hepatitis and hepatitis-B antigen was shown to be present by both haemagglutination and electrophoresis.

This case cannot, of course, be claimed to provide proof of a causal association between acupuncture and serum hepatitis. The possibility of transfer of infection by an inadequately sterilized needle should, however, be borne in mind.—I am, etc.,

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Referees and Rejects

SIR,—The point made by Dr. D. F. Horrobin (27 April, p. 216) on referees and research administrators as barriers to scientific research certainly is topical in small countries where, as pointed out in your leading article (p. 185), personal aspects will come in, often to a dangerous extent. Professor J. M. Tanner (18 May, p. 381) asks for a precise blueprint of a system and I venture to suggest one which at the same time may illustrate some of the problems faced in this connexion by research workers in smaller countries.

(1) Editors should take more personal responsibility in estimating whether a paper may not, for example, require a longer summary than usual or a few pages less than average. As it is, one often feels that strict rules have been laid down to facilitate the running of the journal by clerks. It is true that acceptance of bad papers will in the long run ruin a journal but unjust rejection of a good paper will have its immediate effect on the author who, after all, is more important to research.

(2) Journals should give lists of their referees (for example, on their cover), with more than one expert in each field. This would serve to prevent the possibility that the same men could reject the same paper for more than one journal.

(3) Authors should be permitted to recommend one referee from this list and, if they want, to delete a name in their own case.

(4) Referees should make their remarks in better form than is often the case. Grammatical errors or clumsy constructions in manuscript from foreigners should be marked—for example, with question marks—suggesting that the referee respects the effort it is to present a paper in a language different from the author's own.

(5) Anonymity should extend equally to authors and referees, leaving both sides of the fence guessing. Self-justification is not restricted to authors, who could give their names on separate sheets.

(6) Editors should never at the same time serve as members of granting agencies.

(7) At least 75% of the members of these august bodies should have made contributions to research, and the chairman should belong to this category. Direct appointments by Ministers should not take place and membership should not extend to more than six years.

(8) Members of granting agencies should not be permitted to participate in the discussion of applications from their own institution unless called in for conference, as may be customary for others. It certainly is preferable that members should refrain from applications to their own agency during tenure of membership.

(9) Applicants should, in case of rejection, have access to the verbatim and full comments on their application and should have the opportunity to forward their own remarks and some access to appeal—for example, to experts abroad.

Generally, rules should be laid down to forestall unfortunate developments. It is well known that, not unlike politicians in some Eastern states, many members of the medical profession want to crown a career of influence ("medical politics") with the air of a scientist. If this happens often, the danger

is that scientific research will become a pyramid in each country, and the true scientists will go where freedom is—that is, where research is administered by scientists.

Perhaps I may add that through 38 years I have found referees helpful in nearly all cases, though in most cases there have also been various misunderstandings. The trend, however, is towards some reduction of the former quality and some increase of the latter. The animosity against publishing statistics on man to the same extent as on the mouse has, however, not changed.

I have only once seen an important constructive proposal from a referee. Since this happened with your journal I venture to submit the above comments.—I am, etc.,

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SIR,—Dr. D. F. Horrobin (27 April, p. 216) draws attention to the secrecy and fallibility of the procedures for assessing grants in Britain. New procedures are needed such that the applicant can react rationally to known criticisms, valid or otherwise, instead of having to ponder an unlimited number of conceivable ones. If necessary, subsequent correspondence could be strictly limited.

In the meantime research workers should feel no obligation to justify in detail their research proposals unless, in reciprocal courtesy, the funding agency agrees to justify the contrary view, at least briefly, should that be the outcome of the assessment procedures. Feedback of one sort or another has been in operation for many years in Canada and the United States and elsewhere, hence Professor J. M. Tanner (18 May, p. 381) seems to be incorrect in implying its impracticability.

The Medical Research Council and Department of Health and Social Security, having failed so far to respond constructively to the widespread requests for review of their procedures,¹⁻⁵ should not be surprised if an independent inquiry, as suggested by Professor V. R. Pickles (18 May, p. 382), is eventually set up.—I am, etc.,

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- 1 Dixon, B., *New Scientist*, 1974, 61, 522.
- 2 O'Brien, J. R., *Lancet*, 1973, 2, 1323.
- 3 Pickles, V. R., *Lancet*, 1974, 1, 620.
- 4 Renwick, J. H., *Lancet*, 1973, 2, 624.
- 5 Williams, B., *Lancet*, 1973, 2, 798.

Complication of Proximal Gastric Vagotomy

SIR—All surgeons interested in modern gastric surgery will have read with some concern the complication of lesser-curve necrosis after proximal gastric vagotomy described by Mr. J. F. Newcombe (10 March 1973, p. 610) and again by Mr. J. H. Wyllie (8 June 1974, p. 561). However, I hope none will be persuaded to abandon or not to adopt this important advance in gastric surgery.

We must not forget that bilateral selective vagotomy divides the arterial supply of the lesser curve completely from the cardia to the pylorus, while proximal gastric vagotomy preserves its arterial supply for some 10-12 cm above the pylorus. If lesser-curve

necrosis is a complication of vagotomy it must occur more frequently after bilateral selective nerve section than after the proximal gastric operation.

In some 1,000 bilateral selective operations performed between 1957 and 1970 and some 400 proximal vagotomies since 1970 I have never seen this complication and I am sure that others can record similar results.—I am, etc.,

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Hyperthyroidism and Giant-cell Arteritis

SIR,—Now that immunity is known to be altered in giant-cell arteritis the comparison between this disease and sarcoidosis¹ is closer than was earlier realized. The immune response may account for both the higher incidence of hyperthyroidism in the cases found by Drs. R. D. Thomas and D. N. Croft (25 May, p. 408) and the focal and granulomatous hepatitis, which has occasionally been reported.^{2,5} The systemic reaction satisfactorily explains the anaemia, raised E.S.R., and weight loss, and the immune reaction appears to prolong rather than curtail the inflammation. Giant cells are a feature of both the diseases, the duration of activity of each is similar, and the symptoms of both are controlled by small doses of prednisone. Giant-cell arteritis occurs after middle age, when arteries are more liable to atherosclerosis. The inflammation damages the arteries predominantly, and the lesions elsewhere remain subclinical. The occurrence of the arteritis only in the elderly is unexplained. But in patients whose immunity is already raised microembolism of atheromatous plaques⁶ might cause the focal arteritis. Thyroid biopsies and immune studies in prospective studies of cases of giant-cell arteritis are likely to be interesting. The patients with thyroid or liver involvement might at least show the immune reaction of sarcoidosis.⁷ The arteritic lesions are after all not unlike the granulomas seen at venepuncture sites in some cases of sarcoidosis. Myocardial sarcoidosis is being seen more often now.⁸—I am, etc.,

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- 1 MacGregor, G. A., *Lancet*, 1972, 1, 1067.
- 2 Hall, G. H., and Hargreaves, T., *Lancet*, 1972, 2, 48.
- 3 Long, R., and James, R., *Lancet*, 1974, 1, 77.
- 4 Gibbs, P., *Lancet*, 1974, 1, 351.
- 5 Barnes, C. G., *Lancet*, 1974, 1, 459.
- 6 MacGregor, G. A., *Lancet*, 1961, 2, 1160.
- 7 Caspary, E. A., and Field, E. J., *British Medical Journal*, 1971, 2, 143.
- 8 Fawcett, F. J., and Goldberg, M. J., *British Heart Journal*, 1974, 36, 220.

Ischaemic Colitis Due to Myxoedema

SIR,—We think it worth while to record the following case of ischaemic colitis secondary to myxoedema.

A 53-year-old woman presented with habitual constipation, shock, and abdominal distension. Vomiting had produced severe dehydration. Abdominal radiography showed considerable gaseous distension of the large bowel. After treatment with steroids, plasma expanders, and intravenous fluid replacement the blood pressure improved. At laparotomy the transverse colon was dilated and necrotic at the splenic flexure. Hard faeces obstructed the descending colon. The

affected bowel was resected. The patient was given massive doses of steroids, antibiotics, and fluid replacement for septicaemic shock and gradually recovered. Clinical features of myxoedema were then apparent and this was confirmed by iodine studies. The patient's appearance and bowel habit returned to normal with thyroxine. Histologically, the resected bowel showed features of acute ischaemic colitis.

Constipation and abdominal distension are well-recognized features of hypothyroidism. Gross colonic dilatation in this patient was followed by mucosal ischaemia and necrosis, allowing the development of septicaemic shock secondary to invasive infection. The usually fatal outcome in this condition was avoided by prompt excision of the diseased bowel and intensive therapy for septicaemic shock.—We are, etc.,

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D. A. K. WOODWARD

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- 1 Chadda, J. S., Ashby, D. W., and Cowan, W. K., *British Medical Journal*, 1969, 3, 398.
- 2 Liechty, R. D., Miller, R. F., and Cohen, W. N., *Surgical Clinics of North America*, 1970, 50, 1087.
- 3 Marston, A., et al., *Gut*, 1966, 7, 1.

Conversations on the Social Services

SIR,—I certainly sympathize with some of your special correspondent's criticisms of local authority social services departments (22 June, p. 659) but am glad he appreciates some of our difficulties. Time will doubtless heal the wounds and disabilities inflicted by all the recent reorganization, not least of which are this year's local government and N.H.S. restructurings. However, as we all strive to practise the flexible community-oriented care which the 1972 N.H.S. White Paper outlined "to provide for the population of a given area of a comprehensible size the best health service that the money and skills available can provide,"¹ we realize only too clearly that much of the work of a social services department does indeed present in the general practitioner's surgery.

While social workers do understand the "threat" they and their rapidly developing bureaucracies pose to the single-handed practitioner and the frustration this ever-changing personnel and structures can cause, they equally feel threatened by those doctors who remain on their "professional pedestals." One of the major problems can be lack of accurate and perceptive communication between us when we employ fundamentally different jargon and philosophies, doctors being accused of being unnecessarily brusque and social workers as being hopelessly long-winded.

It is essential that we talk purposefully together. While the case conference offers a valuable avenue, it can be abused when utilized in the way your correspondent describes, and both professions are guilty of that. It should be used only where appropriate and in the enhancement of increasingly necessary interdisciplinary teamwork, both within and outside the hospital. Until the principle of linking social workers in social services departments with group practices is fully accepted by both doctors and social services administrators alike the most functional type of communication must be individual contact, preferably face-to-face, as the needs arise. In that

way we can, it is to be hoped, get to know each other better.

In our patients' best interests, therefore, we can do our jobs realistically only by mutual collaboration. That means remembering that it was our own Seeborn Report which exhorted social services departments to "make a determined effort to collaborate with local general practitioners," and similarly that the authors hoped that "the doctors will also exert themselves."² It was, after all, that very report which reminded us that G.P.s see "a higher proportion of those who are in difficulties than any other of the social services" and they accordingly need "the full support of them all."³

Incidentally, some of my best friends are G.P.s—I am, etc.,

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- 1 *National Health Service Reorganization: England*, p. vi, Cmnd. 5055. London, H.M.S.O., 1972.
- 2 Committee on Local Authority and Allied Personal Social Services, Report, para. 700, Cmnd. 3703. London H.M.S.O., 1968.
- 3 Committee on Local Authority and Allied Personal Social Services, Report, para. 692, Cmnd. 3703. London, H.M.S.O., 1968.

SIR,—As a health visitor may I comment on "Conversations on the Social Services" (15 June, p. 595). There is indeed some overlap between social workers and health visitors since both may be supporting the same client. However, the health visitor is primarily concerned with prevention and early detection of illness, both physical and social, and works with normal families to a greater extent than the social worker.

I should not like your readers to gain the impression that the health visitor is to be regarded as a second-best social worker. Before Seeborn we had in fact several duties that have now been ascribed to the social services departments. Those of us attached to general practices often act as a liaison between the practice and the statutory and voluntary social services in the area. I would also remind your readers that all health visitors hold the S.R.N. and health visitor certificates, as well as having some training in midwifery. The majority of social workers still have no professional qualification.—I am, etc.,

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Medicine in China

SIR,—Dr. I. Gordon (22 June, p. 674) has questioned the epidemiological sense of the concurrent observations that at the present time cervical cancer is common in China while premarital intercourse, venereal disease, and early marriage are reported to be very rare and frowned upon. This confusion ignores the obvious latent or incubation period between cervical cancer and the antecedent sexual behaviour. Dr. Valerie Beral¹ has most elegantly and convincingly demonstrated that the mortality rate for cervical cancer for an age group mirrors the reported incidence of gonococcal venereal disease for the period during which that age group was about 20 years old, based on data for the British Isles. Thus cases of cervical cancer identified today would reflect the sexual activity of 15-20 or more years ago, and reports of cervical cancer deaths today would reflect sexual activity at an even earlier time.

All reports from China today that indicate the low incidence of premarital intercourse, venereal disease, and early marriage make the point that these observations are in contradistinction to the situation prevailing a few decades ago. Thus the concurrent observations are not contradictory, but rather they hold out the possibility that the incidence of cervical cancer in China may be seen to fall markedly in succeeding decades.—I am, etc.,

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- 1 Beral, V., *Lancet*, 1974, 1, 1037.

Jaundice in Acute Pustular Psoriasis

SIR,—With regard to the case presented by Dr. D. J. Warren and others (25 May, p. 406), I should like to report a case of pustular psoriasis sharing one feature—namely, jaundice—with theirs.

A woman of 62 who had a three-year history of psoriasis with arthropathy treated with various drugs, including systemic methotrexate, was admitted with generalized pustular psoriasis. Pulses of intravenous methotrexate were given every 14 days and she remained stable for six weeks, when she developed a spike of temperature. She was started on fusidic acid and clindamycin (because of the report by McFadyen and Lyell¹ that antistaphylococcal treatment induces remissions of pustular psoriasis) and blood cultures were taken, which later proved sterile. No other evidence of infection was found. She had had no methotrexate for the previous 10 days.

Three days later she developed jaundice accompanied by marked leucocytosis. The jaundice was unusual in that it was unaccompanied by malaise; that the serum bilirubin was virtually all conjugated (to a maximum of 11.0 out of 12.2 mg/100 ml); that the bilirubin levels fell two days after her antibiotics were stopped and had returned almost to normal before any abnormality in the transaminases and alkaline phosphatase was noted; and finally that the leucocytosis reached very high levels (55,000/mm³), rising and falling in parallel with the bilirubin level. Thrombocytopenia prevented liver biopsy at this time. She died six weeks later and at necropsy there was a small, pale liver, histological examination showing moderately acute hepatitis with mixed cell infiltration of the portal tracts and severe fatty degeneration sparing the periportal areas.

The type of jaundice was difficult to classify, the conjugated bilirubin making it closest to, but much more severe than, the Dubin-Johnson type of congenital hyperbilirubinaemia. The subsequent rise in transaminases and alkaline phosphatase and the postmortem histology also make this diagnosis unlikely. It seems unlikely that the jaundice was due solely to oligaemia, pustular psoriasis, or methotrexate treatment. It seems possible, in view of the temporal relationship, that the giving of antibiotics and the jaundice were related. Both antibiotics concerned are excreted by the liver, and fusidic acid can compete with bromsulphalein for its excretory pathway, suggesting that an acquired intracellular transport defect could have developed.

However, it also seems possible that the liver in pustular psoriasis is predisposed to damage by the factors mentioned above, and it might be prudent to avoid drugs excreted by the liver in patients with generalized pustular psoriasis.—I am, etc.,

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- 1 McFadyen, T., and Lyell, A., *British Journal of Dermatology*, 1971, 85, 274.