the real obstacles to a renal transplantation programme, which should be rapidly expanding and for which there is such need. Such expansion will not occur until there is an improvement in the nursing establishment and medical junior staffing on the average acute medical or surgical ward, particularly in hospitals where the actual renal transplantation is not done.—I am, etc.,

JOHN GARFIELD

Wessex Neurological Centre,
Southampton General Hospital

V.D. Statistics

SIR,—When will producers of television programmes on Venereal Disease (B.B.C.2, 17 November), some of the participants, and unfortunately the authors of otherwise admirable papers (Dr. R. A. S. Wigfield, 6 November, p. 342) learn that statistics produced by venereal disease clinics can be most misleading unless explained? The figures widely quoted represent infections or conditions and not individual patients.

In the last few years the number of conditions recorded on the annual returns requested from the clinics by the Department of Health has increased considerably. Obviously if we increase the number of diseases recorded the figures must rise, and multiple infections, especially in women—that is, gonorrhoea and trichomoniasis, or gonorrhoea and moniliasis, or all three, or even more all added to a grand total must inevitably give a distorted view of the overall picture. A quarter of a million registrations does not mean a quarter of a million people.

Surely the first thing we must do when dealing with such a highly emotive subject is to define our objectives. Do we want to disseminate knowledge or fear? The increase in gonococcal infections alone is bad enough without overstating the case even by inference, and it is difficult to see that exaggeration serves any useful purpose.—I am, etc.,

LESLIE WATT

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Provision for the Mentally Handicapped

SIR,—Campaign for the Mentally Handicapped is disturbed by some of the conclusions that Dr. D. C. Jones (13 November, p. 429) has drawn from his visit to services for the mentally handicapped in Denmark and Sweden. He says their hospitals are overstrained because parents are not anxious to accept their adult children home—even though social services in Sweden are extremely well organized—and concludes from this that “the majority of parents and relatives of patients still favour hospital care.”

As an argument for retaining the present British hospital service for the mentally handicapped this is both disingenuous, and unfair to the Scandinavians, who have not only given us the only coherent principles of care for the handicapped we have to work from but are translating those principles into practice at a rate which puts us to shame. The Scandinavian principles of “normalization” demand that mentally handicapped people should be offered as nearly

as possible the experiences and opportunities that the rest of us enjoy. This has led to a range of residential care in which the central homes Dr. Jones visited form only a minor part. The main emphasis is increasingly on residential facilities in the mentally handicapped person's own locality, drawing on normal community provision for their services, and offering—as do the central residential homes—social and educational training rather than anything we would understand by “hospital care.” An important secondary principle is that the adult mentally handicapped person should have the right to leave his family home and establish his own social context, just as we “normals” do.

Dr. Jones points out that the Scandinavians have not yet always provided the locally based residential facilities to make their principles practice. But he cannot in justice conclude from this that parents and relations prefer hospitals. The only point that can fairly be made is that they opt for residential provision for their adult child—as is their right, and his—and that hospitals may be the only places which yet provide this. We know of no research in any country which shows that parents, given a free choice between small local homes which offer their child a continuing link with his community and a necessarily more distant hospital composed of a large number of mentally handicapped people, would opt for the latter.

It is important to establish this point. The Government's plans, in *Better Services for the Mentally Handicapped*,¹ envisage a parallel development of locally based residential services by both hospital and local authorities. Campaign for the Mentally Handicapped believes that this dispersal of mentally handicapped people into the localities they belong to is the right pattern for the future. We are all aware that if the Scandinavian local residential services can be said to be inadequate, ours do not yet exist. If workers in the present hospital service seek to defend the existing pattern of residential care by drawing false conclusions from Scandinavian practice, the task ahead of us in establishing the new service is going to be made even harder than it need be.—I am, etc.,

ANN SHEARER

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96 Portland Place,
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¹ Department of Health and Social Security (Welsh Office), *Better Services for the Mentally Handicapped*. London, H.M.S.O., 1971.

Pregnancy Testing

SIR,—In your leading article on pregnancy testing (20 November, p. 444) you state, in reference to the home pregnancy test (Predictor) my company has just introduced, that a woman's belief she might be pregnant implies that she should have medical advice whether the result is positive or negative. In case your comment evolves from a belief that we are of a different opinion, I wish to draw to your attention the fact that we emphasize twice in the instruction leaflet not only that the woman's doctor should be consulted as soon as possible in the event of a positive result but also in the case of a negative result, of which we say: “If it (a repeat test) shows negative again, it is most

unlikely that your missing period has anything to do with pregnancy. There may be other causes, however, and you are strongly advised to see your doctor for further investigation.”—I am, etc.,

A. B. GILES

Marketing Manager,
Chefaro Proprietaries Ltd.

Morden, Surrey

Prolonged Fever in Bacterial Meningitis

SIR,—Early this year I wrote to you about this subject (15 May, p. 403). In that letter I stated that four sulphadiazine-resistant strains of *Neisseria meningitidis* had been examined and appeared to be related to serogroup 135.¹ Subsequently our anti-serum to the prototype strain of 135 was absorbed with a strain of *N. meningitidis* RAS 10 recently described² to be non-groupable but a strain which cross-reacted with many antisera. This strain, in fact, did not react with any of our range of antisera except 135, with which it reacted very strongly. Following absorption of our anti-serum it still reacted with the prototype strain of serogroup 135 but no longer reacted with the four strains I mentioned. Further examination of these strains, both in this laboratory and also by Dr. Harry Feldman of Syracuse, has shown them to belong to serogroup B.—I am, etc.,

R. J. FALLON

Department of Pathology,
Ruchill Hospital,
Glasgow

¹ Evans, J. R., Artenstein, M. S., and Hunter, D. H., *American Journal of Epidemiology*, 1968, 87, 643.

² Devine, L. F., and Hagerman, C. R., *Infection and Immunity*, 1970, 1, 226.

Caroli's Disease

SIR,—The cases of focal congenital dilations of the intrahepatic bile ducts described by J. Caroli *et al.*¹ differ from that described in the interesting report by Dr. M. J. Kelly (13 November, p. 407). Caroli's patients showed relatively normal extrahepatic bile ducts, quite different from choledochus cyst. The segmental intrahepatic duct dilations were either superficial or deep within the liver parenchyma. Some contained areas of calcification. Jaundice in this disease may be due to ascending cholangitis or passage of a calculus into the common hepatic or common bile duct. Any patient with ascending cholangitis may develop intrahepatic abscesses which communicate with the bile ducts. In view of the long history of cholangitis in Dr. Kelly's patient it is possible that the intrahepatic duct dilations demonstrated are related to abscess formation rather than true congenital dilations.

Associated findings usually present in Caroli's disease, not mentioned by Dr. Kelly in his report, include hepatic fibrosis (usually present, according to Caroli) with portal hypertension, renal tubular dilations resembling medullary sponge kidney, and undermineralization of the skeleton as in any patient with chronic liver disease. As Dr. Kelly mentioned, a choledochus cyst may involve one or more of the main hepatic ducts or the common bile duct. However, Caroli's disease and choledochus cyst are two different diseases with different radiological appearances. Caroli's disease may be

mimicked by multiple abscesses communicating with the intrahepatic ducts.—I am, etc.,

JAMES G. McNULTY

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Dublin 1

¹ Caroli, J., Soupault, R., Kossanowsky, J., Plocker, L., and Para Dowska, E., *Semaine des Hôpitaux de Paris*, 1958, 34, 128.

Operations for Obesity

SIR,—Your leading article entitled "Operations for Obesity" (30 October, p. 247) gave a comprehensive review of the value and hazards of small-bowel shunt surgery in the management of gross refractory obesity. May I comment on this form of treatment from my own limited experience of four patients upon whom I have performed jejuno-ileostomy within the past two years?

Three women and one man have undergone end-to-side jejuno-ileostomy of the "14+4" dimension for refractory obesity amounting to 95-135% above ideal body weight. The follow-up period has been 4-18 months. The figure shows that satisfactory reduction in weight

the laughing stock of the community. The obvious reversion to more normal clothed bodily contours has overcome this social disability, or is in the process of doing so.

With regard to the technique of the operation, I prefer to use a 6-8 in (15-20 cm) midline incision, closed with stainless steel wire, rather than the transverse "melon-slice" approach, deferring apronectomy to a later date. In this way there have been no problems of seroma, haematoma, dehiscence, incisional hernia, or postoperative respiratory difficulties. The operation is hardly formidable, though good strong retraction is necessary.

Though jejuno-ileostomy is still regarded as an experimental procedure, I believe that the "14+4 operation"¹ has now been performed with satisfaction by a sufficient number of surgeons as to justify a place in the management of gross intractable obesity. Not only is it effective and relatively uncomplicated, but it also has the advantage of being reversible. The main proviso to its use in selected patients is that they should be followed closely for several years to de-

and his colleagues agree that 20% is a more accurate measurement than 15%.⁹

There is no doubt that the ¹²⁵I-fibrinogen test is the most useful method at present available for screening large numbers of patients and detecting early, forming thrombi. It is particularly useful in post-operative patients. Nevertheless we have made it clear¹⁰ that there are defects. In the more proximal veins, in the groin and pelvis, there is not sufficient difference in the radioactivity over the veins and adjoining tissues to be confident about diagnosis of thrombosis. In addition, there are difficulties with established thrombosis where the process is static or resolving.

We have now completed an investigation into 82 patients with clinical signs suggesting established deep vein thrombosis. The results of this study are being published in detail elsewhere.¹¹ In each of the patients both the ¹²⁵I-fibrinogen test and phlebography were used. In 15% there was a false-positive finding with the radioactive test. The phlebograms established that there were, in fact, no thrombi there. Subsequently it was found that these patients suffered from such conditions as rupture of muscle fibres in the calf, haematoma within the calf, infection in the region, or other conditions. On the other hand, approximately 25% of old thrombi, proved phlebographically, were negative with the radioactive test. It is curious, and here we agree with Mr. Browse and his colleagues, that apparently static or dissolving thrombi can in a considerable proportion of cases become radioactive. Our practice, therefore, with so many false positives and negatives in suspected cases of established deep vein thrombosis is to use venography. Our experience indicates that this is the more accurate and practical way of assessing the condition at this stage and deciding on the management of established deep vein thrombosis.—I am, etc.,

J. G. MURRAY

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occurred in each, some stabilization developing in the one patient followed for 18 months. One patient has had one bulky stool each day, but the remainder have three to five loose unformed stools daily. This frequency has not been too much of a disability and has varied with dietary intake. No abnormalities of blood picture, haematological indices, or serum vitamin B₁₂ levels have occurred. Only in the patient followed for 20 months has the serum folate level fallen to a level demanding correction. Before operation serum iron levels were either low-normal or subnormal in all the patients, and this abnormality became more pronounced during the follow-up periods. Serum electrolytes, calcium, magnesium, and uric acid values have remained unchanged from preoperative levels. Serum albumin has fallen mildly to low-normal values in two patients. Dramatic falls in serum cholesterol of 32-50% have been seen in all patients.

So far each patient has been highly gratified with the operation and its results. All have lost their presenting symptoms such as breathlessness, bronchitis, and backache. All look healthy, and with their restored mobility two have returned to employment previously abandoned owing to their obesity. They all eat as much as they wish; a habit in which they have not indulged without guilt for some years. A further notable feature has been their social reacceptance; grossly obese patients tend to be cast out by their family or friends as well as being

test early any of the potential nutritional and metabolic abnormalities which may arise.—I am, etc.,

MICHAEL BADDELEY

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¹ Payne, J. H., and DeWind, L. T., *American Journal of Surgery*, 1969, 118, 141.

Diagnosis of Established Deep Vein Thrombosis

SIR,—I was most interested to read the account of Mr. N. L. Browse and his colleagues (6 November, p. 325) on the use of the ¹²⁵I-fibrinogen test in the diagnosis of established deep vein thrombosis. This method has superseded the ¹³¹I-fibrinogen test and was developed in this department.^{1,2} Subsequently the accuracy of the method was shown by ascending functional phlebography³ and later confirmed by numerous workers.⁴⁻⁷ The original method used a scaler, but was superseded by a much simpler technique using a ratemeter.⁸ The results using a scaler and a ratemeter were compared.⁸ Well over 1,000 patients have now been investigated by us using the ¹²⁵I-fibrinogen test. It was pointed out when the ratemeter was introduced that the most accurate method in diagnosing a thrombus was a 20% difference in radioactivity. Subsequent experience has confirmed this. I am happy to see that Negus

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- Kakkar, V. V., *Archives of Surgery*, 1971, in press.

SIR,—We were interested to read the paper of Mr. N. L. Browse and his colleagues (6 November, p. 325), but found their one-day measurement reflected the blood radioactivity in the thrombosed limb rather than the uptake of ¹²⁵I fibrinogen in a thrombus. Previous investigations have shown that serial measurements over several days will show a developing thrombosis, but that early rises lasting one day are of no significance.¹ Rosenthal and Greyson² injected ^{99m}Tc-labelled albumin macroaggregates (into the