also by their total inability to inform them of this communication gap, let alone to tune in on the same wavelength as the doctor.

It was Isocrates who once said, "The proper use of language (speech) is the most substantial index of sound thinking." Is there no way of comparing a minimum standard of expressive speech with a clinical test of oratorical competence? This is remarkable when one realises that it is necessary to pass the asessment of spoken English to become an American citizen. Our medical schools and universities so obviously concentrate on the written word that it is difficult to convince them of their one eyed view. The aim of our modern education system is to achieve a competent standard of written composition culminating in that peak of eminent scholarship, the Civil Service memorandum, which every bureaucrat can read and act on. Nowadays there is a great danger that doctors will retreat behind laboratory doors and treat patients only by automatic responses to programmed instructions. There is an astonishing vitality to speech which adds an extra dimension to the power of the spoken word to affect the listener for good or ill. It is this dynamic aspect of speech that chills the heart of every candidate and examiner in the viva voce. In my opinion the examiners of PLAB and the Royal College of General Practitioners are shirking their responsibility to patients.

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Child abuse

The child abuse controversy (16 July, p 190) is beginning to reflect discredit on medical practice. Parents are increasingly terrified of the possible implications of their child being examined by a doctor. This situation is now exacerbated by the assertions of Lord Justice Butler-Sloss and the Department of Health and Social Security report that reflex anal dilatation is abnormal, requires follow up, may or may not be pathognomonic of child sexual abuse, and should raise suspicion.

Anyone who inspects a child's anus needs to know urgently whether physical signs exist that justify the label of anal sexual abuse. The situation is ludicrous—a physical sign which has major implications in one district is regarded as totally unimportant in another. One general practitioner mother said she could elicit the sign while inspecting her own children's bottoms for threadworms.

Some paediatricians have implied that anal dilatation in a child means that large objects have been pushed in from the outside. Coloproctologists like myself point to the enormous size of stool in a small child relative to the size of the child and to the ease with which the normal rectoanal inhibitory reflex may be triggered in children, particularly if a stool is present in the rectum. The internal sphincter is, after all, the lowest part of the gut muscle, and reflex anal dilatation is the most distal component of normal peristalsis.

My anxiety at the beginning of the Cleveland inquiry, now reinforced by as much investigation as seems to be ethical, was that I had seen reflex anal dilatation from time to time in normal children who had not been abused. I discussed this with many of the country's leading coloproctologists and conducted the following survey among 51 specialists who attended two meetings of the Royal Society of Medicine. They were asked for their interpretation of the following: "You turn a child on to the left side, part the buttocks, and inspect the anus for 30 seconds. During this time the sphincters relax so that the rectal mucosa is visible—(*a*) the child has been the victim of anal sexual abuse; (*b*) it is the normal rectoanal inhibitory reflex and there is likely to be a stool in the rectum; (*c*) it occurs in pathological situations (listed)."

Forty two of the doctors had seen the phenomenon—16 only rarely and 26 on several or many occasions. Those who often see children had seen the sign most often. Only three considered that anal abuse was even a possible explanation, but they asserted that it also occurred in normal children and those with constipation and prolapse. Thirty three thought that it was entirely normal, and 30 thought that it was seen in arguably abnormal situations. Constipation was indicated as a cause by 22, prolapse by 21, and threadworms by three. Several thought that a rectal examination was essential to detect stool in the rectum before making any deductions whatever.

Most coloproctologists remain unconvinced that buggery of small children is common. One leading scholar in the discipline has seen only nine cases in a lifetime of record keeping, and reflex anal dilatation was not a feature (J C Goligher, personal communication). He warns emphatically against making the diagnosis on physical signs and is concerned particularly about making it "just on a look at the anal region." An even greater worry now is that prolonged and repetitive looking at the anal region of children, encouraged by the current publicity, may itself produce more positive results. The substantial abduction force applied to the buttocks to allow photography may have increased the frequency with which the sign was observed in Cleveland, and the "knee-elbow" position may increase the number of positives. We must question the wisdom of photographing children's anuses, especially in this position, in the absence of a definite abnormality. Dilatation alone was virtually the only reason for taking dozens of photographs which I have seen.

The assertion that reflex anal dilatation represents an adaptive response to a repetitive painful experience is improbable. Nowhere else in human neurophysiology does an adaptive response to pain result in muscle relaxation. Anal fissures, corneal foreign bodies, abdominal guarding, etc, all cause reflex contraction of muscles, not relaxation. Reflex anal dilatation is neither diagnostic nor even suggestive of anal sexual abuse.

What of the other signs? Fissures and perianal soreness are common symptoms in children, particularly those with constipation, and cannot stand as evidence of sexual assault. A leading paediatric surgeon regularly makes the following statement in his lectures: "Anal fissures in small children can often be seen in different situations on different days, and a gentle parting of the buttocks will usually result in spontaneous relaxation of the sphincters to make such fissures readily visible to the examiner" (H H Nixon, personal communication). What is this but reflex anal dilatation?

It is impossible, in the absence of anal injury or the presence of spermatozoa, for a doctor to examine the anus of a child and conclude that sexual abuse has occurred. If this assertion is true then no parent need fear that a doctor's inspection can be the starting point for proceedings to remove children from the family, and no magistrate should accept purely medical evidence as the basis for a place of safety order.

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With the publication of the Butler-Sloss inquiry (16 July, p 190) it is apparent that there is an unacceptable amount of child sexual abuse in Britain. My experience in a rural community in central Scotland, however, causes me to wonder whether adolescent fantasising is not leading to overreporting of this phenomenon in older children.

Over the past 18 months I have learnt of five adolescent girls (aged 10 to 16 years) attending one secondary school who were investigated by the caring professions because of alleged sexual abuse. The police have been concerned in three cases and medical and social work personnel in all five. The allegations were made by the children themselves in three cases, and the other two cases were reported by other people. Considerable doubt has been expressed by the carers in two of the cases, and the allegations have been dismissed as groundless after investigation of the remaining three cases. Only one child has been removed from her parental home.

This evidence should engender caution in people dealing with such allegations in adolescent children.

ANONYMOUS

Irritable bowel syndrome in a non-Western population

Dr D Danivat and others (18 June, p 1710) failed to consider two common intestinal protozoal infections present in the tropics. Chronic amoebic colitis and giardiasis may present with symptoms similar to those of irritable bowel syndrome.[1,2] In particular, chronic diarrhoea with episodes of abdominal pain may be the presenting features of these infections. In proved amoebic colitis we too have often seen painless diarrhoea which occasionally could be precipitated by mental stress.

The questionnaire adopted by the authors was based on a survey carried out in a Western population, where the incidence of parasitic intestinal infections is negligible. An identical questionnaire should not have been used in a non-Western population, in which these infections are more prevalent. Furthermore, the authors did not consider the possibility of their subjects having had antiprotozoal treatment that would have altered the clinical presentation. A lack of laboratory facilities means that doctors in the tropics sometimes prescribe antiprotozoal agents, such as metronidazole, for patients with symptoms of amoebic colitis and giardiasis without definite microbiological proof of infection.

Irritable bowel syndrome is diagnosed by excluding organic disease of the large bowel.[3] For this purpose, particularly in the tropics, an examination of faeces for parasites is mandatory. A prevalence rate obtained without carrying out this basic investigation would not be accurate.

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Babywalkers

Dr J D Middleton (16 July, p 202) concludes that babywalkers are potentially harmful. Unfortunately, he also concludes that we should make no further efforts to improve the design standards because babywalkers are of no benefit to infant development and, therefore, are unnecessary and should be removed from the market.

This misses the whole point of babywalkers. As any parent will tell you, children enjoy them. To infants not yet able to crawl and often bored while their carer is occupied with household chores babywalkers provide independence, freedom to explore their surroundings, and a source of extra stimulation. It was because of his obvious delight

while in a friend's walker that we bought our son one, not because of any desire to speed up his development. We minimised any risk by choosing a well designed walker and providing adequate supervision.

We would encourage safer design and better education to reduce the unacceptable injury rate. Well designed walkers with circular bases wider than their tops will prevent finger entrapment injuries and reduce the risk of tipping injuries. An 8 month old child is just as capable of falling down steps while crawling, and the message must be more supervision and stairgates, not a ban on babywalkers.

Your correspondent has a rather narrow view on the potential benefits of babywalkers which ignores their "entertainment value" for the infant. Attempts to ban them because of a lack of proved clinical benefit smacks of medical arrogance. Instead, given well designed walkers and adequate information on potential risks and how to avoid them parents should be free to make their own decisions.

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Dr J D Middleton reported the 1984 figures for injuries associated with babywalkers from the home accident surveillance system of the Department of Trade and Industry (16 July, p 202). In fact these figures have shown a sharp upward rise (table). These reports come from about 20 accident and emergency departments. Total morbidity is therefore much higher than the table shows and in any case excludes injuries managed by general practitioners.

Injuries associated with babywalkers reported to home accident surveillance system[1]

Year:	1977	78	79	80	81	82	83	84	85	86
No:	77	75	84	143	249	205	191	258	238	313

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1 Consumer Safety Unit. *The home accident surveillance system: reports of 1977-1986 data.* London: Department of Trade and Industry, 1978-87.

Accidents in the home

The findings reported by Drs Rafi Alwash and Mark McCarthy (21 May, p 1450) parallel the results of studies being performed in the Illawarra area of New South Wales.

The Illawarra district is situated on the south coast of New South Wales, about 100 kilometres south of Sydney. Like parts of Britain it has a large immigrant population. Half of its households have at least one family member born overseas, and 35% of households have at least one family member from a non-English speaking country. Almost 19% of the population aged over 5 years have been classified as non-English speaking.[1] The area is also one of relative social disadvantage. Almost 56% of people aged 15 years or over have an annual income of less than $12 000 (£5000), while over 10% are government housing tenants, which is high by Australian standards.

The area has well defined geographical boundaries, and a recent general practice survey suggested that around 96% of all child accident victims attend one of the four area health service hospitals with a 24 hour accident and emergency department.[2] These hospitals have been collecting details of all children presenting after accidents or poisonings since November 1986, and these are analysed using the national injury surveillance prevention project computer program developed in Adelaide. Similar data are also being collected from hospitals in all mainland states of Australia.

Since the Illawarra project started we have recorded and analysed some 4000 attendances from a total child population (aged less than 15) of 54 152. We asked "What language is usually spoken at the child's home?" and found that 3190 spoke English and 308 were not specified. The remainder spoke European, African, Arabic, and Asian languages in proportion to the numbers of these groups in the community. Altogether 13·5% of the sample were from non-English speaking homes compared with the 18·9% of non-English speakers in the Illawarra. There was no excess of non-English speaking families in any age group.

We found, however, a positive correlation with low socioeconomic state. The three postcode areas with the lowest social indicators contained 22% of the total child population but contributed 30% of all childhood accidents. Our findings, from a multiracial community on the other side of the world, seem to confirm the conclusions of Drs Alwash and McCarthy—that social disadvantage, rather than ethnic group, is the main predictor of accidents in children.

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Innovation in general practice

Mr Nick Bosanquet and Dr Brenda Leese (4 June, p 1576) have made a valuable contribution to the debate on change in general practice, particularly in areas of developmental difficulty. Their observation that innovative practices were often located in rural or affluent suburban areas complements a comment made in a previous paper where they describe many of the practices which do not have a high investment strategy as "struggling for survival in the face of declining list size, relatively low incomes, and little professional contact."[1]

In our experience the important constraints on change in areas of developmental difficulty are the extensive medical and psychosocial morbidity found in such areas,[2-4] lack of professional contact, and difficulty in recruiting staff to innovative posts. We do not believe that any of these constraints are going to be altered greatly by extending the current fees for services system of incentives, and we endorse the authors' conclusion that "unless help in terms of management and resources is given to practices in such areas it seems unlikely that they will show greater responses to the new incentives than they did to the old ones."

The next phase of innovation in general practice will come through the proper funding and organisation of continuing medical education. We would like to see funding made available for general practitioners to work sessions as local postgraduate tutors and in academic departments of general practice, many of which are in areas of developmental difficulty.[5] Academic departments of general practice must receive funding similar to the service increment for teaching money which is paid to all other teaching departments in a medical school.[6,7] Until there is a commitment to postgraduate tutors and academic departments of general practice the "struggle for survival" will continue to take precedence over innovation. Time, not rehashed financial incentives, must be made available if general practitioners are to be innovative.

The authors defined innovative practices as fulfilling two out of the following three criteria: employing a nurse, participating in the cost rent scheme, and participating in the vocational training scheme. Innovative practices have partnerships with a younger average age than the traditional practices, which fulfilled none of the criteria. The recent white paper on primary health care contains proposals to limit the cost rent scheme and staff reimbursement.[8] There is now an excess of trainers and trainees, and standards required of training practices are rising and being enforced more firmly. These factors will make it more difficult for those general practitioners who wish to change to be able to participate in such innovations. This raises the worrying spectre of an increasing divide in general practice between the innovative practices in "nice" areas and the traditional practices in areas of developmental difficulty. This is in accord with the recognition that innovation widens socioeconomic gaps unless specific action is taken to prevent this.[9] Selective concentration of resources for continuing medical education and structural improvement grants in areas of developmental difficulty should be considered.

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Inflammatory joint disease and HIV infection

The association between inflammatory joint disease and infection with human immunodeficiency virus (HIV) reported by Dr S M Forster and coworkers (11 June, p 1625) is striking. A similar link between acute polyarthritis and HIV infection was reported recently in Zimbabweans.[1] We present a possible explanation for these observations.

We have investigated the serum concentrations of γ interferon using a commercial radioimmunoassay (IMRX™ interferon γ assay,[2] Centocor) in five patients with advanced HIV infection. Two had AIDS related complex and three had AIDS. Their mean age was 27·4±6·9 years. γ Interferon concentrations were increased in all the patients (median concentration 230 U/l, range 139-2416 U/l) compared with those in five healthy heterosexual controls negative for HIV and matched by age and sex (median concentration 23 U/l, range 13-37 U/l). There was a significant association of high γ interferon concentrations with high neopterin concentrations in serum and urine ($p=0·004$ using Fisher's exact test) measured by commercial radioimmunoassay and high pressure liquid chromatography respectively.[3] Neopterin is a product of human macrophages stimulated by γ interferon.

γ Interferon is considered to play an important