General practitioners naturally weigh all these points when deciding whether to seek bacteriological aid. A comprehensive study on survival and overgrowth of pathogens in different transport situations would seem to be long overdue.

D J RODGERS

Sheffield

Plasma CEA concentrations in pancreatic disease

SIR,—Dr L K Ashman and his colleagues in their paper on carcinoembryonal antigen (CEA) assay in the diagnosis of cancer (28 June, p 721) draw attention to the fact that cancer-free hospital patients may be better suited for reference material than healthy young adults. To our knowledge it has not also been pointed out that sampling for plasma CEA assay should be restricted to fasting patients if basal levels are sought.

As shown, for example, by Barton *et al*¹ and Goebell,² elevated serum levels of pancreatic lipase and amylase may be found after the administration of secretin and cholecystokinin (pancreozymin) to patients with pancreatic disease. We thought that a similar provocation test might be used to increase the sensitivity of the CEA test for pancreatic disease. Secretin and cholecystokinin (1 U/kg body weight of each peptide, obtained from the Karolinska Institute, Stockholm) were given intravenously and plasma CEA concentrations were determined in duplicate with the Roche kit.

Eight patients with pancreatic carcinoma, 10 with chronic pancreatitis, and six with other diseases (non-tropical sprue, Christian-Weber disease, cholelithiasis, liver disease, and non-specific diarrhoea) were studied. A varying but significant increase in plasma CEA concentration was noted after secretin and cholecystokinin administration in six patients with pancreatic carcinoma with slightly or moderately elevated basal CEA concentrations; of two patients with high basal levels, one did not respond (see figure). Similar results were noted in the patients with chronic pancreatitis, the single patient

with a high basal CEA concentration showing no response, while all but one of the remaining nine showed a varying but significant increase. No change or only a slight increase was noted in the patients with other diseases.

It may be concluded that it is possible to increase the plasma CEA concentration in patients with pancreatic disease by stimulation with secretin and cholecystokinin. Whether this is also possible in patients with other disorders is at present being studied. The provocation test may possibly increase the clinical value of the CEA assay. We have not systematically studied the effect of food intake, but preliminary data indicate that variations occur after a meal, possibly as a result of the release of gastrointestinal hormones.

G LINDSTEDT
P-A LUNDBERG

Department of Clinical Chemistry and
Department of Medicine II,
University of Gothenburg,

Sälgren's Hospital,
Gothenburg, Sweden

- 1 Burton, P, *et al*, *Gut*, 1960, 1, 125.
- 2 Goebell, H, *Internist*, 1970, 11, 117.

Respiratory function in rheumatoid arthritis

SIR,—Dr P J Whorwell and his colleagues (26 April, p 175) report significantly reduced values of diffusing capacity for carbon monoxide (DCCo) in patients with rheumatoid arthritis as compared with the predicted values and the control group. The decreased DCCo correlated significantly only with smoking and the Waaler-Rose and latex scores in women.

Almost simultaneously we performed lung function tests (data completed by the end of 1974) on 62 patients (55 women, 7 men) with "classical" or "definite" rheumatoid arthritis. Persons with heart disease or anaemia or dust exposure were excluded. Lung function tests consisted of spirometry, plethysmography, blood gas analysis, and measurement of DCCo and lung compliance. Our own lung function data differed negligibly from the results obtained by other authors¹⁻⁵ (see table). The various parameters were then correlated with age, duration and stage of disease, rheumatoid factor titres, and therapeutic data (gold, steroids). A statistic-

Author	Percentage of patients within abnormal range		
	CO diffusing capacity	Lung compliance	Vital capacity
Davidson <i>et al</i> ¹	24	—	—
Frank <i>et al</i> ²	41.4	—	—
Huang and Lyons ³	57.1	—	27.2
Laitinen <i>et al</i> ⁴	30	20	20
Morere <i>et al</i> ⁵	55.4	40.5	—
Present findings	47.4	38.4	29

ally significant correlation was found between DCCo and the presence of rheumatoid factor and its titre. An abnormal DCCo (<1.34 mmol min⁻¹ kPa⁻¹) occurred more frequently in the group of seropositive patients than in the seronegative patients ($P<0.05$). Furthermore, when ranking the patients into groups with increasing Waaler-Rose titre a linear relationship ($P<0.01$) was found to exist between the titre and the percentage of patients with abnormal DCCo within the groups.⁶ In addition, seropositive patients

frequently showed a decrease in lung compliance; these changes, however, were less than those in diffusion capacity.

The pathogenesis of the decreased DCCo in seropositive rheumatoid arthritis patients may be explained by immune-complex deposits at the site of blood vessels and by necrotic changes that can be demonstrated in lung specimens of seropositive patients only.⁷

G SCHERNTHANER
F KUMMER
O SCHERAK
G KOLARZ

Second Medical Clinic,
University of Vienna,
Austria

- 1 Davidson, C, Brooks, A G F, and Bacon, P A, *Annals of the Rheumatic Diseases*, 1974, 33, 293.
- 2 Frank, S T, *et al*, *Chest*, 1973, 63, 27.
- 3 Huang, C T, and Lyons, H A, *American Review of Respiratory Diseases*, 1966, 93, 865.
- 4 Laitinen, O, Salorinne, Y, and Poppius, H, *Annals of the Rheumatic Diseases*, 1973, 32, 531.
- 5 Morere, P, Stain, J P, and Nouvet, G, *Poumon et Coeur*, 1973, 29, 335.
- 6 Kolarz, G, *et al*, *Scandinavian Journal of Rheumatology*, 1975, suppl 8, abstr. 066.
- 7 Fassbender, H G, *Pathology of Rheumatic Diseases*. Berlin, Springer, 1975.

Disaster wound treatment

SIR,—The most interesting letter from Professor Philip Rhodes on cyclone Tracy (16 August, p 419) should lead all interested in disasters and the management of mass casualties to study the relevant articles in the *Medical Journal of Australia* of 24 May 1975 (pp 641-650). The magnificent handling of the Darwin disaster in dreadful conditions reveals once more the tendency to forget certain previously learnt lessons and especially the necessity of managing wounds by delayed primary suture in disasters with large numbers of wounded.

Gurd *et al*¹ state that a policy of wound toilet and primary suture of skin was adopted and give as one reason that "most wounds were clean-cut lacerations less than 12 hours old." It is known that contaminated wounds become infected in six hours. They go on to mention that "during the next few days some patients were seen with infected wounds" and that one patient "presented on the fourth day with tetanus." O'Shea² states that among the illnesses seen on the third day were "continuing infections of wounds," while Degotardi and Grant³ mention "at least one suspected gas gangrene patient" and "another possible gas gangrene patient" and state that "the injuries were similar to those of war casualties and the treatment in such circumstances should be along established military surgical principles." Scott-Findlay³ includes among his recommendations that "the delayed primary closure of wounds should be undertaken always in a disaster similar to this, in which there are large numbers of injuries."

The medical histories of wars and disasters show that lessons previously learnt are too easily forgotten, and in particular the importance of practising delayed primary suture of wounds and of avoiding the evacuation of casualties with wounds sutured primarily. Tetanus and gas gangrene are highly preventable by correct wound care, thorough debridement, and delayed primary suture. While in no way detracting from the splendid work done in this dreadful Darwin disaster, there are lessons to be learnt in wound care as a result of it. In this day and age no

medical man should be unfamiliar with the requirements of war and disaster.

A G D WHYTE

Department of Anatomy,
Marischal College,
Aberdeen

- 1 Gurd, C H, Bromwich, A, and Quinn, J V, *Medical Journal of Australia*, 1975, 1, 641.
- 2 O'Shea, R F, *Medical Journal of Australia*, 1975, 1, 649.
- 3 Degotardi, P R, and Grant, A F, *Medical Journal of Australia*, 1975, 1, 646.
- 4 Scott-Findlay, J, *Medical Journal of Australia*, 1975, 1, 644.

Misleading job advertisements

SIR,—As a junior hospital doctor I am a regular reader of your job advertisement columns. Over the past year I have noticed an increasing tendency to vague or misleading descriptions of the locations of the posts advertised.

The advertisements I refer to are of two types. Firstly, there are advertisements in which there is no mention of the hospital or hospitals in which the applicant will be required to work. The applicant is merely given the name of the area or district involved. More misleading than this is the other type of advertisement in which, although the hospital location of the job is not specified, the applicant is asked to write to an administrator based at a certain hospital. The unsuspecting doctor who reads this may think that the post is located at the same place as the administrator. Frequently this is not the case.

There is little doubt in my own mind that the cause of this problem is the remote bureaucracy that now prevails since the NHS reorganisation. I think it would be of benefit to your readers if you were to refuse to accept vague, misleading job advertisements of the kind I have mentioned.

T J CANTOR

Fulford Hospital,
Fulford, York

. Most advertisements do specify the hospital concerned, but we are asking health authorities to try to make their advertisements more specific in future.—ED, *BMJ*.

Diazepam withdrawal fits

SIR,—A young woman was admitted after taking a trifling overdose of unidentified tablets as a self-poisoning gesture. Forty-eight hours later she had three grand mal fits, becoming briefly confused. There was no previous history of epilepsy, but for three years she had been continuously taking diazepam 10 mg three times a day. This had been abruptly discontinued at admission. She had been under prolonged outpatient psychiatric care for anxiety symptoms arising out of sexual disharmony in her marriage. It was felt that the sudden withdrawal of prolonged diazepam medication rather than the overdose was responsible for the fits.

Diazepam withdrawal as a cause of seizures and psychological disturbance is insufficiently recognised in Britain, although Hollister^{1,2} has associated these with the prolonged use of diazepam and other benzodiazepines in the United States. As these drugs are now ubiquitously used the possibility should be

included in the differential diagnosis of fits (and delirium) occurring for the first time in an otherwise physically healthy young adult.

I VYAS
M W P CARNEY

Northwick Park Hospital and Clinical Research
Centre,
Harrow, Middlesex

- 1 Hollister, L, *Current Therapeutics*, 1972, 13, 65.
- 2 Hollister, L, *Clinical Use of Psychotherapeutic Drugs*. Springfield, Thomas, 1973.

SI units

SIR,—One hesitates to add further to the plethora of letters on the subject of SI units. Might I enter the suggestion, however, that the need for uniformity is based on a very patronising attitude towards doctors and scientists? Anyone not capable of converting the units of one system to another is hardly worthy of the name of professional man, especially in these days of portable electronic calculators, and anyone not capable of doing such a conversion is hardly likely to be able to give a very significant opinion anyway.

The obsession with uniformity would appear to be a bureaucratic activity favoured by those who have more time than work—rather similar to the situation which arose quite recently when metrication was introduced and it became the custom to pack instruments in sets of five as a "decimal figure" despite the fact that the instruments were normally used in twos. Unless uniformity produces advantages greater than its hazards it is not achieving its objective. Science involves order and measurement, but order and measurement do not constitute science, nor are they in themselves efficiency or reliability except to the non-intellectual ignorant mind.

GEORGE T WATTS

General Hospital,
Birmingham

Miliary tuberculosis presenting with polymyalgia rheumatica

SIR,—The case report by Dr D L Child (13 September, p 652) of miliary tuberculosis presenting with polymyalgia rheumatica requires clarification. The diagnosis of polymyalgia rheumatica, suspected on clinical grounds, is usually supported by a raised erythrocyte sedimentation rate (ESR) and a dramatic response to corticosteroids. Dr Child's patient initially had a normal ESR, and no information is given about the administration of corticosteroids or the interval of time before the appearance of the skin lesions. On the evidence the diagnosis of polymyalgia rheumatica is in doubt, and if steroids were used this could cast a different light on the development of miliary tuberculosis.

C R MCGAVIN

Department of Respiratory Diseases,
City Hospital,
Edinburgh

Injectable quinine for falciparum malaria

SIR,—Dr Neena Stewart (20 September, p 705) rightly emphasises how delay in diagnos-

ing falciparum malaria can result in unnecessary death. Another delay in dealing with falciparum malaria may also have serious consequences—the hospital pharmacy may not stock quinine suitable for injection. Prompt specific treatment with intravenous quinine (quinine dihydrochloride injection BP) is the most important therapeutic factor in recovery from severe falciparum malaria.¹ (Parenteral chloroquine usually suffices if the infection is acquired in Africa, but chloroquine-resistant falciparum strains may also appear there at any time.) I know of one fatal case of falciparum malaria in which the hospital concerned held no stock of injectable quinine and inquiries at neighbouring hospitals also failed to produce an ampoule. How many pharmacies in British hospitals carry no stock of quinine ampoules?

H ALISTAIR REID

School of Tropical Medicine,
Liverpool

- 1 Reid, H A, *Lancet*, 1975, 1, 167.

Junior hospital staff contract

SIR,—Following the publication of the Review Body's Supplement to the Fifth Report (HMSO Cmnd 6243) it is now possible to calculate the basic rates of pay of juniors of various grades. It is upon these rates, which are applied to the first 10 units of medical time (UMTs), that supplements will be calculated (Class A 30%, Class B 10% of basic salary).

Grade	Flat rate/UMT (£)	Class A rate/UMT (£)	Class B rate/UMT (£)
Junior house officer (JHO)	5.50 5.91 6.33	1.65 1.77 1.89	0.55 0.59 0.63
Senior house officer (SHO)	7.04 7.51 7.98	2.10 2.25 2.40	0.70 0.75 0.80
Registrar	7.98 8.41 8.84 9.23 9.83	2.40 2.52 2.64 2.76 2.94	0.80 0.84 0.88 0.92 0.98
Senior registrar	9.23 9.83 10.39 10.95 11.51 12.08	2.76 2.94 3.12 3.30 3.45 3.63	0.92 0.98 1.04 1.10 1.15 1.21

Having calculated these rates, it is possible to study some examples.

Example 1—The junior on an alternate night duty roster.

In a 14-day period he will work the following hours:

- (i) Weekdays—He will be on call for 24 hours for five days and work for eight hours in each of the remaining five 160
- (ii) Weekends—He will work one weekend and the Saturday morning of his weekend off 52

Total hours worked/14 days 212
Total hours worked/week 106

This is the equivalent of 10 UMTs (standard) plus 17 UMTs. With one free qualifying unit per week he will attract additional salary for 16 UMTs for 52 weeks of the year (remember that the new contract is based upon a prospective average weekly assessment).

The supplemental payments will be as follows: