cantly ($t = 4.185$, $P < 0.001$) lower than in controls.

The finding that co-trimoxazole in dosages commonly used for curing bacterial infections in man partially suppresses antibody response warrants more detailed investigation. Whether the effect is due to the combined drug or trimethoprim alone also remains to be investigated.—We are, etc.,

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Ultrasound in Diagnosing Hydrocephalus

SIR,—Ultrasonic scanning with both B and A displays has been shown to be of value in many obstetric problems. Recently in the Walsgrave Maternity Hospital, Coventry, we have used the technique to diagnose fetal hydrocephalus.

Fig. 1 shows the sonogram of a grossly hydrocephalic fetus. This is the typical appearance when neither the lateral ventricular echoes nor the midline echo is obtain-

able. The transverse diameter of this head was 14 cm at the 34th week of pregnancy. Figs. 2 and 3 show sonograms in a patient who was referred for ultrasonic scanning at the 38th week of pregnancy after a radiograph had shown a hydrocephalic fetus. The biparietal diameter was 11.5 cm. However, the lateral ventricular and midline echoes were clearly visualized, though the ventricles appeared to be slightly dilated. In discussion

with paediatric colleagues it was decided that the baby had a reasonable chance of recovery and development. A lower segment caesarean section was performed when the head failed to descend into the pelvis in labour, and a healthy girl was delivered weighing 3,670 g. The circumference of the head was 41 cm and there was a simple occipital encephalocele. There were no other abnormalities and the limb tone seemed normal.

The encephalocele was excised after 12 days. It contained no brain tissue but the cerebellum was absent. On the 10th day the head circumference was 42.5 cm. By the 51st day it had increased to 49 cm, and a Spitz Holtzer valve was inserted. Since the operation the baby has remained well and her limb movements appear normal.

Thus it would seem that ultrasonic scanning can be used to differentiate between hydrocephalus of gross and mild degree in that if the midline echo or the lateral ventricular echoes are visualized the prognosis is favourable. This method of investigation should be further pursued in departments having suitable apparatus.—I am, etc.,

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Diagnosing Secondary Syphilis

SIR,—While Dr. I. Rose (19 August, p. 473) is to be congratulated on his acumen in diagnosing his recent case of secondary syphilis, there are some dangers inherent in the over-confident diagnosis of secondary syphilis without confirmatory serological tests.

In the past few years several patients have presented in this department, often in great distress, having been told they had syphilis when, in fact, they had a more banal condition such as tinea versicolor, pityriasis rosea, lichen planus, seborrhoeic eczema, or a skin

reaction to ampicillin prescribed for a sore throat in a case of what was later found to be glandular fever. By the time of examination many of the patients had already informed sexual contacts, family, or employers with all the resulting brouhaha.

The diagnosis of secondary syphilis is not simple, and apart from clinical examination adequate special investigations such as demonstration of *Treponema pallidum* from the lesions and at very least corroborative standard serological tests for syphilis must be carried out.—I am, etc.,

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Surgical Preadmission Clinic

SIR,—We would like to compliment Mr. D. L. Crosby and his colleagues (15 July, p. 157) on their contribution to the important problem of long surgical waiting lists. However, we would like to examine critically some of their premises and conclusions.

A long surgical waiting list cannot be defended on the ground that it will ensure that a proportion (23% in the Cardiff series) of patients placed on it will either cure themselves or go elsewhere and so reduce the demand for admission. The patients in Mr. Crosby's series who had a spontaneous cure included those with submandibular salivary adenitis, pilonidal sinus, mastitis of puberty, and anal skin tags. Many of these conditions can be managed conservatively and perhaps should not find their way on to a surgical waiting list.

Day-stay surgery or short-stay surgery are probably more effective in reducing waiting lists than a preadmission clinic. An alleged purpose of a preadmission clinic is to detect abnormalities that otherwise might not be detected until the patient had been admitted. In our experience, the proportion of patients in whom something unexpected is detected on admission is about 2%, and it was similar in the Cardiff series. It could be argued that complicating conditions could best be detected at the primary outpatient consultation or when the decision to admit for operation is made.

Does a preadmission clinic improve economic efficiency in the use of hospital facilities? Extra visits to an outpatient department add to staff and servicing costs. They may also cause the patients trouble and expense. These have to be weighed against the possible saving in hospital beds. A preadmission clinic decreases the number of days a patient spends in hospital, since the preadmission stay is shortened. If there is a short waiting list and some essential screening tests are done in the primary outpatient clinic it is still possible to admit patients on the day of operation or at least the day before.

Mr. Crosby and his colleagues do not state what use was made of the empty beds gained from the shorter preoperative stay. If they were unused little money was saved. We are currently studying the problems of increasing the efficiency of surgical admissions and we have employed the technique of preadmission examination. We find it saves little in time or money compared with the more usual form of admission. The greatest advantage has been that the house