Pollen Count and Asthma

SIR,—Working in a busy casualty unit, I saw very few sequelae attributable to the recent extraordinarily high pollen count; presumably all the hay fever was being controlled by G.P.s.

When the spell of hot weather ended with the usual British downpour the pollen count fell from 130 to 23 overnight, bringing relief, one would have thought, to thousands of hay fever sufferers. However, on this particular night I saw two young adults, both with a long history of hay fever, having their first attack of asthma. Both were extremely dyspnoeic. Their symptoms had started a few hours after it had started to rain, lowering the pollen count.

Two cases are hardly of statistical significance but I wonder if others have noted this phenomenon, in which the asthma was possibly caused by a change in antigenic stimulus (in these cases a lowering) rather than a high level per se.—I am, etc.,

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Double-lumen Tube for Gastric Secretion Studies

SIR,—It has been shown that the accuracy of gastric secretion studies may be improved by making a correction for losses of gastric juice through the pylorus.^{1,2} This pyloric loss may be determined with an inert marker, such as phenol red, which is instilled into the upper part of the stomach at a constant rate while the gastric juice is being aspirated from the antral region.¹ This arrangement allows mixing of the marker with the gastric juice. The fraction of the marker recovered during any period represents the fraction of gastric secretion that has been recovered in the same period. No double-lumen nasogastric tube that meets these requirements appears to be commercially available. The following is a description of how to assemble such a tube.

A standard nasogastric tube (14 or 16 F.G.) is used and the second lumen is provided by a length of vinyl tubing (external diameter 0.99 mm, internal diameter 0.51 mm). In order that this shall not get damaged it is contained within the parent nasogastric tube. A wide-bore needle (17 gauge, 5 cm long) is inserted into the lumen of the nasogastric tube at point A (see fig.) approximately 12.5 cm from the proximal end. A second needle is inserted at point B, 12.5 cm proximal to the tip of the nasogastric tube, in the manner indicated. The fine tubing is passed through the first needle and along the stretched nasogastric tube to enter and pass through the second needle. Both needles are then removed. The tubing is cut flush at its site of exit (point B) and a simple manipula-

tion results in its end retracting into the lumen of the parent tube. A side hole, approximately 2-3 mm long, is made in the fine tubing where it lies on the surface of the nasogastric tube (point C), and distal to that point the remainder of the fine tube is crushed with an haemostat to prevent any further downward flow of the marker. As suction is used to obtain the samples of gastric juice the proximal site of entry of the tubing (point A) is a possible site of leakage of air and so this is sealed—for example, by spraying with Nobectane (B.D.H. Pharmaceuticals Ltd.). A No. 1 Luer needle fits snugly into the fine tubing, thus allowing a routine attachment to the instillation apparatus.—We are, etc.,

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¹ Hobsley, M., and Silen, W., *Gut*, 1969, 10, 787.
² Hassan, M. A., and Hobsley, M., *British Journal of Surgery*, 1971, 58, 171.

Confidentiality and the Road Traffic Act

SIR,—Members of the B.M.A. will be extremely grateful to you for the generous space which you have given to the important case involving Dr. J. D. W. Hunter of East Grinstead (7 July, p. 57). Even so, in summarizing the evidence, it may be that in one instance a false impression could be gained that the B.M.A. is only interested in advising on "difficult" ethical problems.

You quote me as saying: "It is only in difficult cases we [the Central Ethical Committee] are asked to advise. I should say this case falls far short of that. We were not asked to advise; Dr. Hunter consulted his medical union." In fact we are always very pleased to advise members on any ethical problem, and in so doing we sometimes consult (or, as in this case, are consulted by) the defence bodies. There was urgency in this case, as Dr. Hunter was about to be summonsed, and so he telephoned his defence body directly.

As I recall I gave the reply that "this case falls far short of that" to a different question from the Chairman of the Bench as to when a doctor could disclose confidential information, and I went on to give my reasons. I am of course prohibited from commenting on the case itself, which is still sub judice, pending an appeal.

In the mean time let your readers remain in no doubt that one of the many important advantages of membership of the Association is access to advice on any ethical problems that may confront a member in practice. In particular, if any member is asked by the police to give confidential information about his patients without their consent, and he feels unable to comply with this request, he

should get in touch at once with Secretary of the Association.—I am, etc.,

J. S. HAPPEL

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Central Ethical Committee, B.M.A.

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Prescription Charges for Levodopa

SIR,—Over the past few years we have all become very interested in the treatment of Parkinsonism with levodopa.

Most clinicians and others of scientific bent would, I think, accept the suggestion that since many of the symptoms of Parkinsonism can be corrected by the administration of levodopa, and since in cases of Parkinsonism there is an undoubted deficiency of dopamine in the cells of the basal ganglia, it might reasonably be suggested that in some ways Parkinsonism is a deficiency disease similar in a way to the deficiency situation we see in Addison's disease or even diabetes.

We have suggested to the Department of Health and Social Security that people needing regular therapy with levodopa, should, in fact, be granted exemption from prescription charges. We have even gone so far as to approach one member of Parliament on the subject, but the answer in all cases (though the member of Parliament was very sympathetic) has been that the appropriate sub-committee of the General Medical Services Committee does not feel that people with Parkinsonism should qualify for exemption from the charges. I have recently received a letter from the secretary of the committee saying that they have sought the views of the Chief Medical Officer in the Department of Health and Social Security, who also says he does not consider the use of levodopa in Parkinsonism justifies exemption from prescription charges.

You will see that we are really faced with a blank wall, and since many of my senior colleagues, even in different disciplines, with whom I have discussed the situation all feel that there is a logical case for exemption I am wondering whether you would care to give this problem a little publicity.—I am, etc.,

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Artificial Insemination by Donor

SIR,—Professor J. S. Scott's interesting suggestion (30 June, p. 781) that men awaiting vasectomy might donate semen for A.I.D., or for their wives' future use, sounds a good idea in theory since these men have all proved their fertility. In practice, however, it would not be so ideal and the semen would have to be frozen rather than used for fresh insemination. It is difficult enough to arrange for a medical student to deliver a fresh semen specimen at the right time and place to inseminate a matched recipient: to ask a middle-aged man to take a half-day off work to deliver a fresh specimen would be quite impracticable unless he were paid a vast fee.

Couples who request A.I.D. are, not unnaturally, very curious about the background of the donor. I doubt if they would be satisfied to be told no more than that the donor was an unknown man awaiting