A second point, and this was emphasized by Dr. Powles and his colleagues, is the problem of the transmission of serum hepatitis, the risk of which constitutes a major theoretical disadvantage of using freeze dried plasma. The type of patient usually put on the blood cell separator is, because of his reduced immunological competence, at considerable risk from serum hepatitis. Using pooled plasma it is impractical to test for Australia antigen and one must therefore obtain plasma from "safe donors" with the co-operation of the regional blood transfusion service.

In some ways the problems of patient selection and the transmission of hepatitis are similar to those encountered during haemodialysis. It seems likely that continuous flow blood cell separators will become increasingly important in rapidly removing relatively large volumes of plasma during exchange procedures and in the procurement of therapeutically useful numbers of formed elements. It is therefore important that the logistic problems associated with the use of haemodialysis should be closely studied by those involved with blood cell separators.—I am, etc.,

C. B. FREEMAN

Department of Medical Genetics,
St. Mary's Hospital,
Manchester

Antileprosy Drugs

SIR,—I was interested to learn of Dr. A. S. Garrett's early experience with dapsone (23 October, p. 300) and was surprised that in the early 1950s he was giving such very large doses (1,200 mg/wk). At that time I was giving 700 mg/wk and had a 10% incidence of psychosis among my patients in the Jordan Hospital, Redhill, but no psychosis among larger numbers of outpatients treated with the same dosage. But among my cases of psychosis were patients receiving drugs other than dapsone, which confirmed the findings of psychiatrists who had studied psychosis in leprosy, that in leprosy hospitals one must expect an incidence of psychosis in the region of 10%, irrespective of the type of drug given. For instance, Lowinger¹ found an incidence of psychosis at Carville, U.S.A., of a little over 10%, and after studying an earlier report by Cazenette, deduced that of 427 leprosy patients admitted to Carville between 1923-27 (that is, before the introduction of sulphone therapy) psychosis occurred in 9%. Hence I am surprised that Dr. Garrett claims that he "scarcely ever had any mental trouble" prior to the introduction of sulphone therapy.

The only thing that can be said for certain is that dapsone, given in the dosage now generally used, will not cause psychosis, and I am sure that Dr. Garrett will agree with this.—I am, etc.,

W. H. JOPLING

London W.1

¹ Lowinger, P., *American Journal of Psychiatry*, 1959, 116, 32.

Hyposensitization Treatment

SIR,—Dr. A. P. Smith (23 October, p. 204) ascribes improvement in asthmatics to hyposensitization to *D. pteronyssinus*. In view of the small number of patients, the fact that only patients receiving the course of hyposensitizing solution (8 out of 11) had

sore arms, and the absence of any data on improvement in ventilatory function, the quality of the assessment must be questioned. Though it is possible that hyposensitization had a beneficial effect, in view of the side effects of treatment not found with placebo, it does not seem that observation can have been totally "blind." Patients also must have had an inkling that they had received effective therapy, and a counter-irritant effect could have been beneficial to their asthma.

I cannot feel that Dr. Smith's conclusions are yet fully justified.—I am, etc.,

W. J. H. LECKIE

County Hospital,
Hereford

Future of Hospital Management

SIR,—Recent minutes of a district hospital management subcommittee disclose the recommendation that "a Senior Management Group be established, consisting of the Group Secretary, Treasurer, Chief Nursing Officer, and the Chairman of the Medical Executive or his deputy."

I have thought for some years that medical responsibility for administration in hospitals was, with a few exceptions, on the decline, but surely this represents the nadir so far. May I make two comments. First, there is no member to represent patients' interests directly. Second, there will be only one doctor on this powerful committee of four and he will need to be superhuman to embrace the interests, for example, in the district hospital I know best, of 668 patients in geriatric and psychogeriatric beds, some 600 in psychiatric beds, 272 in acute wards, 187 in maternity, and 151 in general practitioner beds. And how one may ask would the majority of these patients fare under a senior management group if all the members have a general hospital background and none are experienced in the present practical provisions for, and differences between, geriatric and psychogeriatric care, psychiatric care of the elderly, and care of the older mentally handicapped?

The hospital exists primarily for patients, not for administrators, nurses, or even doctors. Surely any proposal like the one above should be thought out afresh, paying closer regard to the functions that the district hospital actually performs and the needs of the people whom it aims to serve.—I am, etc.,

R. W. PARNELL

Sutton Coldfield,
Warwick

Motor Race Rescue Unit

SIR,—We are a group of motor race officials who over the years have become appalled at the lack of safety at some motor race meetings.

Last year we instigated a rescue unit and with considerable assistance from many parties interested in the sport we now have a comprehensive range of rescue equipment. However, we feel that our service would be of more use to race organizers if we could incorporate a medical service with our rescue unit.

We wonder if through the columns of your journal we could contact any doctors who live in our vicinity and who are interested in motor sport and who might be interested in joining our unit. If any members of the profession are interested I would be glad if they could contact me when we could discuss details and arrange a meeting.—I am, etc.,

RUSSELL S. J. MARTIN

4 North Street,
Nazeing,
near Waltham Abbey,
Essex

S. Luke's Medical Fellowship

SIR,—We would desire the courtesy of your columns to bring the attention of communicant Anglican doctors to the fact of the existence of S. Luke's Medical Fellowship. This is a revival of what used to be known as the Union of S. Luke. We feel that there is definitely a place for such a fellowship in order to deepen the spiritual lives of Anglican doctors and at the same time to foster a warm alliance with the clergy. The two callings have much in common with each other and can benefit from discussion of common problems.

The first meeting of S. Luke's Medical Fellowship has been held. It included a celebration of Holy Communion at the Church of S. James, Piccadilly and the first annual general meeting.

Full particulars of membership can be obtained from the honorary secretary at the address given below.—We are, etc.,

J. B. GURNEY SMITH
Chairman

BARBARA SHUTTLEWORTH
Honorary Secretary

Rowanhurst,
Northbrook Avenue,
Winchester, Hants.

Dissect

SIR,—The di-semination of di-similar pronunciations of "dissect" has caused recent correspondents (2 October, p. 51, and 23 October, p. 235) to express their di-satisfaction. This di-sension over the di-sonance of "di-sect" does us a di-service. If the dissenters read this di-ertation aloud, perhaps they may be di-suaded from further di-sidence.—I am, etc.,

JAMES R. NOLAN

Edinburgh

Normal Range for Serum Transaminases

SIR,—Professor D. N. Baron and his colleagues rightly draw attention to the danger of uncritically accepting manufacturers' stated normal ranges (4 September, p. 583). Three is, however, a risk that their own values may come to be accepted as correct and their stated range indiscriminately applied although this does not seem to be intended by the authors.

We wish to describe our own experiences with the spectrophotometric assays according to Henry *et al.*,¹ and to offer a possible explanation for Professor Baron and colleagues' findings. Until recently, these assays were performed in our laboratory using the Unicam SP 800 spectrophotometer.² We then changed to the LKB Reaction Rate

Analyzer. The conditions remained identical apart from increased concentration of indicator enzymes.³ Normal ranges were determined for each system on blood drawn from healthy volunteers. The results are given in the Table. The range for aspartate aminotransferase was much narrower with the LKB instrument, the upper limit of normal falling by 8 units. This was due to the standard deviation being virtually halved, since the mean was similar to the previous value.

Instrument	No.	Mean (I.U./l)	S.D.	Mean $\pm$ 2 S.D.
SP 800	519	21.0	8.6	3.8 - 38.2
LKB	103	20.2	5.4	9.4 - 31.0

The explanation is as follows: the S.D. reflects the true biological variation in the population together with the variation due to analytical error; the latter was greatly reduced on changing from a manual to an automatic

technique and so the normal range of observed values contracted, thus lowering the upper normal limit. The earlier range was compiled by five technicians over a period of several weeks; the recent range was the work of a single technician over a two-day period. It is likely that Professor Baron's data conform more with the second than the first conditions. The data on which the Boehringer ranges are based⁴ were obtained by analysing 11,000 sera with an Eppendorf spectrophotometer. It is likely that a large number of technicians were involved over a lengthy period, with a consequent increase in the contribution of analytical error to the observed range.

A within-batch precision study was made with both systems by an experienced graduate. The coefficient of variation for aspartate aminotransferase was 3.31% (SP 800) and 1.65% (LKB). These values closely mirror the S.D. data in the Table. We would expect the difference to be even greater in the hands of less skilled staff.

Other workers⁵ have reported coefficients of variation for 2-hydroxybutyrate dehydrogenase assay as follows: 8.0% (SP 800) and 2.6% (LKB). The lessons to be learned from these experiences are the dangers of relying upon other people's "normal ranges," whether derived from manufacturers, from other scientists, or even from one's own laboratory; and the need to review the range when changes are made in laboratory instrumentation.—We are, etc.,

D. M. GOLDBERG
G. ELLIS

Department of Chemical Pathology,
Royal Hospital,
Sheffield, Yorks

¹ Henry, R. J., Chiamori, N., Golub, O. J., and Berkman, S., *American Journal of Clinical Pathology*, 1960, 34, 381.

² Ellis, G., and Goldberg, D. M., *Spectrovision*, 1970, 23, 8.

³ Ellis, G., and Goldberg, D. M., *Clinica Chimica Acta*, in press.

⁴ Laudahn, G., Hartmann, E., Rosenfeld, E. M., Weyer, H., and Muth, H. W., *Klinische Wochenschrift*, 1970, 48, 838.

⁵ Smith, A. F., Brown, S. S., and Taylor, R., *Clinica Chimica Acta*, 1970, 30, 105.

Points from Letters

Failure of the Minipill

MR. B. ETON (Buchanan Hospital, St. Leonards on Sea, Sussex) writes: Since the switch-over to the low-dosage combined oral contraceptive pill with its reduced oestrogen content, an increasing number of patients has been referred to me who became pregnant in spite of having taken the pill conscientiously. In the last 13 months I saw eight such pregnancies. . . . This series does not include any conceptions due to patient error, recent change-over to another type of pill, or recent onset of pill-taking. I am perturbed by this observation, and I am wondering whether the failure is due to the low-oestrogen ingredient. Have we achieved a reduction in the incidence of thrombosis at the expense of reliability? I do not think that all these unwanted pregnancies are due to patient error because I did not see nearly so many cases before the low-dosage pills became popular. . . .

Vaccination Against Influenza

DR. M. S. DHATT (Shoreditch Chest Clinic, London N.1) writes: "A Neurological Note on Vaccination Against Influenza" (25 September, p. 755) prompts me to mention another reaction which some of the recipients of influenza vaccine mention. They complain of getting symptoms like that of the common cold a few days after the injection of influenza vaccine and no other reaction.

Descriptive Analogies

DR. B. BENTLEY-PHILLIPS (Department of Dermatology, University of Natal, South Africa) writes: I was most interested in Professor Hector M. Cameron's amusing "Personal View" (11 September, p. 635), as I, too, am now working in "darkest Africa." An early error of mine was to advise fair-skinned patients to avoid sunlight, whereupon many of them informed me that they never used anything but "Palmolive" or "Lifebuoy." I now advise avoidance of sunshine.

Fees for Certificates

DR. W. J. J. LEGG (Fovant, Wilts) writes: Having recently been accused of extortion by an elderly car owner when I demanded the B.M.A. recommended fee of £3.50 for a certificate of fitness to drive, may I reinforce the views expressed by a general practitioner (19 September 1970, p. 712) when he exhorted each and every one of us to stick to the B.M.A. scale of fees, and not provide ser-

vices at cut-price rates. The patient concerned has only recently joined my list, and was quick to point out that the doctors he had dealt with previously had never charged him more than £1.50—sometimes not even that! I cannot for the life of me understand how the profession can expect the B.M.A. to campaign vigorously on our behalf for increased salaries, when a large number of us seems quite content to accept half or even a quarter of the recommended scale for part-time services. No doubt those who deal so leniently with the public are among our negotiators' most vociferous critics. . . .

Strengthening General Practice

DR. M. J. LEVERTON (Millom, Cumberland) writes: I know that it is not possible to give comprehensive general practice services, such as your leading article describes (23 October, p. 184), to an urban community at a staffing ratio worse than five doctors/10,000 patients. Until this sort of figure is recognized as valid, all future plans for strengthening general practice must fail.

Non-specific Backache

DR. CLIFFORD HARLEY (Woldingham, Surrey) writes: . . . I cannot agree with your statement with regard to the examination of Back Pain patients that "in most of them no specific abnormality is found" (2 October, p. 4). Firstly, examination by pressure over lumbar facet joints, iliolumbar ligaments, and short posterior sacro-iliac ligaments may reveal tenderness, often unilateral, which indicates inflammation and responds to hydrocortisone injection. Secondly, an examination by osteopathic techniques can be made. These are simple to learn, diagnostic with practice, and essential to any doctor who wishes to treat backache effectively. The ability to manipulate a hypomobile lumbar spine is a valuable medical aid. Doctors who try it find that it works.

Significant Differences and Medical Ones

DR. A. C. CARR (St. James's Hospital, London S.W.12) writes: In the present wave of enthusiasm for statistics with chi-squared analyses in every paragraph, it is worth reminding ourselves of a common pitfall. "Significance" is quite independent of clinical significance, and gives no indication whatever of the importance or otherwise of the difference under discussion. Your recent report of a trial of baclofen (2 October, p. 15) reports a highly significant

difference between baclofen and a placebo; this only means that we are sure there is a little difference. The vital question—whether there is a worthwhile difference—remains to be settled. . . .

Pensions

DR. A. V. CLEMMEY (Liverpool) writes: I think it should be better known that all part-time hospital medical staff engaged before 1966 who worked less than nine sessions weekly still have their pensions based on 1½% of earnings before 1962. A year spent as a whole-time casualty officer in 1949 at £450 a year will attract a pension of about £75 (1/80th of £6,069 whole-time retiring salary) for consultants doing nine sessions, while the same will only bring less than £7 (1½% of £450) for one doing six or seven sessions. Similar low results obtain for the other four or more years of training and pre-Pilkington salaries. In view of the continuing inflationary reduction of the value of money, I suggest that our negotiators should make every effort to get all part-time consultants who started before 1966 an option for their pensions to be based on their final three years.

Prevention of Coronary Disease

DR. T. J. BURKE (Lytham-St.-Annes, Lancs) writes: Drs. R. W. D. Turner and D. G. Illingworth (23 October, p. 228) rightly cite smoking, obesity, hypertension, and hyperlipidaemia as predisposing factors in the alarming increase in coronary deaths in the 30 to 50 age group, but make no reference to the real culprit, the real enemy in our midst, the motor car. This is lethal enough in all conscience, though the subtle part it plays in the incidence of coronary disease is frequently glossed over or completely ignored. . . . The weekly round of golf or the Sunday afternoon stroll with the dog does not compensate for six days of sloth and ease. The heart is a muscle and like all muscles it thrives on usage within its everyday limits. Disuse atrophy is no myth.

G.M.C. Annual Retention Fee

DR. J. F. MATHER (Bedlington) writes: I wonder why the G.M.C. is apparently unable to see that the "once-and-for-all" fee of 11 guineas I paid in 1951 when my hospital salary was £350 a year was no more of a hardship to me than £50 odd should be to a new doctor in a similar job at £1,626 a year. . . .