moving its offices from Croydon to Bexhill on Sea. This would provide an ideal focus for a region covering west and east Sussex, Kent, and parts of Surrey. Serious consideration should be given to this proposal.

NIGEL KIRKHAM

Department of Pathology,
Royal Sussex County Hospital,
Brighton BN2 5BF

How much should private medicine cost?

SIR,—At frequent intervals we hear from the medical provident societies that subscriptions are to be increased. This is usually accompanied by publicity in the medical press asking that consultants do not increase their fees to patients. Perhaps before losing too much sleep over this matter your readers would be interested to hear my own recent experience.

I had to undergo an arthroscopic operation. The inpatient stay for this was under 24 hours but did not include overnight accommodation. The time spent in the operating theatre was about one hour. The fee, excluding any charges from the medical staff, was £2050. When submitting the account to my insurers I did write to say that I wondered if there was a mistake but received only an acknowledgement to say that the sum had been paid. Is it the provident associations or ourselves who have a wrong sense of priorities?

M G WRIGHT

Beckenham, Kent BR3 2RP

Death in the clouds

SIR,—Some reply is required to Mr Richard Wakeford's article (20-27 December, p 1642) and to the letter by Drs P J C Chapman and D A Chamberlain (17 January, p 181).

Firstly, the cabin crew in British Airways are highly trained in first aid and resuscitation and do not rely "on the chance presence of a doctor to deal with the more serious emergencies." Indeed, the presence of such a doctor, if he is skilled in such matters, is a bonus and we were very grateful for the help given by Mr Wakeford and an American doctor on this sad occasion, and both have been thanked for their efforts.

However, I must say that the cabin crew concerned performed well beyond the normal call of duty. Indeed, the unfortunate passenger was first thought to have suffered from some form of food poisoning—although he had not eaten on board. Additionally, he was very dehydrated and it was thought he might be suffering from a diabetic condition. Because he lapsed into unconsciousness the captain came back to assess the situation and decide whether to divert to Gander or return to Heathrow. Shortly afterwards the patient collapsed. The two cabin crew members were able to give him cardiopulmonary resuscitation and some recovery was noted. Sadly, he later collapsed and died.

We have looked carefully at the use of in flight defibrillators, as advocated by Drs Chapman and

Chamberlain. We believe that to be competent in the use of these you have to be in constant practice, dealing with real emergency cases, and that an itinerant doctor would certainly not be competent to deal with such equipment at first sight on an aircraft.

At present we are looking at three ways of improving medical training for cabin crew and the facilities aboard aircraft. Firstly, we are looking at extended medical training for selected cabin crew members; secondly, we intend to fit cardiac monitors which can be telemetered via an in flight telephone system and satellite to our consultant cardiologist; and, thirdly, we are revising first aid kits in keeping with these changes.

FRANK S PRESTON

British Airways Medical Service,
London (Heathrow) Airport,
Middlesex TW6 2JA

Vaccine related poliomyelitis in non-immunised relatives and household contacts

SIR,—Dr D E Bateman and colleagues suggest that "non-immunised parents and household contacts of children receiving primary immunisation should be immunised against poliomyelitis at the same time as their children" (17 January, p 170). They present a logical case for a policy which is similar to that advocated by the DHSS.¹ However, is the policy practical and is it desirable?

Polio vaccination began in 1956 and from its outset had a high rate of uptake. We can expect 80-90% of parents to have completed a primary course. Experience in clinics is that most mothers assume they have been immunised but few are certain and hardly any can produce documentation. How many doctors can lay their hands on their own immunisation records? We are at least a decade away from the time when children who now have computerised immunisation records will have children themselves. So, apart from a few families where grandmother is known to have vetoed all immunisation, it is almost impossible to identify the 10% of parents who are unprotected. This is one reason why most child health clinics ignore the DHSS recommendations and would find the policy unworkable.

To ensure universal protection would require offering polio drops to every parent and household contact, most of whom would already be immune. Aside from considerations of finance and administration such a blanket policy would not be without morbidity. Vaccine induced polio is a rare but inevitable consequence of mass immunisation, and immunising those not at risk should not be done lightly.

ANGUS NICOLL

Department of Child Health,
University Hospital,
Nottingham NG7 2UH

¹ Department of Health and Social Security. *Immunisation against infectious disease*. London: DHSS, 1984:27.

Correction

Association between liberalisation of Scotland's liquor licensing laws and admissions for self poisoning

An error occurred in this letter by Drs S P Lockhart and J H Baron (10 January, p 116). The χ^2 value should have read 4.3, not 43; the associated p value and the conclusion remain correct.