grains in Ireland than in England and Wales.⁴

Additional support is afforded by our recent report.⁵ We found that relapsed schizophrenics who on admission ate a cereal-free, milk-free diet for a relatively brief period were discharged from hospital twice as fast as those who had been on a high-cereal diet. The disappearance of this beneficial effect when wheat gluten was secretly added to the cereal-free diet indicates that it was not due to non-specific psychological factors.

Though findings such as these need full confirmation before acceptance or application, I believe they, plus previous evidence, amply justify further studies. In addition to genetic-epidemiological studies such as the one suggested by Dr. Walsh and more extensive dietary experiments, I suggest that unmedicated, relapsed schizophrenics consuming a high-gluten diet for weeks or months should be investigated for coeliac-like histological and metabolic abnormalities. In particular, peroral multiple biopsies of the small intestine should prove fruitful, since prior to the use of phenothiazines—a time when cereal grain consumption was much greater than now—patchy pathological changes in the small intestine, more or less similar to those more recently described in coeliac and dermatitis herpetiformis patients, were found at necropsy in a high proportion of schizophrenics.⁶⁻⁸—I am, etc.,

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Haemolytic-Uraemic Syndrome with Pericarditis and Pleurisy

SIR,—The report by Drs. J. A. Utting and D. R. Shreeve (9 June, p. 591) of pleural and pericardial haemorrhage occurring late in the course of the haemolytic-uraemic syndrome raises three important points.

First, streptokinase was given for twice as long as the manufacturers' recommended five-day period. Prolongation beyond this time may give rise to complications arising from the development of antibodies.

Second, the data provided do not allow a firm conclusion to be reached concerning the cause of the haemorrhagic pericardial and pleural effusions which occurred one month after admission. The absence of a rise in blood urea argues against recurrence of the original disease process. A very marked rise in serum fibrin degradation products was recorded but, in the absence of other evidence of increased intravascular coagulation (recurrence of thrombocytopenia, fall in coagulation factor levels, increase in circulating fragmented red cells) this might have been caused by lysis of fibrin within the haemorrhagic effusions. It would therefore

be of value to know the platelet count at the time of the haemorrhage and also the degree of prolongation of the thrombin clotting time resulting from heparin therapy.

Third, the clinical improvement which occurred in parallel with the introduction of aspirin and dipyridamole is not necessarily evidence of a cause-and-effect relationship.—We are, etc.,

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Congenital Hemihypertrophy

SIR,—The memorandum by Dr. M. Henry and others on congenital hemihypertrophy with aortic, skeletal, and ocular abnormalities (13 January, p. 87) is of interest. The authors mention possible lines of pathogenesis, and in a subsequent letter Dr. A. W. Johnston (17 March, p. 678) has reported that out of nine cases of congenital asymmetry only one had abnormal chromosomes. The accompanying photograph illustrates a further case of greater development of one side of the body than the other. The longer left side was noted from infancy, and the ultimate leg length difference of 3 cm produced a scoliosis, corrected by an appropriate raise. There was no special congenital disorder present and no chromosome studies are available.

The more dramatic features of patients with hemiatrophy or hemihypertrophy should not be allowed to overshadow the patients who have asymmetry extending to the lower limbs only. Greater clinical awareness is required, since asymmetry of this kind is not apparently as gross as that associated with hemihypertrophy. Once suspected, accurate measurement is required. The tape-measure or iliac crest palpation may give misleading results, as was shown when they were compared recently with a simple x-ray method¹ involving no more radiation than that for an x-ray of the pelvis, suitable protection being used as necessary. The x-ray taken erect gives accurate in-

formation about the actual discrepancy in the height of the femoral heads. It is interesting to note that any scoliosis observed clinically always appears greater on the x-ray. Lesser degrees of scoliosis may not be detected clinically, and this and other clinical features are obscured by obesity.

Though the least discrepancy worth correcting is still not clearly established, there are good clinical grounds for believing that it is at least $\frac{1}{2}$ in (12.5 mm), and in a report on one very large series based on radiological measurements it was suggested that 7 mm is the upper limit of the normal range.²—I am, etc.,

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Antibiotic Sensitivity of Klebsiella

SIR,—In our report on the contamination of E.C.G. electrode pads (19 May, p. 400) we stated that the *Klebsiella aerogenes* isolated appeared sensitive to ampicillin on disc sensitivity testing, and despite the finding that the minimum inhibitory concentration was well into the resistant range we do not share Dr. T. D. M. Martin's concern (9 June, p. 614) regarding our antibiotic sensitivity methods. Disc testing of this organism has produced the same results in two separate laboratories on several occasions.

We used the word "appeared" advisedly as the problems of interpreting disc sensitivity results of β -lactamase-producing organisms are well known. Almost all strains of *K. aerogenes* produce β -lactamase to a greater or lesser extent. Even with well-controlled disc sensitivity methods false results are easily obtained for such organisms, apparently as a result of small differences in inoculum. Hence in this paper, as elsewhere, when β -lactamase-producing *K. aerogenes* appears sensitive to ampicillin on disc testing, we would use the minimum inhibitory concentration as an essential and more accurate indication of susceptibility.—We are, etc.,

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Epidemiology of Simple Hypospadias

SIR,—Our colleagues Dr. C. J. Roberts and Mrs. Setsuko Lloyd reported (31 March, p. 768) that there was a marked seasonal variation in the incidence of hypospadias among 93,000 newborn infants in South Wales during the period 1964-6. This seasonal fluctuation was even more marked if the date of last menstrual period was used as the index of incidence. A similar finding had also been reported from the United States for 1963-5 by Wehrung and Hay.¹

In England and Wales the local public health authorities keep a register of all congenital malformations which are reported at birth, from which the Registrar General has kindly provided a tabulation of hypospadias or epispadias for each month during the past five years, notified from the whole country. This is given in the table.

England and Wales, 1967-71. Births Notified with Hypospadias or Epispadias per 100,000 Total Births (Male and Female)

Month of Birth	Year of Birth				
	1967	1968	1969	1970	1971
Jan.	104	119	101	100	100
Feb.	97	81	105	105	132
Mar.	74	87	100	84	126
Apr.	65	84	91	100	114
May	72	100	113	94	126
June	77	81	109	114	127
July	74	92	93	90	109
Aug.	91	70	76	116	107
Sept.	84	91	110	98	127
Oct.	59	95	103	98	102
Nov.	99	93	114	107	115
Dec.	102	89	95	78	127

These data differ from those of Dr. Roberts and Mrs. Lloyd in that their data included all cases found by careful record linkage between public health authorities, obstetricians, surgeons, paediatricians, and general practitioners in a local area, whereas the Registrar General's reports are based upon the public health information available from birth notification and health visitor examinations for the whole country. The possible loss of cases due to inadequate case finding may not be great, as Dr. Roberts and Mrs. Lloyd found 93 cases in 93,000 total births, which gives a rate of 100 per 100,000 and the Registrar General reports varying annual rates from 83 per 100,000 total births in 1967 to 118 in 1971.

An analysis of variance to determine the various components in the trend over the 60 months has been completed. The analysis first calculated the linear trend over the five years and then estimated if there was any cyclical deviation from this trend. There is clear evidence of a steady increase in the number of cases reported over the five years, but there is no evidence of any cyclical or other non-random variation from this trend. It is not clear whether the secular increase is due to a biological increase or whether it is due to improved reporting over time.

We are grateful to the Registrar General and the staff of the Office of Population Censuses and Surveys for the details of the monthly rates and permission to publish these results.

—We are, etc.,

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¹ Wehrung, D. A., and Hay, S., *British Journal of Preventive and Social Medicine* 1970, 24, 24.

Better Aids for the Deaf

SIR,—Your leading article (9 June, p. 569) on "Better Aids for the Deaf" comes at an extremely timely moment. The Department of Health and Social Security has been considering for some time the provision, under the National Health Service, of post-aural hearing aids for adults as an alternative to the body-worn aids. The advantages of the former include that they move more with the head rather than with the body of the user, they do not scratch on cloths, and they can be worn relatively unobtrusively. At the moment the Department of Health provides post-aural hearing aids for children, but when they are worn out they are replaced by body-worn aids, while adults who pre-

fer post-aural aids have to pay the full commercial price. The cosmetic advantage of the post-aural aids makes them very attractive to young adults despite their cost of £60-80.

The Department of Health has been considering the provision of the two kinds of aid with a choice for the patient for several years. Mr. Jack Ashley, M.P., has been pressing the Government on this question. It is to be hoped that it will soon find itself able to cater for the needs of hundreds of thousands of hard-of-hearing adults, particularly old age pensioners.—I am, etc.,

HAROLD HILLMAN

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Hospital Social Workers

SIR,—I note from the answer to a question in the House of Commons on 28 March¹ that the future of the hospital-based social worker is still in the balance. This member of hospital staff has made herself indispensable owing to the difficulties of clearing hospital beds of handicapped patients.

With the increasing age of hospital patients it is progressively more and more difficult to send these patients: (1) home; (2) to part III accommodation; or (3) to a geriatric bed. A census of the number of patients occupying beds simply because none of these disposals can be arranged would reveal the magnitude of the problems. The hospital-based social worker can work with the hospital consultant to implement this often desperately difficult disposal, whereas numerous local-authority-based social workers cannot all develop the same knowledge and gadgetry acquired by working in close conjunction with the hospital consultants.—I am, etc.,

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¹ Hansard, House of Commons, 28 March 1973, col. 318.

Points from Letters

Pruritus Vulvae

Mr. K. D. WATTS (Hereford) writes: Is Mr. C. N. McFarland (2 June, p. 553) aware that "open crotch" tights are regularly advertised in the small advertisements of the daily papers? Perhaps his patients could be persuaded to change to this garment if reluctant to abandon the usual design?

Redesign of Medical Records in General Practice

Dr. E. F. RICHARD (London S.E.17) writes: The argument for the new A4 international paper size . . . to be "in line with the generality of hospital and local authority health service records" does not seem to be valid, as the records primarily serve day-to-day general practice and only remotely the interchange between G.P. medical recording and hospital/health authority recording of medical facts. The interchange, where at all required, can easily continue to be done by correspondence as it is being done now. To what dimensions would medical recording swell, if hospitals, local health authorities, etc., could add their material of information to the G.P.'s without somebody doing the necessary pruning of inessential and overlapping reports we are doing now on our own judgement? Moreover, quite a few things in good doctor-patient relationship have to be clouded over and left unidentified and un-

Payment for Contraceptive Services

SIR,—The Annual Conference of Representatives of Local Medical Committees calls for a separate fund to finance the scheme for the provision of contraceptive services, and I am quite sure the Department of Health and Social Security will raise no objection since the Review Body has made quite clear that its recommendations are encompassed by a "pool system," if anything more pernicious than its predecessor. Perhaps you will recall Lord Halsbury's comments on private earnings? Though, he said, they were not within their remit, nevertheless, in fixing the intended average net income ". . . we must have some regard to them." He assessed them at about £400 a year and abstracted this sum from his recommendation.

No doubt when he compiles his future recommendations subsequent to April 1974 he will "have some regard" to the separately funded contraceptive service also, and so we shall finish paying ourselves, as a profession, for the work involved.

When will the General Medical Services Committee take courage and have this totally unacceptable system erased?—I am, etc.,

L. M. ELLIS

Storrington, Sussex

Representation of Hospital Doctors

SIR,—With reference to the letter of Dr. R. M. Mayon-White (19 May, p. 424) I would like to remark that I have received no bulletin, no memoranda, and no questionnaire from him in the past seven years during which I have been a consultant in the Ipswich Group. Perhaps I was not on his mailing list; perhaps there are other consultants in the group also not on his mailing list. This may explain why the response was poor.—I am, etc.,

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recorded. Would I like somebody else but my partner to know that I consider Charlie to be malingering or having come to me for confidential treatment of V.D. or being a homosexual?

Significance of Ectopic Beats

Dr. F. SCHNEIER (Johannesburg) writes: With reference to your leading article (28 April, p. 191), it is an observation made by many clinicians, particularly in intensive care units, that extrasystoles, particularly if numerous, and more so if of the ventricular configuration, require specific therapy. These often precede more severe arrhythmias, particularly ventricular fibrillation and flutter, and their treatment is frequently most rewarding.

Practice in the United States

Dr. J. A. LACK (Stanford Medical Center, California) writes: I regret that Dr. D. Bentley (14 April, p. 118) is misinformed on the requirements for medical licensure in the U.S.A. He is quite correct in pointing out that the E.C.F.M.G. exam is required for hospital practice, and is not a licence for general practice. For this the Federal Licensing Examination (F.L.E.X.) is required, an examination held in December and June (written), with subsequent oral examination. However, an exchange visitor's visa is adequate, as several colleagues and I can testify.