suggest that they are at high risk of developing leptospirosis, the remarkably low incidence of the disease in such communes argues to the contrary. The clustering of so many cases in the commune, the finding of only a moderate rise in the temperature at the centre of a meatball cooked on a hot plate,[2] and the very peculiar interaction of the index case with the commune strongly suggested that food was the common source.

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1 Sanford JP. Leptospirosis. In: Petersdorf RG *et al*, eds. *Harrison's principles of internal medicine*. New York: McGraw Hill, 1983:1048-51.
2 Pardisi F, Bartoloni A, Aquilini D. Is fast food toxo food? *N Engl J Med* 1985;313:1092.

Immunoscintigraphy of metastases with radiolabelled human antibodies

SIR,—Dr F Al-Azzawi and coworkers (28 February, p 546) comment that the dose of antibody that they used (700 μg) was far below that normally used for immunoscintigraphy with rodent antibodies. We have had considerable experience of monoclonal antibody imaging over the past five years and have successfully identified tumour sites using 200 μg of murine monoclonal antibody radiolabelled with 1·5 mCi iodine-131.[1,2]

We would like to point out that the physical characteristics and quantity of the radiolabel used have at least as great an influence on image quality as the quantity of antibody used and that the dose of iodine-131 used in the report by Dr Al-Azzawi and coworkers (1·5 mCi) is similar to that used in most immunoscintigraphy studies.[3,4] The use of human monoclonal antibodies may well allow smaller doses of protein to be used for immunoscintigraphy, but the authors' report does not show this.

Furthermore, we believe that the authors have understated the importance of this work. The production of a human antitumour monoclonal antibody may have considerable implications not only for tumour imaging but also for antibody directed tumour treatment.

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1 Farrands PA, Perkins AC, Pimm MV, *et al*. Radioimmunodetection of human colorectal cancers by an anti-tumour monoclonal antibody. *Lancet* 1982;ii:397-400.
2 Ballantyne KC, Perkins AC, Pimm MV, *et al*. Localization of monoclonal antibody-drug conjugate 791T/36-methotrexate in colorectal cancer. *Br J Surg* 1986;73:506.
3 Berche C, Mach J-P, Lumbroso J-D, *et al*. Tomoscintigraphy for detecting gastrointestinal and medullary thyroid cancers; first clinical results using radiolabelled monoclonal antibodies against carcinoembryonic antigen. *Br Med J* 1982;285:1447-51.
4 Epenetos AA, Britton KE, Mather S, *et al*. Targeting of iodine-123 labelled tumour associated monoclonal antibodies to ovarian, breast and gastrointestinal tumours. *Lancet* 1982;ii:999-1004.

Late abortions

SIR,—After the Bishop of Birmingham's bill and the case of C *v* S Dr Peter Bromwich's article (28 February, p 527) is well timed. He suggests that the lowering of the limit to 24 weeks would prevent abortions for severe fetal defects, but there is a widely used solution to the problem of late diagnosis of fetal abnormality.

Take the case of babies with Potter's syndrome or anencephaly who are diagnosed by ultrasound examination at 32 weeks' gestation. The mothers are informed that the babies will survive for only a short while after birth. It can be said that such babies are capable of being born alive but are not viable. Many mothers in these unfortunate circumstances express a desire to end the pregnancy, thereby foregoing eight weeks of carrying a doomed baby. It is widespread practice to offer these patients induction of labour to end the agony, especially as such babies are likely to die more quickly with the added burden of prematurity. I have to admit that this is termination of pregnancy but is it abortion or child destruction?

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Points

AIDS and intravenous drug use

Dr D J GOLDBERG (Ruchill Hospital, Glasgow G20 9NB) writes: I wonder if Dr Peter J W Wood's beliefs that drug misusers "have encountered few if any barriers in obtaining needles and syringes" and that "in many areas of the country needles and syringes may be bought from chemists" (28 February, p 571) are true of the whole country. Because of the number of intravenous drug users in Glasgow (5000-10 000) 39 pharmacies throughout Glasgow were studied to determine the availability of needles and syringes. Pharmacies were classified as being in areas with a large population of intravenous drug users (A), an intermediate population (B), or a low population (C). When the pharmacists were asked whether they sold needles and syringes, four in group A replied yes and 15 no; none in group B replied yes and 11 no, and six in group C replied yes and three no. Only 16% of the pharmacies were prepared to sell needles and syringes in areas considered to have large populations of intravenous drug users, and indeed many of these areas had no retail source of needles and syringes whatsoever. Of those prepared to sell, most did so reluctantly, and usually only diabetic syringes (often unacceptable to drug users because of the size of the barrel and needle) were available.

Child abuse

Dr GERALDINE R BOOCOCK (Bury, Lancashire BL0 9RZ) writes: I disagree with Dr Bernard Valman (7 March, p 633) on one point: when a child with a fairly minor injury is examined from top to toe by a paediatrician and then admitted to hospital the reason is usually only too clear to the parents. The relationship between the doctor and parents in cases of suspected child abuse is at best a delicate one, and failure to explain the real reason for admission at an early stage can destroy it completely. Diagnosis of abuse is not an end in itself but is usually the starting point of work with the family. This will fail unless a policy of frankness and open discussion is pursued from the start.

Syringe driver in terminal care

Dr D SNADDEN (Beauly, Inverness-shire IV4 7DT) writes: The rural practice in which I work has recently acquired two Graseby MS 26 syringe drivers, which have revolutionised our ability to provide adequate relief from the symptoms of nausea and pain normally associated with terminal disease and enabled us to keep patients comfortable at home who might otherwise have ended up in hospital. The days of patients experiencing breakthrough pain while waiting for the doctor or district nurse to drive 10 miles to give them a pain relieving injection are now gone. We have found the MS 26 series syringe drivers to be extremely well suited to terminal care in general practice. They are convenient to use, as Dr Simon B Dover pointed out (28 February, p 553), and seem very robust and reliable. Having experimented with various combinations of antiemetics and diamorphine, we have found the most popular mixture to be that of metoclopramide and diamorphine. I would urge all practitioners interested in terminal care to consider acquiring such a machine. This is the sort of venture that communities can easily be persuaded to donate the right sort of funds for.

The elusive orthopaedic senior house officer

Dr J K ANAND (Peterborough Health Authority, Peterborough PE1 1LN) writes: With reference to the shortage of orthopaedic senior house officers (14 March, p 70), in the short term we ought to tap the sizable European Community reservoir, particularly as doctors from European Community countries are acceptable here and experience few registration problems. In Peterborough Health Authority we have recruited doctors from Holland, as have other health authorities. Similarly, in long term planning we should consider the medical manpower needs of the European Community as a whole, bearing in mind the fact that a fully trained doctor has a professional lifespan of 30 years or more. We should be prepared to reduce and expand the intakes of medical schools throughout the European Community from time to time in order to balance demand and supply.

Poor start for the Health Education Authority

Dr C F DONOVAN (Temple Fortune Health Centre, London NW11 7TE) writes: At a time when, like Dr Richard Smith (14 March, p 664), many in the profession are taking a more realistic view of prevention and health promotion should we not be asking what has happened to the old Health Education Council and why? Unless those who believe in a health rather than a sickness service raise their voices to express their anxiety it could be that the old council will quietly be taken over by people more interested in propaganda and politics than the highly professional activity of health education, and much of the skill developed over the years could be lost. The Health Education Council had a primary care advisory working party, which evolved from the old general practitioner working party that I chaired for several years. It is to be hoped that the new authority will continue some system whereby those who work in primary care may not only advise but also help to plan campaigns such as those on heroin abuse and the acquired immune deficiency syndrome. Experience of such campaigns shows that there is a danger not only of poor evaluation but also of failure to realise that it is necessary to inform and help those working at the "coal face" at the same time as putting out national messages. I hope that the new health authority will realise these needs, but why the long silence? Why not more consultation in the setting up of the authority? Dr Smith has shown us the way. Those of us who feel anxieties should voice them now before it is too late.

Corrections

Osteoporosis: cause and management

We regret that an error occurred in this letter by Mr A W Fowler (14 March, p 701). The end of the first sentence in the second paragraph should have read: "that osteoporosis related to age is an atrophy of bone caused by disuse" (not "disease").

Why doctors must grapple with health economics

We regret that a printing error occurred in this letter by Dr R A Storring (21 March, p 769). The second sentence should have read: "Mr Appleby ... seems to be unaware of the role of the clinician" (not "children").