indeed, by any consultant who has been fortunate enough to have an appropriate share of the services of a medical secretary. The contribution these women make to the hospital service is difficult to over-emphasize, and their important role should be recognized by providing much better salaries and career prospects than those which are currently available to them.—I am, etc.,

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St. Stephen's Hospital Group

SIR,—Dr. R. Lefever's letter (19 August, p. 475) echoes the widespread concern of both professional and lay users of our group of hospitals. His tribute to Dr. Gordon Signy and his laboratory is much appreciated by his colleagues. The comment of the laboratory's misplacement and the effect on the group, and St. Mary Abbots Hospital in particular, cannot go unheeded.

The decision to build the new district general hospital on the St. Stephen's site was made nearly 15 years ago and has been the subject of considerable controversy ever since. Whether the choice was made to support the postgraduate complex development in the area, or the early staff appointments at St. Stephen's Hospital encouraged its development, or there was an over-all strategy plan which was obscure to us, it resulted in the provision of the major component of our acute general hospital unit on the diminutive five-acre site at the southernmost part of our future area health board. Owing, however, to insufficient development to date we cannot effectively concentrate all our acute facilities on this site, and in any case we intend to go on providing acute outpatient and day-time casualty facilities at St. Mary Abbots Hospital and may well continue to house some acute in-patient facilities there, other than E.N.T., geriatrics, and psychiatry.

To this end we wish it to be widely known that near-equal outpatient and ancillary department facilities are offered at both hospitals and I do hope that local general practitioners and the public will continue to use St. Mary Abbots Hospital to its fullest capacity.—I am, etc.,

O. A. N. HUSAIN

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Group Medical Advisory CommitteeChelsea and Kensington Hospital Management
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Problems with Asthma

SIR,—I would like to express my agreement with Dr. G. P. Maher-Loughnan's letter (15 July, p. 173) on problems in the treatment of asthma and also, if it is not too late, to comment on your article on steroid drugs in chest disease (20 May, p. 459).

Chest physicians spend much time in trying to wean patients, sometimes children, off steroids which may have been started some years earlier. I agree that asthmatic patients should be put on long-term steroids only when all other approaches have failed—including, indeed hypnotherapy in appropriate cases. I think that in elderly patients with intrinsic asthma a small daily dose may often

be justifiable. I am glad to note that much higher doses of steroids are now being applied to the relief of status asthmaticus.

I believe there has always been some confusion in the minds of physicians on the significance of side effects when steroids are used in high dosage for a short period for a specific purpose and in long-term low dosage. If I refer briefly to the use of steroids in pulmonary tuberculosis apropos of your article this is not an irrelevance. Originally steroids in massive dosage were used (with chemotherapy) in cases of fulminating phthisis with gross toxæmia (hypersensitivity).¹ The immediate effect was hyposensitization with rapid clinical and radiological improvement, which was maintained. These results were confirmed by good controlled trials in this country² and the United States.³ The overall findings were summarized in 1966.⁴ Also in the original publication it was stated that in cases of drug hypersensitivity (streptomycin and PAS) lasting desensitization occurred if the allergens (drugs) were given in maximal dosage under immunosuppressive dosages of steroids. In both these situations hyposensitization depended on the confrontation of high antigen stimulation and massive (immunosuppressive) steroid dosage.

Modifications of this regimen were not successful. Unfortunately in the early fifties doctors had not been allowed to use steroids for a time and subsequently were admonished to use only minimal dosage. As a result there were very many reports of small doses of steroids being used (with chemotherapy) in limited and relatively inactive cases of pulmonary tuberculosis. Likewise small steroid dosage was added during the course of conventional desensitization in cases of drug hypersensitivity. These measures were virtually useless and may well account for the reference in your article to a "brief vogue" for the use of steroids and for what I consider to be its incorrect conclusion that steroids have little value in tuberculosis.

This same technique has been used by me and my colleagues in cases of allergic asthma since 1958. When a specific allergy has been demonstrated maximal antigen administration was started at once without a slow build-up and this was covered by immunosuppressive steroid dosage (ACTH 80 units and prednisone 120 mg daily) for seven days followed by rapid reduction. The antigen was continued for a total of 10 days without reaction. Patients treated in this way were closely followed for 10 years.⁵ This curious empirical clinical phenomenon is now under examination and trial at Benenden Chest Hospital, monitored by sophisticated clinical and laboratory techniques.—I am, etc.,

L. E. HOUGHTON

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- 1 Houghton, L. E., *Lancet*, 1954, 1, 595.
- 2 *Tubercle*, 1961, 42, 391.
- 3 Johnson, J. R., et al., *American Review of Respiratory Diseases*, 1965, 92, 376.
- 4 *Lancet*, 1966, 1, 192.
- 5 British Allergy Society, *Acta Allergologica*, 1966, 21, 523.

Latex Agglutination Test and H.A.A.

SIR,—The paper of Dr. J. M. Leach and his colleagues¹ describing the latex agglutination reaction as a screening test for hepatitis associated antigen (H.A.A.) prompts us to

describe our experience with a similar method.²

A 30-year-old woman and her 36-year-old husband first donated blood in July 1971. Routine tests were positive for H.A.A. in the former, though inquiry showed that neither she, her husband, nor her 5-year-old son had a history of hepatitis or blood transfusion. The H.A.A. reaction was positive in two different tests^{3,4} and remained so until February 1972. In the latter month the whole family underwent full physical examination and a series of laboratory tests, including a liver biopsy. The results showed no evidence of liver disease in any of the three, though the latex agglutination test gave positive results for H.A.A. in specimens of sputum, urine, and faeces from all three members of the family, and, additionally, in specimens of serum from the mother.—We are, etc.,

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HERMANN SCHÖNTHALEv. Johanneskrankenhaus Bielefeld,
West Germany

- 1 Leach, J. M., and Ruck, B. J., *British Medical Journal*, 1971, 4, 597.
- 2 Bonacker, L., and Stärk, J., *Klinische Wochenschrift*, 1972, 50, 166.
- 3 Al-Hujaj, M., and Schönthal, H., *Diagnostik*, 1971, 4, 530.
- 4 Wallis, C., and Melnick, J. L., *Applied Microbiology*, 1971, 21, 867.

Lumbar Disc Problems

SIR,—There is one awkward fact that Mr. A. H. G. Murley (26 August, p. 529) must bear in mind in attributing backache largely to overuse of worn posterior vertebral joints. If such degeneration were the chief cause the incidence of backache would increase as age advanced. In fact it reaches a peak at 50 years old and diminishes after the age of 60.—I am, etc.,

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Defence Society Subscriptions

SIR,—Dr. J. D. J. Parker's letter (19 August, p. 477) draws attention to a rather important state of affairs in that membership of a defence society is usually obligatory and that these societies have exercised the advantages of a monopoly position. Any increase of the order of 100% surely demands more explanation than the bald statement that the increase is necessary.—I am, etc.,

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Placental Tumour

SIR,—Recently I predicted that a patient had twins. The leading vertex was engaged in the pelvis and there was a ballotable mass the size of a fetal head in the fundus. I was surprised when straight abdominal x-ray examination showed a single fetus. The patient had a normal delivery of a normal female infant. The cord, however, came away with very little traction and the placenta, which was inserted in the fundus, was removed manually. There was a large placental mass (8 x 8 x 6 cm) just under the insertion of the cord. The histology showed a "haemangioma placenta" with "a