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.,

S. COPELAND

Chase Farm Hospital,
Enfield, Middlesex

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.,

JAMES P. S. THOMSON
R. C. G. RUSSELL
MICHAEL HOBSLEY

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London W.1

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

Chairman,
Central Ethical Committee, B.M.A.

B.M.A. House,
London W.C.1.

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.,

L. A. LIVERSEDGE

Department of Neurology,
Royal Infirmary, Manchester

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

vasectomy. I find that they will always accept an anonymous medical student as the father of their child and I like to believe that this is because the medical profession is still held in high regard by the public.

And if a man donates semen with the proviso that some of it should be reserved to inseminate his own wife if this becomes necessary he would have to produce an awful lot of semen. Experience shows that the average middle-aged woman, who is not highly fertile, can require quite a lot of inseminations before she becomes pregnant. The expense of keeping vast quantities of frozen semen for men who might change their minds after vasectomy is not one which the National Health Service should be expected to bear.—I am, etc.,

ROBERT NEWILL

University College Hospital,
London, W.C.1.

Women Doctors and Family Planning

SIR,—I am writing about the uncertainties now facing many women doctors working in family planning. It is not at all clear what their future prospects are to be now that family planning is to be fully integrated into the National Health Service. I note from the discussions about family planning at the Annual Representative Meeting of the B.M.A. that a motion to the effect that family planning work "should be undertaken by a special clinic set up for the purpose" was carried only after the "may" was substituted for "should" (*Supplement*, 23 June, p. 140). Surely the clinics should still continue, not only to limit the increase in the work load which would otherwise devolve on the

general practitioners but also to give patients a degree of choice which is still clearly essential in view of the reluctance of some practitioners to countenance this kind of work.

Successive governments have been concerned about women doctors continuing to practise; family planning is one of the fields to which they have been attracted and to which indeed they are entirely suited. Over the years such doctors have worked for the Family Planning Association without paid holidays and without pension schemes, etc., because they were dedicated to an ideal and for the more practical reason that the mainly sessional nature of the work fitted in with their family life (many being wives and mothers). Are women doctors now to be deprived of this and their expertise lost? If a similar number of male doctors (1,900) faced the same uncertainty about their prospects I feel there would be a much greater outcry.—I am, etc.,

ELPHIS CHRISTOPHER

London N.10

Laparoscopy or Peritoneoscopy?

SIR,—Twenty years or more ago I was introduced to an instrument called the "peritoneoscopy," which was used for examining the contents of the abdomen without laparotomy, and sometimes even for performing minor operative procedures. Very useful I found it, and I still use it. It seems to me well named, for every abdominal organ one examines in the peritoneal cavity is viewed through peritoneum.

The word *λαπαρά* is given in my lexicon to mean "the soft part of the body between the ribs and hip, the flank, flanks." Laparo-

tomy, or cutting the flank, was first practised at a time when to open the peritoneal cavity was considered fatal. By an acceptable extension it is now, however, used to describe opening the abdomen. Laparoscopy, if it means anything, means observing the flank or flanks, and seems to me an unacceptable solecism. I was first introduced to it a year ago when I was asked by a gynaecologist if he could borrow my laparoscope: I replied in honest ignorance that I had no such instrument. Now that I have joined the ranks of the opsismaths I fear it is too late to abort this abomination, but may I make a despairing plea to my gynaecological colleagues for prior consultation before entering into further foreign fields?—I am, etc.,

MICHAEL REILLY

Plymouth

College of Omphalology

SIR,—Regarding Dr. Bryan Williams's Personal View (23 June, p. 712), may I point out that his suggested inauguration of a College of Omphalology was proposed in detail—complete with requirements for membership and fellowship—in a lecture given by Professor O. H. Mavor (1881-1951) of Glasgow, better known by his pseudonym James Bridie, the Scottish playwright, about 35 years ago.

If Dr. Williams, whose Personal View I much enjoyed, is further interested, he will find that a report of Professor Mavor's lecture was published in the *B.M.J.*¹—I am, etc.,

IAN CAMPBELL

Swinton,
Mexborough, Yorks

¹ Mavor, O. H., *British Medical Journal Supplement*, 1939, 1, 245.

Points from Letters

Neurological Disease Associated with Folate Deficiency

Dr. A. MOREL-MAROGER (Paris) writes: In their interesting paper (19 May, p. 398) Dr. E. H. Reynolds and his colleagues suggest that neurological disorders may be due to folate deficiency. I would like to mention that in 1969 Drs. P. Castaigne, D. Laplane, A. Lemonnier, and I,¹ in a critical reappraisal of the histidine-load test, had already concluded that folate deficiencies could be responsible for a number of neurological disorders. I am surprised that Dr. Reynolds has not been acquainted with this publication, in which many references, including his own works, were quoted.

¹ Castaigne, P., Morel-Maroger, A., Laplane, D., and Lemonnier, A., *Annales de Médecine Interne*, 1969, 120, 479.

Practice in the United States

Dr. J. R. T. DAVIDSON (University of North Carolina, Chapel Hill) writes: Regulations governing medical licensure in the U.S.A. depend entirely upon which state one settles in. Thus there are certain states—e.g., New York—that may be willing to grant a full licence to practice medicine to postgraduate British doctors who have only the E.C.F.M.G. and not the F.L.E.X., whereas other states require citizenship and the F.L.E.X. before full parity can be obtained. Furthermore, there is the matter of reciprocity among the states. The advantage of the F.L.E.X. examination is that it constitutes a uniform assessment of medical knowledge throughout the country, and although the vast majority of states will grant reciprocity to a

candidate who has passed the F.L.E.X. elsewhere, each individual state is free to set its own pass mark and there still exist certain places in which reciprocity is not granted at all. In such a case, it would be necessary to take the state board licensing examinations.

A Clinical sign of Adenomyosis?

Mr. F. G. FEINSTEIN (Bulawayo) writes: For some time now I have been impressed by the extreme tenderness experienced when the uterocervical canal is sounded premenstrually, in patients subsequently found to have adenomyosis. Nothing like this discomfort is experienced by others. As this is a notoriously difficult condition to be sure of clinically, I would be interested to hear comments through your columns.

Redesign of Medical Records in General Practice

Dr. H. F. FILE and others (Brixham) write: May we join Dr. J. M. Brown and other correspondents (26 May, p. 483) in expressing our concern and anxiety on the subject of the A4 folders for all the reasons they have already mentioned. We wish to point out in addition that, though circular ECN 946 refers to the storage space required as having to be twice the size of the present space, a firm of cabinet manufacturers approached by us suggests that up to six times the present cubic space is to be seriously considered. . . . If this is to be believed, many doctors will have to abandon their premises

and most will have to undertake important structural changes. . . . Finally, may we point out that not a single A4 folder is available for inspection and that no one in official circles is able to give us any idea as to whether any form of financial help will be available.

Dr. P. A. WALFORD (Felsted, Essex) writes: The reason for the decision to use larger record files is that our present record envelopes are bursting at the seams; and the reason that they are bursting is not because of the records they contain but because of the hospital letters. The reason these letters take up so much room is that they are written on notepaper that has to be folded once or twice to fit the record envelope. There are two possible solutions. One is to make the hospital notepaper smaller; the other is to make the files bigger. The powers that be have selected the second alternative, to the dismay of all practitioners who will have to find at least twice as much floor space as is needed for the present ECs 5 and 6.

Hospitals in Switzerland

Dr. W. T. MENKE (London W.5) writes: In the interesting article "Two Rheumatologists—Geneva and Glasgow" (16 June, p. 656) there seems to be some confusion relating to hospitals in Europe. In a teaching centre in Switzerland the university hospital is the cantonal hospital, and there is a dual official interest via the Department of Education and that of Health. Because Switzerland has no Federal Department of Education such hospitals achieve "state" level for the teaching side.