Cause of Unexplained Anaemia

SIR,—There is a high incidence of thalassaemia trait in large areas of the Indian subcontinent. This should always be borne in mind when investigating apparently simple iron-deficiency anaemias in the immigrant population. The finding of ankylostoma eggs may be a red herring, as the unsatisfactory response to iron therapy (oral or intravenous) will sooner or later reveal.

We have recently picked up four such cases in patients whose faeces contained eggs of the parasite. They were admitted for various conditions such as cerebral vascular accidents, appendicitis, pregnancy, and pneumonia. Despite a low serum and stainable bone marrow iron content, after iron medication the haemoglobin values showed no significant improvement and the morphological changes in the red cells remained largely unaltered. However, the number of cells with punctate basophilia increased, and the diagnosis of β -thalassaemia was subsequently confirmed by the presence of abnormal amounts of HbA₂ (4.2 to 6.3%).

These observations underline the importance of quantitating haemoglobin A₂, especially in immigrants originating from the northern regions of India and West Pakistan, particularly the Muslim section, in whom the incidence of the β -thalassaemia trait would seem to be the highest.—We are, etc.,

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Lung Transplantation

SIR,—Your leading article on lung transplantation (28 September, p. 755) states that one of the difficulties that will arise when the lungs are denervated is "slow-deep respiratory activity that is perhaps analogous to complete heart block." Section or block of the cervical vagi in animals does produce slow, deep breathing, but this is not true in man. The evidence for this is as follows:

In anaesthetized normal man, block of the cervical vagus nerves by lignocaine produces no change in tidal volume, respiratory rate, or pattern of air flow.² In conscious normal man lignocaine block of the glossopharyngeal and vagus nerves at the base of the skull produces no change in tidal volume, respiratory rate, or pattern of air flow.³ This information is now included in recent reviews⁴ and in standard textbooks.⁵

It can be predicted, therefore, that total lung transplantation in man will not result in slow, deep breathing as a result of denervation.—We are, etc.,

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REFERENCES

- 1 Breuer, J., S.-B. *Akad. Wiss. Wien, math.-nat. Kl.*, 11 Abt., 1868, 58, p. 909.
- 2 Guz, A., Noble, M. I. M., Trenchard, D., Cochrane, H. L., and Makey, A. R., *Clin. Sci.*, 1964, 27, 293.
- 3 Guz, A., Noble, M. I. M., Widdicombe, J. G., Trenchard, D., Mushin, W. W., and Makey, A. R., *Clin. Sci.*, 1966, 30, 161.
- 4 Campbell, E. J. M., *Ann. Rev. Physiol.*, 1968, 30, 105.
- 5 Comroe, J. H., *Physiology of Respiration*, 1965, Chicago.

SIR,—Your leading article on lung transplantation (28 September, p. 755) repeats an assertion made in two previous leaders on the same subject^{1,2} that "total denervation results in a type of slow-deep respiratory activity that is perhaps analogous to complete heart block." The suggestion is then made that some part of the host's own lung must be retained to "drive" the graft. These opinions derive from the work of Alican and Hardy.³ The altered pattern of respiration which they described as following pulmonary reimplantation and contralateral pneumectomy has not been observed by us.

Faber and his colleagues⁴ achieved long-term survival in 4 of 15 dogs following bilateral reimplantation with an interval between the two operations of only 7 to 10 days. This is good evidence that an intact nerve supply may be important but is not essential to satisfactory pulmonary function.

We believe that the adverse consequences of total pulmonary denervation have been overemphasized. In the presence of gross pathological sequelae of the operation such as pulmonary oedema, atelectasis, or vascular occlusion, it seems unnecessary to seek alternative explanations for a diminished lung function.—We are, etc.,

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REFERENCES

- 1 *Brit. med. J.*, 1963, 1, 1302.
- 2 *Brit. med. J.*, 1966, 2, 1218.
- 3 Alican, F., and Hardy, J. D., *J. Amer. med. Ass.*, 1963, 183, 849.
- 4 Faber, L. P., Pereira, A. L. S., Pevsner, P. H., and Beattie, E. J., *J. thorac. cardiovasc. Surg.*, 1965, 50, 761.

Psychiatric Interviews in General Practice

SIR,—I submit that Drs. B. Blackwell and D. P. Goldberg (12 October, p. 99), having at first set a fair course, subsequently steer into stormy seas in two areas. Firstly, they advocate that "at least a third of the available time at the first interview needs to be spent on this task" (that is, explaining treatment). Why are they so keen to institute treatment so soon, and to spend so long in a very short interview in explaining it? My own experience is that two or three interviews may be necessary before the real illness emerges, and that more often than not explanations are neither sought nor needed by the patient. The second stormy area is that in which the authors assume that treatment requires or involves tablets. The setting in which they have placed the doctor, as offering treatment, anticipating side-effects, predicting the likely duration of treatment, and warning patients against stopping treatment abruptly attributes to him overmuch authority and omniscience. It is unnecessary to become involved in arguments about the therapeutic value of antidepressive drugs, but not all doctors deny the significance of environmental influences in the causation of mental illness. These influences always demand careful and sometimes detailed consideration before the illness can be successfully resolved, and the fact that the authors omit any reference to them is a very serious deficiency.

Medical students are taught that the aim of treatment is to remove the cause of the illness. A patient who is being asphyxiated by escaping gas is removed from the room. A patient with pneumonia is treated with antibiotics, which by killing or reducing the bacterial population allows natural recovery. Similarly, the cause of patients' mental illness may frequently be removed or modified. The notion that mental illness results from an undefined intrinsic biochemical disturbance has little evidence to sustain it.

General practitioners, who because of their close contact with families should have a specialized knowledge of family relationships, will be wise to think very carefully before they grasp at supports which appear to offer them a simple solution. Sooner or later the patient who has swallowed tablets for weeks, months, or even years, will be back.—I am, etc.,

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G.P. Obstetric Units

SIR,—Not only your leading article (7 September, p. 567), but also the many contributors to your correspondence columns all wisely agree that the future of obstetric practice in this country is moving towards an institutional era. Unfortunately there are widely differing views as to which institution.

There are some consultants who believe that all deliveries should take place in specialist units *only* (perhaps with some general-practitioner beds attached)—possibly an interesting belief, but unquestionably unrealistic and impracticable. It is well known that in Britain there are many big towns situated many miles from the specialist units, and therefore it is obvious that these areas should have general-practitioner maternity units. Of course, such general-practitioner maternity units should always be well covered by the consultant (including flying squad) services of the nearest specialist department whenever complications unexpectedly arise. I cannot believe that any British doctor would wish to see normal, healthy mothers in labour being transported 20–30 miles (32–48 km.) across country, sometimes in snow and fog, in order to reach a specialist unit. So it follows that from the mother's point of view alone, independent general-practitioner maternity units in many areas must inevitably be considered both desirable and safe.

It must now be emerging in our minds "what are to be the future duties of the general-practitioner obstetrician? Do we wish to encourage general practitioners to undertake full obstetric responsibility in the future, or are we to ask them simply to undertake the antenatal and postnatal care, and only occasionally be involved in the delivery?" I believe that such a policy would be retrograde, and adhere to the belief that *full* responsibility by general-practitioner obstetricians should be maintained. Of course, one would qualify this belief by insisting that the general-practitioner obstetrician should be well trained. Surely the time has now arrived when a national committee with the interests of all the general-practitioner obstetricians well represented from the B.M.A. and the Royal College of General Practitioners might attempt to authoritatively answer these questions, and thereby give a