entity; Harkness, in his classic monograph, names more than 50 conditions known to cause urethritis.⁸ One of these is post-dysenteric Reiter's syndrome.

The situation is obviously confusing, and your leading article (14 August, p. 386) carefully avoided the textbook statement that Reiter's syndrome is usually a complication of venereally acquired non-gonococcal urethritis. Nevertheless, in the statement that the incidence of the disease is estimated at about 1% of the patients with non-gonococcal urethritis it perpetuates the textbook teaching without mentioning any of the discordant facts.

A pedantic approach is often necessary to make a difficult subject intelligible to students; it is unfortunate that this sometimes carries over into scientific thought and clinical practice.—I am, etc.,

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¹ Baron, J. H., *British Journal of Clinical Practice*, 1960, 14, 679.

² Mason, R. M., Murray, R. S., Oates, J. K., and Young, A. C., *British Medical Journal*, 1958, 1, 748.

³ Fernandez-Herlihy, L., *New England Journal of Medicine*, 1959, 261, 259.

⁴ Reiter, H., *Deutsche Medizinische Wochenschrift*, 1916, 42, 1535.

⁵ Paronen, I., *Acta Medica Scandinavica*, 1948, 131, Suppl. 212.

⁶ Adamson, H. G., *British Journal of Dermatology and Syphilis*, 1920, 32, 183.

⁷ Reed, W. B., *Acta Dermato-Venereologica*, 1961, 41, 396.

⁸ Harkness, A. H., *Non-gonococcal Urethritis*, Edinburgh, Livingstone, 1950.

Fluorescent Staining and Human IgM

SIR.—When antibody is united to an insoluble antigen, the class of globulin attached may be ascertained readily by the fluorescent antibody technique, using conjugated antiglobulins of appropriate class-specificity.¹

In human serum, during and after acute infection, a rising and falling titre of specific IgM fluorescent staining against a virus seems to indicate reliably the amounts of virus-specific IgM,^{2,3} but, according to the results shown in the Table, IgM-specific fluorescence given by random human sera not associated with recent virus infection is of more doubtful significance. The Table represents mostly the incidence of IgM-specific staining given by individual sera from rheumatoid arthritis and also by normal sera, when these are applied to HEP₂ cells, infected with herpes-simplex virus.

Source of Sera	Number Tested	Before Absorption with Aggregated IgG	After Absorption with Aggregated IgG
RF-positive Rheumatoid Arthritis	35	31 (1)	3 (5)
RF-negative Rheumatoid Arthritis	10	1 (2)	0 (1)
RF-positive non-Rheumatoid Patients	4	3 (0)	1 (1)
RF-negative non-Rheumatoid Patients	41	4 (8)	0 (6)
Acute Virus Infections (Herpes, Measles, Mumps, Rubella)	29	28	27*

Figures in brackets faint, but specific, additional reactions.

RF=rheumatoid factor. Tested by IgG-coated latex on serum diluted 1:3.

* One weakly positive rubella serum negative after absorption.

Sera, absorbed with human tissue powder and HEP₂ cells applied to acetone-fixed virus-infected cells at estimated dilution 1:5 followed by fluorescein-conjugated sheep and anti-human-IgM.

It is clear that much IgM-specific staining of herpes simplex virus by rheumatoid and by normal sera is caused by IgM anti-globulins, as is evident from removal of the staining property by absorption with aggre-

gated human IgG. Moreover, many sera which do not have sufficient rheumatoid factor to show in a latex-globulin agglutination test do produce IgM-specific staining which also is removed by aggregated IgG. It is relatively easy to show that, as one would expect, a serum which contains rheumatoid factor will cause IgM-specific staining of cells infected with different viruses, provided virus-specific IgG is also present in the serum, and it can also be shown that rheumatoid factor itself is responsible for this staining. We do not give these experiments here.

In sera from rheumatoid arthritis and in normal sera there are, too, IgM antibodies to herpes simplex virus which resist absorption by aggregated IgG, and we show in the last line of the Table that virus-specific IgM found in acute herpes simplex, measles, mumps, and rubella is likewise resistant to absorption by aggregated IgG.

It is possible that some kinds of virus-specific IgM, like antinuclear factor,⁴ may be associated with or may react also with denatured globulins and so explain our findings, but no other evidence of it has yet been found.

Since our results affect surveys of sera for virus-specific IgM,^{3,5,6} we propose, when reporting on virus fluorescent antibody, to adopt the terms "primary" or virus-specific, IgM staining and "secondary" or anti-IgG virus-non-specific IgM staining, according to whether absorption of the staining factor by aggregated IgG is resisted or not. The terms primary and secondary IgM staining will avoid confusion with other terms already used in fluorescent antibody work such as direct, indirect, and non-specific staining. The type of IgM staining given by a serum may be important in the pathogenesis of virus diseases, especially when antiglobulins cannot be detected by other means. Associations between reacting components may be more complex than we assumed in a previous survey.⁶—We are, etc.,

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¹ Baublis, J. V., and Brown, G. C., *Proceedings of the Society for Experimental Biology and Medicine*, 1968, 128, 206.

² Brown, G. C., Baublis, J. V., and O'Leary, Theresa P., *Journal of Immunology*, 1970, 104, 86.

³ Haire, Margaret, and Hadden, D. S. M., *British Medical Journal*, 1970, 3, 130.

⁴ McCormick, J. N., and Day, J., *Lancet*, 1963, 2, 554.

⁵ Connolly, J. H., Haire, Margaret, and Hadden, Diana S. M., *British Medical Journal*, 1971, 1, 23.

⁶ Millar, J. H. D., et al., *British Medical Journal*, 1971, 2, 378.

Future of the Species

SIR.—The review of *Sex and the Population Crisis* (4 September, p. 590) once again reminds us that "our whole species is in peril and time is very short." A similar conclusion was reached by Dr. S. R. Eyre at this year's British Association Meeting (*The Times*, 4 September).

Why then do we persist in refusing to allow this imminent peril to alter our current medical attitudes? It can only be folly of a most short-sighted kind that condones, for instance, the prescription of fertility drugs, elaborate procedures for saving spina bifida babies, or extravagant treatments for restoring the elderly.

If mankind is indeed in a swarming phase the practice of medicine must take the long-term ill effects of such therapies into account, however painful the denial of immediate satisfactions may be. Governments may soon be forced to interfere with personal reproductive habits. Meanwhile, there must be grave doubts thrown upon that meddlesome interference with nature which so easily goes by the name of therapeutic advance.—I am, etc.,

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Long-term Haemodialysis without Transfusion or Drugs

SIR.—We have read with interest the paper by Dr. Stanley Shaldon and others (24 July, p. 212) recommending the use of testosterone for the treatment of anaemia in patients on maintenance haemodialysis, as well as the disappointing results obtained by Drs. P. P. Mayer and B. H. B. Robinson (7 August, p. 373) using the same preparation and doses of testosterone. We should like to present here our relative observations indicating that improvement in haematocrit and haemoglobin can occur in the adequately nourished and dialysed patient, independent of any kind of therapy.

Six patients (age range 23-60 years) were undergoing long-term haemodialysis 12-14 hours weekly with a R.S.P. Travenol artificial kidney, using a coil type dialyser at a blood flow rate 200-300 ml/min. This was done with potassium-free dialysate, except when the patient was on digitalis, when potassium 2.5-3.5 mEq/l. was added. All patients received a liberal diet containing ≥ 1.25 g/kg first-class protein and 70-75 mEq sodium and potassium. No regular blood transfusions, haemopoietic drugs (iron, folic acid, androgens), or exchange resins were given. The patients' general condition improved rapidly. Blood urea and serum potassium were 0.60-1.75 g/l. and 2.25-5.75 mEq/l. respectively between two successive haemodialyses. Their initial anaemia of a mean value P.C.V. 18.3%; Hb 6.0 g/100 ml (range P.C.V. 12-23%; Hb 4.5-7.1 g/100 ml) was improved in 4-6 months to mean value P.C.V. 26.4%; Hb 8.5 g/100 ml (range P.C.V. 22-37%; Hb 7.0-11.8 g/100 ml) and it remained round this value for one to three years (12, 14, 17, 18, 23, and 33 months).

Adequate haemodialysis with liberal diet, perfectly possible by using a potassium-free

dialysate,¹ is recommended routinely for all chronically dialysed patients. It is suggested that the patient under this treatment can not only substitute iron, folate, and amino-acid losses from the remaining blood into the dialyser, blood sampling for analysis, and to the dialysate, but also effectively utilize these elements incorporated in the diet, according to his real needs.—We are, etc.,

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¹ Yatzidis, H., Triantafillidis, D., Voudiclaris, S., and Koutsoyannis, C., *British Medical Journal*, 1970, 4, 52.

Social Services and Community Health

SIR,—The recent Department of Health and Social Security circular¹ is very opportune as it does officially confirm that the medical officer of health is still medical adviser to his council on all subjects and problems appertaining to community health (and this includes social welfare).

Many medical officers of health have suspected that with the advent of the new departments of social services their advice and expertise were no longer welcome. Close reading of the circular makes one wonder why there was ever any real need for such an upheaval and reorganization of health departments as followed the Social Services Act, 1970. Has not the change been wrongly made for the sake of expediency? Has the immediate aim not been to relieve the intensive pressure brought to bear by social workers for unified social welfare departments and was not this pressure directed

so influentially that they gained their objective?

Now the Department of Health and Social Security appears to have sensed the obvious danger, to the detriment of the patient, for whose benefit the services exist, in splitting the health and welfare services down the middle. Many medical officers of health will have a wry smile as they read between the lines of this circular. I consider it naive to expect that all will be as before in this field of community welfare. There is no guarantee that the advice given by the medical officer of health will be implemented. There is also no provision for the cost in money, manpower, and resources of providing within health departments the machinery for this liaison. Many health departments may even be in the process of running down their establishments or finding it difficult to maintain their staff in what appears to be an increasing atmosphere of indifference and uncertainty as to the future. This is a particularly pertinent point when it is remembered that the creation of the new social services departments was itself a costly manoeuvre.—I am, etc.,

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¹ Department of Health and Social Security. *Co-operation between Social Services Departments and Health Departments*. L.A.S.S.L. 33/71.

Uses of Bureaucracy

SIR,—The finding of the missing baby Denise Weller is a direct result of the initiative of Mr. Harris, the superintendent registrar of births for Brighton, in seeking the collaboration of the chief nursing officer and her staff in the Brighton Health Department. The discrepancy between the peculiar request for registration to Mr. Harris, and the

absence of any official legal notification of a birth to the medical officer of health, showed that something was amiss and needed investigation.

This success demonstrates the value of the proper application of the routine information we require. It is easy to label local authority staff as bureaucrats and to abuse us when we require forms to be filled in. There is constant outcry from the profession about certificates and the like but family doctors cannot have it both ways. The choice is theirs. If they do not want to collaborate, they deny us the opportunity of this sort of rescue operation. The whole country now sees what we do with the information we seek.—I am, etc.,

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Stilboestrol and Cancer

SIR,—I read with great interest your leading article on "Stilboestrol and Cancer" (11 September, p. 593), but I would like to point out that stilboestrol is not a hormone but a hormone analogue.

Diethylstilboestrol was produced in the Courtauld Institute of Biochemistry in the Middlesex Hospital Medical School, by my colleagues and myself after many years of intensive investigation. Its synthesis was published in *Nature*,¹ and is, as far as I know, the only substance that bears no structural relationship to a natural hormone, but has the same action.—I am, etc.,

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¹ Dodds, E. C., Goldberg, L., Lawson, W., and Robinson, R., *Nature*, 1938, 141, 247.

Points from Letters

Anxiety and the G.P.

DR. C. W. D. PHILLIPS (Huddersfield, Yorks) writes: The accessibility of the general practitioner is a topic that needs to be discussed openly now that many doctors have (quite rightly) introduced appointments systems. The problem arises when enough time is not allocated for appointments. One of our main tasks is to alleviate anxiety, and we may fail to do this if the patient has to wait too long to get an appointment to see us. The question of what is urgent in general practice is a vexed one. How long should a middle-aged man with a vague pain in his chest have to wait before he can see his doctor? Dr. C. A. H. Watts (14 August, p. 419) says that all patients in general practice, apart from those clearly not urgent, should be seen within 24 hours. Disquiet is being expressed at the vast quantities of medication, especially hypnotics and tranquilizers, consumed by the British populace. Most of this medication is presumably prescribed by us general practitioners. Do we sometimes take the easy way out, and continue to sign prescriptions for these drugs without seeing the patients, rather than spend a few minutes with the patients to see if the prescription is really necessary?

General Practitioner Obstetrics

DR. M. B. CLYNE (Southall, Middx) writes: Mr. R. M. Burton (28 August, p. 532) is one of our local consultants with whom we general practitioners in the area of Hillingdon Hospital and Perivale Maternity Hospital work so well

together in shared antenatal care. The benefits of this shared care are immeasurable, both for patients and for general practitioners. The patients benefit not only by saving waiting time and long journeys, but also because they are always aware that their general practitioner is taking ultimate care of them during pregnancy. General practitioners benefit because the shared system of care is bound to raise their level of antenatal care and because they are never ignorant of their patient's condition during pregnancy, as is apt to happen when the patient is taken over by an antenatal department. . . .

Scotland's Anaesthetists

DR. C. S. JONES (Worcester, C.P., South Africa) writes: Dr. S. D. Parbrook's interesting report on anaesthetic staffing and training requirements in Scotland (31 July, p. 293) is apparently based upon the premise that all anaesthetics in Scotland should be given either by consultants or by anaesthetists in the specialist training programme. . . . I wish to disagree most emphatically and to call attention to a large and most useful group of doctors who should be incorporated in the anaesthetic services—that is, the general practitioners. . . . An analysis of the anaesthetics administered in Scotland will reveal that a very large number are for such operations as dilatation and curettage, cystoscopy, open bone operations on the extremities, operations for varicose veins and hernia, breast biopsies, and mastectomies, and many others performed on patients who are usually healthy and who can be anaesthetized

by simple techniques. All these anaesthetics can very well be administered very adequately by general practitioners who have a special interest in, and have been given some training in, anaesthetics, and who have consultant anaesthetist supervision and assistance readily available. Consultant anaesthetists should surely be reserved for anaesthesia for "poor risk" patients; for anaesthesia for major surgery; and for those special techniques which exotic surgery demands. They should also be freely available for advice and assistance to, as well as for the teaching of, non-consultants also practising anaesthetics. This surely is what is implied in naming them "consultants"? . . .

Onycholysis and Enzyme Detergents

DR. H. R. VICKERS (Department of Dermatology, Radcliffe Infirmary, Oxford) writes: I have been trying to find the incidence of skin damage caused by enzyme detergents, and from replies received to a questionnaire sent to all British dermatologists the incidence is extremely small. One interesting feature about the case described by Drs. G. Hodgson and R. T. Mayon-White (7 August, p. 352) is the fact that the patient was in contact with the washing agent for such a long time each day and this degree of exposure must be unusual in Britain. It is also of interest that if the keratin of the nail was so severely damaged the keratin of the skin was only mildly affected. Loss of nails as described is very uncommon and no other similar cases were reported to me in my inquiry.