survey, which may invalidate estimates. These elements include ignorance by the doctor of the syndrome, repugnance which may prevent acceptance of the possibility that a parent could kill a child, avoidance of confrontation by ascribing death to an associated existing clinical entity, the gulf between strong suspicion and proof, and, in a particular case, the overriding need to protect confidentiality and to safeguard a doctor-patient relation in the interest of the remaining members of the family. That the patients should be well known to the investigator is probably responsible for the confidence of the Tunbridge Wells Study Group¹ in Hall's figures, which gave rise to the national projection of 700 deaths from child battering. Support comes from two further investigations. Oliver² gave a national figure of 300 deaths per year—this presumably in a group which was known well to him. The Winnipeg³ investigation, which explored the number of children identified at a hospital as battered, showed that what was a figure of three deaths in 1957 rose to 18 in 1964, when investigators were themselves knowledgeable about the syndrome, but had risen to 34 in 1971, when others were also informed about the syndrome. Thus Oliver's figures could easily arise to 600 should others be as knowledgeable of the syndrome as the investigators themselves.

Discussion on statistics, however, could easily confuse the main issue. Whether it is 80 or 800 children a year who die from child battering, too many die.—I am, etc.,

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¹ Tunbridge Wells Study Group, *Non-accidental Injury to Children*, 1973.

² Oliver, J. E., *British Medical Journal*, 1975, 3, 99.

³ McRae, K. N., Ferguson, C. A., and Lederman, R. S., *Canadian Medical Association Journal*, 1973, 108, 859.

Asymptomatic Urethral Gonorrhoea in Men

SIR,—Drs. Patricia M. Perera and K. S. Lim, who report 24 cases of asymptomatic urethral gonorrhoea in men (16 August, p. 415), presumably confirmed their diagnosis, or made it in Gram-negative cases, by culturing the gonococcus. Clearly this is important in a controlled epidemiological study of this nature. The fact that five patients defaulted suggests that in the ordinary management of known contacts of known cases of female gonorrhoea, as with known contacts of known cases of male gonorrhoea, there is a strong case for epidemiological treatment before culture results are available and even where initial smears reveal no apparent gonococci. To wait for culture results, let alone insist upon second cultures two weeks after the first, in such instances, except in controlled epidemiological research projects or in cases where husband and wife accuse each other of introducing the infection, is necessarily fraught with the possibility of losing 20% of cases before treatment.

In the present context we would do well to remind ourselves that all male urethral gonorrhoea is asymptomatic in the incubation period, and men who have intercourse during this time and with more than one partner present a far greater problem in the control of gonorrhoea than Drs. Perera and Lim's 24 cases in seven months. It is the former who constitute the true counterpart

to the asymptomatic female who has traditionally been blamed for the spread of venereal disease.—I am, etc.,

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Pregnancy Tests—A McKinsey View?

SIR,—In "Anomie in the N.H.S.—A McKinsey View" (16 August, p. 424) Mr. Robert Maxwell states wisely that "we must recognize . . . that some things will have to be left undone, and we should know what these are likely to be." I would suggest that one of the things which might well be left undone is the testing of urine for pregnancy confirmation; this has become almost a routine procedure for every woman who misses a menstrual period. In this laboratory pregnancy testing consumes an ever-increasing proportion of our running costs.

It would seem reasonable that if a woman wishes an early diagnosis of pregnancy for social, domestic, or business reasons she should pay for the test as a separate item; this would considerably reduce demand. However, if a doctor wishes to know, for stated medical reasons, that a woman is pregnant this would be a justifiable N.H.S. expenditure.—I am, etc.,

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Miliary Tuberculosis Presenting with Polymyalgia Rheumatica

SIR,—I was interested in the description by Drs. C. Kennedy and G. K. Knowles (9 August, p. 356) of miliary tuberculosis presenting with skin lesions. I wish to report a similar case presenting with skin lesions but with the additional features of polymyalgia rheumatica.

A woman aged 69 was referred to the rheumatological outpatients department with a three-month history of pain and stiffness in the neck and shoulders. Examination revealed restriction of movement of the neck, both shoulders, and hips. Her erythrocyte sedimentation rate (E.S.R.) was 10 mm in 1 h. At follow-up she was noted to be anaemic and she had developed cutaneous nodules and a chronic bone-deep ulcer at the base of the right index finger. The nodules were 6 mm ($\frac{1}{4}$ in) in diameter, firm, slightly reddened, and initially non-tender, later becoming tender. They were situated on the dorsum of the left forearm, behind the left elbow, and on the posterior aspect of the left thigh. There were no other physical signs but the E.S.R. had risen to 102 mm in 1 h.

Biopsy of a nodule showed caseating giant-cell granulomata and fat necrosis. Mycobacteria were demonstrated with Ziehl-Neelsen stain. Liver biopsy was performed and the presence of caseating tuberculoid granulomata confirmed the diagnosis of miliary tuberculosis. Culture of the skin biopsy specimen grew acid-fast bacilli sensitive to streptomycin, rifampicin, PAS, and isoniazid. At no time was there any radiological evidence of pulmonary tuberculosis except for a transient minimal pleural effusion of doubtful significance. After starting rifampicin, PAS, and isoniazid a fluctuant swelling developed over the left scapula. Incision showed this to be a cold abscess related to an area of tuberculous osteomyelitis of the left scapula. After a year's treatment she developed a further cold abscess in the left forearm, which was incised, drained, and found to be sterile. Antituberculosis therapy was stopped after two years when the patient had made a good recovery with resolution

of the skin lesions and the pain and stiffness in the limb girdles.

This case serves further to show the value of biopsy in cutaneous abnormalities associated with miliary tuberculosis. Secondly, it underlines the need to investigate thoroughly the syndrome of polymyalgia rheumatica for any of the known associations.

I am grateful to Drs. J. A. Mathews and J. Taylor for permission to publish this case.

—I am, etc.,

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Medical Priority Rehousing: A New Approach

SIR,—I was interested to read of the medical priority rehousing scheme recently introduced in Sheffield as described by Dr. W. H. Parry (26 July, p. 233), as there appear to be significant differences between this approach and that developed in Dudley.

In 1966, following an approach by the Dudley Local Medical Committee, the housing application form was modified to include a section for use if the applicant wished to claim medical priority. This form was then passed to the medical officer of health, who contacted the family doctor of the patient. As the application form contained details of the existing accommodation it was found necessary in only a small proportion of cases to arrange for a visit by a health visitor or public health inspector. The standard letter from the medical officer of health to the family doctor included a clause indicating that it would be assumed that if no reply was received within 10 days there was no case for priority. With the boundary changes of 1974 the scheme was extended to the former municipal boroughs of Stourbridge and Halesowen, where the practice had been for the medical officer of health to visit applicants individually and make an assessment.

Because of the number of claims made on rather tenuous grounds applicants are now given a confidential inquiry form which they seal in an envelope addressed to the community physician. This, together with the housing department file, is then sent to the medical officer for environmental health, who decides from the information given whether there is a case for further investigation. If this is decided, the family doctor is asked to complete a problem-orientated housing medical report for which a fee is payable.

Regular weekly meetings are held with senior officers of the housing and social services departments to discuss applicants whose problems are more difficult to solve, and when outright priority for rehousing is recommended the case is decided by the special cases subcommittee of the housing services committee. In the year 1 April 1974 to 31 March 1975 2 194 cases were referred for assessment of medical points, and no points or priority were awarded in 30% of cases.

In the Dudley scheme the decision as to whether a claim is to be investigated rests with the medical officer for environmental health, and medical reports are submitted to him. No housing visits are made by a doctor, but in approximately 5% of cases visits are made by health visitors or environmental health officers for this specific purpose. Doc-