I do not share their pessimism with regard to staffing since I feel that a multi-disciplinary approach to sexual matters will appeal to a new generation of doctors, particularly if abortion services were part and parcel of a unified family planning service with the problems of contraception, sterilization, and sexual difficulties well represented.

The problems are complex but since there is public demand, it is our duty to give carefully thought-out advice. If a new specialty is needed should the medical profession demur; has there ever been a time that a new challenge has been ignored successfully?—I am, etc.,

J. D. WILLIAMSON

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Sex and the Single Girl

SIR,—Dr. J. Campbell Murdoch (22 July, p. 235) is right to criticize Drs. C. McCance and D. J. Hall (17 June, p. 694) for saying that a contraceptive service should be "morally uncommitted," but he is right for the wrong reason. He is right to say that a doctor who leaves his standards behind him becomes a danger to himself and to others, but he is wrong to imply that moral standards and a sense of commitment are the prerogative of those who believe in God.

Surely, a doctor has both moral standards and a sense of commitment if his words and actions are based on his own beliefs in what is in the best interests of his patient. The doctor, however, must be aware of the consequences of his action: what is the effect upon the patient? Is the patient filled with a sense of beatification comparable to that in the doctor at the end of his homily?

According to our age/sex register, there are over 4,000 girls in their twenties and thirties in our group practice: the area consists largely of large houses divided up into flats. It is our experience that the alternative to contraception is not continence but pregnancy. If a girl is advised against contraception she might go to another doctor or to the F.P.A. or she might risk pregnancy by using the "safe" period or coitus interruptus. If the girl intended to be continent then it is unlikely that she would have asked for contraception in the first place, and, furthermore, our experience would corroborate the findings from Aberdeen that many girls seek contraception after first intercourse.

Thus, advice against contraception is given too late and if heeded will cause guilt (which is the most damaging and far-reaching of all iatrogenic diseases) on the one hand or pregnancy on the other.—We are, etc.,

ROBERT LEFEVER
TOM TREVELYAN
JOHN WEST

London S.W.7

A Virus from Epidemic Vomiting Disease

SIR,—The authors of this excellent paper (8 July, p. 86) rightly state that the commonest abdominal symptom is a feeling of distension. May I add that x-rays of the abdomen taken at this stage show considerable gaseous distension confined to the transverse colon in the supine position. The gas would shift by its buoyancy into the ascending or descending colon in left or right

recumbency. Unlike gastroenteritis caused by other pathogens, fluid levels in the colon are absent or insignificant. There is probably a causal relationship between the two phenomena, the excess gas in the transverse colon being responsible for the feeling of epigastric distension.

In hospital practice these cases are often referred to the x-ray department under the clinical suspicion of appendicitis in children or of pancreatitis in adults. The picture is sufficiently characteristic for the radiologist to suggest that epidemic vomiting disease might be taken into consideration in the differential diagnosis (Fig.).—I am, etc.,

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¹ Hajdu, N., *Réunion Internationale de Radiologie Pédiatrique*, 1963, Abstract 37.

Women Returning to Medicine

SIR,—No doubt many readers will have read with interest the article in *The Times* "Women's Role in Medicine" (14 June) giving an account of the existing part-time, postgraduate training arrangements custom-built to fit each woman's needs. We refer to Dr. Rosemary Rue's scheme in Oxford and Dr. Michael Essex-Lopestri's scheme in the South-west Metropolitan Region.

Now that Sir Keith Joseph has announced his women doctor's retainer scheme (17 June, p. 723), many women may feel a strong urge to take advantage of it, but are fearful to embark least they are unable to cope in the event of some domestic crisis. Crèches, play groups, and other such services are valueless when your child falls ill.

In Leeds we now have the answer to this problem in the form of the Family Emergency Association. This organization, which has been running successfully since 1969, is a mutual members club, and is legally recognized by the Town Clerk. (A mutual members club has two kinds of members—mutual members and donor members. The former are those who anticipate a need for help, though they can, if they wish, also provide help at other times; the latter provide help requested. We have not yet failed any member who required a "substitute mum" in an emergency. We feel that there must be many women medical graduates in Leeds who would gladly take advantage of these very good retraining schemes if they also had an insurance against the event of a domestic crisis.

It is for this reason that we wish to draw their attention to the existence of this service, and prevent them from letting splendid opportunities for retraining pass them by.—We are, etc.,

E. A. COLVILLE
J. WENBAN

Leeds

Platelet Adhesion and Aggregation

SIR,—Your leading articles must be factually correct, but when talking about platelet embolism and platelet aggregation and adhesion to glass you state that "these two properties appear to be identical" (8 July, p. 67). Most workers in the field would insist that you are wrong. It is true that in Glanzmann's thrombasthenia both platelet aggregation and adhesion to glass are abnormal. However, it is also generally accepted that in von Willebrand's disease platelet retention in a glass bead column is markedly decreased, and this test certainly involves platelet adhesion to glass. Platelet aggregation however is strictly normal. Contrarywise, immediately after two major operations, for example, platelet aggregation relative to the preoperative level is decreased but retention in the glass bead column is increased.¹ Thus these tests can vary independently, and this must mean that although perhaps some properties are shared, nevertheless some quite different mechanisms must operate. This at least is established even if full details of these two processes are still unknown.—I am, etc.,

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¹ O'Brien, J. R., Etherington, M., Jamieson, S., and Klaber, M. R. *Lancet*, 1972, 1, 1302.

Cytology in General Practice

SIR,—Dr. B. Scaife and his colleagues (22 July, p. 200) describe a model for screening a busy industrial practice for precancerous conditions of the cervix. They are to be congratulated in reaching almost 90% of patients considered to be at risk.

May I comment on English "resistance" to cytology tests? Recently, as part of a research project, I visited a large industrial firm in Birmingham in an attempt to find out why a repeat screening by cytology produced almost the same percentage of acceptance (less than 20%). With my colleagues A. J. Lucas, general practitioner, and Margaret Attwood, head of the Ministry cytology school in this department, I attended a meeting arranged by the medical officer in charge of the health of an industrial complex with some 8,000 women employees. Women shop stewards discussed with us the reasons why employees continued to decline cytostests. Their reasons correspond to those given by Dr. Scaife and his colleagues, namely that (pregnancy apart) English women suffer from a kind of shyness when the organs of reproduction are mentioned. The women shop stewards made the original suggestion that we should approach all husbands by letter, explaining the value of preventing cancer of the neck of the womb so that they might encourage their wives to take a "prevention test."

In the factory there were many women

who, according to their shop stewards, did not take the test because as they put it "they didn't want to know." Some, not all, believed that cytostests simply told one that there was cancer of the womb, and "you find that out soon enough." The test of course is aimed at curable pre-cancer, but it seems that we had not put this over in our invitations and posters in simple terms.

Dr. Scaife and his colleagues come to the same conclusion as the British Columbia workers in this field, that the key to success in any screening programme is the family doctor. If he says the test is of value, and even more if "nurse says so," then a busy housewife may well come for a test. Otherwise 70 to 80% of English women will ignore poster or postal invitations to take regular tests.

There are now fortunately in England large numbers of skilled cytologists. Their special skills are not at the moment being fully exploited. Dr. Scaife's report is thus timely, and one hopes that many other doctors in family practice will set up a scheme to screen their patients. An ideal time is perhaps when their children come for their immunization against polio or diphtheria.

In cytology we have a method of protecting patients from a form of cancer which is at the moment killing 2,500 women in England each year. The total picture, allowing for cures, is 5,000 new cases each year. What this amounts to in suffering and misery for the patient and her family is only too well known. Two million cytostests are now done each year in England, always a start, but the target is 14 million a year and we now have cytologists to do this. Whether on Teesside with a 2% pick up rate or on the Pacific coast with 1% the key to the successful use of cytology is the family doctor who takes time to tell his patient that the test will protect from the risk of cancer.—I am, etc.,

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Chronic Prostatitis

SIR,—While it was a pleasure to see your leading article (1 July, p. 1) devoted to a subject which so far has been rather inadequately dealt with in the English language literature, there are a number of comments to be made on this contribution.

In the first place, it is not the experience of one of us who has made a fairly extensive study of prostatitis that gonococcal or non-specific urethritis are common precursors of this condition. This may be because cases of urethritis in the Services are usually promptly and effectively treated; it is therefore possible that the phenomenon of prostatitis following on venereal urethritis is an indication of late or inadequate antibiotic treatment of the primary condition.

While controversy does exist about the significance of pus cells in the prostatic fluid, most workers use the "high power field" or one-sixth inch objective and not the 1/12 inch (2 mm) objective as you have suggested; the figure of 10 pus cells per field taken as indicative of inflammation within the prostate is, in fact, 10 pus cells per high power or one-sixth inch field.

Following on the original work of Stamey

and his associates,¹ more recent studies on the secretion of antibiotics into the prostatic acini and ducts have shown that other drugs may reach potentially therapeutic levels in prostatic fluid. For example, trimethoprim has been found in prostatic fluid in concentrations higher than in simultaneous blood samples,² and this has been confirmed both in experiments using the dog³ and also in humans.⁴ Other studies^{5,6} have suggested that sulphonamides, clindamycin, and chloramphenicol may also reach inhibitory levels in prostatic secretion. Although results of animal experiments ought to be regarded with caution, other work⁷ suggests that tetracycline, as opposed to the oxytetracycline recommended in your leader, has more favourable pharmacological characteristics in this context.—We are, etc.,

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- 1 Winningham, D. G., Nemoy, N. J., and Stamey, T. A., *Nature*, 1968, 219, 139.
- 2 Reeves, D. S., and Ghilchik, M., *British Journal of Urology*, 1970, 42, 66.
- 3 Robb, C. A., Carroll, P. T., Tippet, L. O., and Langston, J. B., *Investigative Urology*, 1971, 8, 679.
- 4 Fowle, A. S. E., and Bye, A., *Proceedings of the 7th International Congress of Chemotherapy*, Prague, 1971. In press.
- 5 Winningham, D. G., and Stamey, T. A., *Journal of Urology*, 1970, 104, 559.
- 6 Reeves, D. S., Rowe, R. C. G., Snell, M. E., and Thomas, A. B. W., *Proceedings of 2nd National Symposium on Urinary Tract Infection*, London, 1972. In press.
- 7 Hessel, J. M., and Stamey, T. A., *Journal of Urology*, 1971, 106, 253.

Trapped Nerves

SIR,—In a leading article (6 May, p. 307) you referred to my recent article on abdominal cutaneous nerve entrapment syndrome.¹ As a matter of interest I would like to relate some further information on the subject. Although I have made no attempt to map out changes in cutaneous sensation, I believe the effort would be fruitless. The cutaneous nerves in the area of the rectus muscle overlap and interconnect in a web of nerve fibres such that even when the cutaneous branch is severed at the rectus margin the loss of sensation is vague or imperceptible. Since the appearance of this article we have operated on four more patients. Severing the nerve at its exit from the rectus foramen has apparently given permanent relief to each patient, and confirms my impression that the symptom complex arises from the distal nerve rather than from a more proximal source.

Though I emphasized the fat hernia in the aetiology of the syndrome, I am increasingly impressed by the mechanism of traction against relatively unyielding soft-tissue structures. A further example of this mechanism is demonstrated in a patient I recently saw who gave a history of fractured rib at the costal margin. Apparently the seventh nerve was slightly displaced in its course. This resulted in traction on the nerve and typical symptoms of nerve entrapment. I strongly suspect that the patient with hypermobile ulnar nerve syndrome (the nerve subluxates from its groove at the elbow) suffers from a shortened nerve; perhaps the result of some asymmetry of the axial skeleton on the affected side. Since

clavicle fractures are common, a deformity in this area may very well place the brachial plexus under tension, leading to a shortening of the ulnar nerve, which has to follow a somewhat longer course to the hand than do the medial and radial nerves. When the elbow is flexed, the ulnar nerve is dislocated from its groove or else it would be torn.

Though I have not documented it, I also feel that many chest pains are due to sensory nerve entrapment of the intercostal nerve with similar symptoms to that of abdominal nerve entrapment, and it does not take much imagination to suspect many other pain syndromes of being due to nerve entrapment in soft tissue. Rueggesser² has been injecting local anaesthetic into the muscles of the neck with excellent results in some headaches. Are these injections actually being placed in the exits of nerves from between and through the cervical muscles? Are the nerves being placed under undue traction by muscle spasm and/or minor skeletal misalignments?

Examining the diagrams of the acupuncturist, I am struck by the fact that many of the puncture points lie over muscular nerve exits. I believe we are only beginning to recognize the extent to which soft tissue nerve entrapment affects our daily lives, and I expect that more nerve entrapment syndromes will soon be elucidated in the literature.—I am, etc.,

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¹ Appligate, W. V., *Surgery*, 1972, 71, 118.

² Rueggesser, P., *Journal of the American Medical Association*, 1969, 209, 1022.

Distress of Dying

SIR,—May I endorse the plea of Dr. M. A. Simpson (22 July, p. 231) for more adequate teaching of care of the dying to medical students? When this is done, the cry for euthanasia—as voiced in the ensuing letter from Dr. S. L. Henderson Smith—will probably vaporize. As Dr. W. Dewi Rees pointed out in his survey (8 July, p. 105), the conclusion to be drawn from his discovery that 74% of dying patients may suffer physical distress is that they need to be more adequately managed, not that they should be killed off.

For many terminal patients who cannot be satisfactorily cared for at home the ideal place is a specialized unit. Such centres are opening in England, and one hopes that before long every community will have its hospice. Many patients who would otherwise have died in hospital may be managed at home if the general practitioner and hospice staff join forces.¹

Encouraging though this development may be, it cannot proceed unless there is proper teaching of care of the dying to students.—I am, etc.,

RICHARD LAMERTON

London E.8

¹ McNulty, B., *Nursing Times*, 1970, 66, 1160.

Alpha-fetoprotein and Gastric Carcinoma

SIR,—The association between alpha-fetoprotein and hepatocellular carcinoma is well known. We wish to report an example of the rarer association with gastric carcinoma.¹⁻³

A 63-year-old man was admitted with a