We feel that Gram-stain examination and culture of the fluid is the best means of differentiating between infection of the peritoneum and aseptic peritonitis, two conditions that require different management.—We are, etc.,

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Reaction to D-Penicillamine in Rheumatoid Arthritis

SIR,—We read with interest the letter from Drs. J. Shafer and F. D. Hollanders (4 August, p. 289) and would make the following comments. Firstly, like Dr. C. F. Hawkins (18 August, p. 406), we would expect an exacerbation of symptoms in a substantial proportion of patients in whom all therapy had been withdrawn immediately before being offered D-penicillamine. There can be no doubt that a latent period before the drug becomes effective is the norm with this therapy. Moreover, we do not consider withdrawal of concomitant therapy until the patient begins to show laboratory evidence of improvement, often six to eight weeks from the start. This does not apply to previous gold therapy, however, for the more we have used penicillamine during the past six years the more uneasy we feel about the incidence of bone-marrow depression in patients on penicillamine who had had previous cryotherapy. We do not offer penicillamine to these patients any longer.

Secondly, Drs. Shafer and Hollander's reference to "the disorder of taste which is known to occur in one-third of patients on penicillamine therapy" is worthy of comment. In our series of 107 patients (the first of whom started treatment in 1966) we have had to withdraw only one patient because of loss of taste. A further 16 had transient impairment of taste—10 of them while receiving a dose above 1.2 g/day, as reported before.¹ The incidence of impairment of taste has a correlation with high doses of penicillamine, and almost all those unfortunate enough to experience it on a low dose can expect recovery (without interruption of treatment) within two months.—We are, etc.,

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¹ Golding, J. R., Wilson, J. V., and Day, A. T., *Postgraduate Medical Journal*, 1970, **46**, 599.

Sex and Social Class

SIR,—Apropos your leading article (21 July, p. 121) on the use of family planning services in England and Wales,¹ clearly much more can and must be done to encourage women of all ages in social classes 4 and 5 to follow the example of their middle-class contemporaries in enjoying the benefits of existing family planning services. But more must be done to improve further and expand services if the needs of many communities and of the nation as a whole are to be fulfilled and these must be suitably publicized via the responsible local press and informative public notices.

My experience in Aberdeen is that women in the late 30s and 40s of all classes are invariably very appreciative personally of

family planning advice. Such women can be encouraged by the doctor to discuss the topic with their teenage daughters and can be provided with booklets² and informative material. In Aberdeen family planning education is included in mothers' and parents' club programmes, and in one working class area mothers bring their teenage daughters to family planning talks and discussions at a clinic on a council housing estate.

Certainly some diffident women may be deterred from attending clinics where they feel a lack of privacy—"everyone knows what you've come for." This can easily be overcome, as in Aberdeen, by provision of multipurpose clinics. One Aberdeen clinic is in a building complex with medical and dental clinics, with a local library adjacent and near to a shopping centre. No embarrassment here! Obviously accessibility is vital, with convenient location and opening times. However, the need is often unvoiced where advice is most necessary. Parents in one Aberdeen urban area requested a clinic after they had organized an opinion poll, yet this was a low-density housing area with a low birth rate and high motivation for family planning advice. No such request was received from the highest-density housing area with the largest number of births, but when facilities were provided the attendance soared so much as to require a busy clinic twice weekly. Clearly the general practitioner has a vital role to play. But G.P.s require to take more interest in follow-up and domiciliary cases. In this the G.P. has an invaluable colleague in the health visitor to co-ordinate efforts.

The numbers of abortions in older women might level off and decrease if there was more discussion of the option of sterilization for women in their 30s whose families are complete. (There were 17,500 terminations in women over 30 years in England and Wales in 1969.³) Such sterilization is often the method of choice for some women who find years of continuous pill taking too much of an organization. Abortion in younger women could also be made safer by greater efforts to encourage advice at earlier stages of gestation. A publicized, confidential pregnancy diagnostic service provided along with family planning services could improve this. The knowledge of facilities available to prevent unwanted pregnancy is, as you state, passed by word of mouth but they can also be effectively publicized, as in Aberdeen, by circulating informative brochures to industry and work places.

Basic to all improvements is the inclusion of sex education in a first-class health education programme. One idea is the benefit of social studies courses in schools, in which studies and visits are undertaken to various places to show what the community has to offer.⁴ The numerous facilities relevant to the well-being of young people should be included in such courses so that information is combined with knowledge of services and facilities and confidence in obtaining professional advice.—I am, etc.,

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¹ Bone, Margaret, *Family Planning Services in England and Wales*, London, H.M.S.O., 1973.
² Pilkington, R., *Facts of Life for Children*, Barnes, K., *15+ Facts of Life*, London Family Doctor Publications, 1971.

³ Registrar General's Statistical Review for England and Wales for 1969, Supplement on Abortion. London, H.M.S.O., 1971.

⁴ Dallas, D., *Sex Education—Exploring Education in School and Society*, National Foundation for Educational Research in England and Wales, 1972.

Child Injury Intensive Monitoring System

SIR,—Drs. Geoffrey Diggle and Graham Jackson (11 August, p. 334) raise several important issues. They believe that a "realistic and accurate assessment" of the scale and nature of the battered baby problem can be made by a computer-based system working initially at local authority, regional, and eventually national level. They fail to mention, however, that several local authorities have already established confidential central registers concerning such children. Furthermore, medical personnel now have at their disposal a "request for information form" that provides information similar to the more elaborate scheme they propose.

The use of these forms in Birmingham has been recently assessed during the course of an investigation based on 134 cases admitted to hospital. The relevant form was made available at casualty departments and paediatric wards throughout the region and doctors were instructed that when confronted with a case they should complete the form and forward it to the social service department. Following this they received a prompt reply informing them whether the child had been previously battered or suspected of being battered. A list of the names, telephone numbers, and addresses of those previously involved with the child were also supplied. This procedure was approved by the Medical Defence Union as involving no breach of confidentiality. Nevertheless, of 134 cases, in only one-third was the form completed.

Perhaps, therefore, Drs. Diggle and Jackson's confidential files might be used if they are made available at paediatric hospitals rather than social service departments. However, it may still be erroneous to assume that their scheme will necessarily provide reliable statistics because there are still likely to be a number of doctors who fail to provide their computer with information. To rely on the discretion of casualty officers and others to provide relevant information seems rather optimistic in the light of experience. Even in the U.S.A., where mandatory reporting of battered baby cases has been in existence for a number of years, "conflicting estimates" still occur. Improvement could readily be made if doctors accurately recorded the correct diagnosis on the summary discharge sheet. This still too rarely occurs.

Even if reliable statistics are available, this does not necessarily imply efficient management of the battered baby syndrome. Indeed, management of the problem has in the past too often been plagued by a tendency to rely on the case conference on the assumption that discussion alone is in the best interests of the child. I would suggest, however, that this is extremely inefficient and would instead propose that a regional team, hospital-based, consisting of a paediatrician, psychiatrist, social worker, and psychologist, should be established to tackle the overall problem. This would circumvent the present system of leaving the management of