The very fit man had the highest rise, from 0.9 to 10.9 $\mu\text{g/l}$. In contrast, the level in the older Greek runner remained virtually unchanged (0.8 and 1.0 $\mu\text{g/l}$).

Our investigation confirms the significant rise of plasma GH previously reported after physical exercise.¹⁻³ This work is one of a series of studies on the effects of physical exercise on plasma hormones and muscular metabolism. We hope to find tests to distinguish in advance between men who are fit enough to run the marathon and those for whom it may be dangerous.⁴ That such tests may be necessary has already been demonstrated by the case of Philippides, the dispatch-runner who died on arrival at Athens after the Battle of Marathon on 22 September 490 BC.⁵

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Pregnancy in adolescence

SIR,—Your leading article "Pregnancy in adolescence" (20 September, p 665) has prompted me to write about Hayward House, which is one of a number of family group homes run by the Messenger House Trust.

Hayward House was opened in March 1975 for young West Indian mothers aged 14 to 18 years in order that they may keep their babies. There is an increasing number of these schoolgirls who do not wish to give their babies for adoption, who have been rejected by their families, and who in the normal course of events return to school while their children are placed in residential nurseries or foster homes and are reclaimed by the mothers when they are of school-leaving age. In our experience in these circumstances no normal bonding between mother and child has developed; in one case a much damaged child of 4 years was in due course given up for adoption and in another the toddler, having returned to the mother, suffered severe burns before being taken away from the mother. In contrast Hayward House is a happy place where five girls care for their children and at times for each other's, and with home tuition it is hoped that these mothers will mature and in due course be able to manage in council flats at the age of 18. Some may make early marriages, and with our system of aftercare perhaps be successful in bringing up their families in a more adult manner than without the care of the voluntary visitors and the work that we have done together at our large group meetings, which are held with the mothers from the other houses and with members from the social services also present.

I feel that many similar small houses should be leased to voluntary bodies by the local authorities where these young mothers

could live and that this is an effective way of preventing emotional damage to young children. We shall be opening our next house, to be named after the late Dr Donald Winnicott, in the next few months. Further particulars may be obtained from the address below.

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"Caecal squelch" and appendicitis

SIR,—At times the differential diagnosis of acute appendicitis is difficult. The history of diarrhoea or headaches and the finding of a high fever ($>39.5^{\circ}\text{C}$), inflamed fauces, and diffuse lymphadenopathy are well-known features that point away from the diagnosis of acute appendicitis.

We would like to emphasise an additional sign which we have found very helpful in deciding whether an appendicectomy is necessary—when a "caecal squelch" is palpable in the right iliac fossa an acutely inflamed appendix is unlikely to be present.

During the past 18 months over 400 patients with the possible diagnosis of acute appendicitis have been seen by one surgical team at this hospital. The presence or absence of fluid bowel contents that "squelch" on pressing in the right iliac fossa has been particularly noted. During this time there were only three patients who had a "caecal squelch" and who subsequently had acutely inflamed appendices removed. These three all had otherwise characteristic histories and signs of appendicitis. Significantly, they all had a distal appendicitis, the proximal parts being macroscopically normal.

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Isolated glomerulonephritis with mesangial IgA deposition

SIR,—In their paper on this subject (13 September, p 611) Dr J G P Sissons and his colleagues are incorrect in claiming that "no other series has been reported from this country." We reported the occurrence of recurrent haematuria and mesangial IgA deposition in a paper given to the Pathological Society in January 1973. The features of six patients with this clinicopathological association were reported in the *Journal of Clinical Pathology*.¹

At this hospital between 1971 and 1975 the association of recurrent haematuria with mesangial IgA deposition was seen in 16 (7%) out of 220 renal patients whose biopsy specimens were examined by immunofluorescent techniques (transplants excluded). "Entities" are notoriously ill-defined in nephrology, but recurrent haematuria with mesangial IgA is seen sufficiently frequently for it to be given a special place. Until the aetiology and pathogenesis have been clarified "Berger's nephropathy" seems a useful eponym for this association of recurrent haematuria with mesangial IgA.²

It seems likely that other patients with mesangial IgA deposition and "isolated glomerulonephritis" but who present with symptoms other than haematuria also belong to this group. The pattern of immunoglobulin deposition in the glomeruli is more

likely to reflect the underlying disease process than is the clinical presentation.

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- 2 Berger, J, et al, *Actualités néphrologiques de l'Hôpital Necker*, 1967, 172.

Prescriptions for pill

SIR,—It may be helpful to draw to the attention of doctors who are used to giving prescriptions for six packets of the pill at a time the fact that there are 13 menstrual months in a calendar year. On the basis of being given two six-monthly prescriptions patients will return at the end of the year, a month before they are eligible to complete another Form FP 1001. In our practice we intend to issue a seven-month prescription between 1 January and 30 June each year in order to try and avoid this pitfall.

D S JEFFERY

Old Windsor

Fibrinogen uptake scanning

SIR,—In Dr V C Roberts's plea for standardisation of the interpretation of the fibrinogen uptake test (23 August, p 455) we find several aspects in which his experience differs from our own, although our techniques of leg reading appear to be identical.

In the first place, our patients receive their dose of ^{125}I -fibrinogen immediately after operation and we cannot therefore compare postoperative with preoperative readings. Secondly, we find background radiation negligible and readings virtually the same with and without reference to this parameter.

More fundamentally, however, the pattern of leg counts in our patients without isotopic evidence of venous thrombosis is significantly different from his. Our own figures are taken from the records of 50 randomly selected patients. We have averaged the six-day percentage counts at each of 10 points on the leg and deduced the standard errors of means from the means of the standard deviations.

The mean counts in our patients at positions 1, 2, 3, 4, 5, and 9 differ significantly from his (the t values being 4.81, 6.11, 4.27, 2.00, 2.00, and 2.56 respectively). The six-day means (SEM in parentheses) in Dr Roberts's series are: 31 (1.2), 28 (1.0), 27 (1.0), 27 (0.9), 27 (0.9), 28 (1.0), 29 (1.0), 29 (1.0), 28 (1.0), and 26 (1.0) compared with our figures of 41 (1.7), 39 (1.5), 34, (1.3), 30 (1.2), 30 (1.2), 30 (1.2), 27 (1.2), 26 (1.2), 24 (1.2), and 23 (1.3). In our experience it is usual for the percentage counts to fall progressively from groin to ankle.

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Methods of laparoscopic sterilisation

SIR,—We read with interest Dr G Hughes and Mr W A Liston's retrospective comparison of laparoscopic tubal diathermy and abdominal tubal ligation (13 September, p

637). The pregnancy rate after the former, particularly in 1970 was high, but not unexpectedly so for gynaecologists and trained registrars using a new method which undoubtedly requires special training to acquire the necessary level of skill and expertise.

The risk of visceral damage (as high as 0.6% in other series¹) associated with diathermy remains a serious and potentially life-threatening complication. As this complication may result from faulty instruments or operator error alternatives to diathermy sterilisation are required. Furthermore, a significant increase in the number of young women requesting sterilisation has recently occurred. Diathermy and division of the Fallopian tubes virtually precludes the chances of successful reversal should this be required.

A prospective trial of laparoscopic sterilisation using spring-loaded clips has recently been completed.² This method avoids the dangers of diathermy and destroys only 3 mm of the Fallopian tube. The initial results are encouraging in that no major complication occurred in the first 250 women, although the failure rate of 2.6% (seven patients) was high. Five of the seven failures were due to operator errors and two to spring weakness. The clips and laparoscopic applicators have been redesigned and it is hoped that the results of a multicentre trial now in progress will reduce the failure rate to clinically acceptable levels.

We think that laparoscopic sterilisation is a major advance in terms of lowered post-operative morbidity, patient acceptability and shorter hospital stay. The most appropriate method of laparoscopic tubal occlusion remains to be determined.

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- 1 Wheelless, C. R. and Thompson, B. H. *Obstetrics and Gynecology*, 1973, 42, 5.
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Malaria in Britain

SIR,—Dr Neena Stewart's letter (20 September, p 705) draws attention to 104 cases of malaria recorded in Scotland over the period 1970-4 and stresses that 12% of these cases occurred in persons who had visited Asia but failed to observe the usual prophylactic measures.

This observation is also pertinent with regard to the whole of the United Kingdom. Over the past five years there has been a striking increase of malaria imported into this country from Asia.¹ Whereas the annual number of cases of imported malaria averaged 150 during the period 1965-70, the available figures for the following four years are as follows: 1971, 261; 1972, 336; 1973, 541; and 1974, 662.² Much of this increase is due to the fact that many UK residents born in India, Pakistan, and Bangladesh frequently visit these Asian countries, where the incidence of malaria has recently shown a considerable rise not only in rural but also in urban areas.³ In the 1960s most of the malaria imported into Britain originated in Africa and *Plasmodium falciparum* represented about 60% of all diagnosed plasmodial species involved. Over the past three years, with the greatly increased proportion of cases

of malaria imported from Asia, there has been a marked shift in the proportion of the two main species of malaria parasite. Thus in 1974 *P. vivax* represented 66% of all infections while *P. falciparum* was reported in 21% of cases, *P. malariae* in 4.5%, and *P. ovale* in 2%; the remainder consisted of mixed or undiagnosed infections. While *P. vivax* malaria is undoubtedly less dangerous to life than *P. falciparum* its symptoms may appear six months to a year after the exposure and have a tendency to relapse unless properly treated.⁴

As pointed out by Dr Stewart, very few visitors to these Asian countries take preventive antimalarial drugs, and a determined effort should be made by general practitioners to make the prospective traveller aware of the risks involved. The possibility of malaria should be considered in anyone returning from these and other tropical countries.⁵

Other points mentioned by Dr Stewart, including the importance of screening prospective blood donors for the possibility of malaria infection, have been stressed in the British medical press and in WHO publications.^{6,7}

Finally it must not be forgotten that while *P. falciparum* is not likely to be transmitted by our indigenous *Anopheles atroparvus*, this mosquito may be relatively easily infected by *P. vivax*. The possibility of one or more cases of "introduced" malaria of local origin appearing in some, mainly south-eastern, counties of England cannot be ruled out.

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"Bright ring of words"

SIR,—Thank you for "Bright ring of words" (20 September, p 666). In 1949 when I was Sims professor one of my Dominion hosts wrote that his plans for me were now "finalised." This was the first time I had met that horrid word. Now it and others like it are common and I regret to say, are used by arts fellows of Oxford colleges. My two favourites, both transatlantic, are "funeralised" and "surgerised."

GEORGE PICKERING

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Junior hospital staff contract

SIR,—At a meeting in Glasgow Royal Infirmary on 30 September 260 junior doctors from the West of Scotland voted to accept the new contract as priced by the Review Body by a majority of 4:1.

The pricing itself was considered insulting and was accepted only because of the current economic situation and will remain acceptable only so long as the £6 a week rule is

adhered to by other groups in the public sector.

As soon as the current anti-inflation measures are repealed our negotiators must demand the removal of the "free qualifying" unit and a realistic rate for extra units of medical time.

GRAHAM MCCUNE

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SIR,—Until now we regarded those juniors who wrote expressing their concern over the negotiations for a new junior contract as misinformed idealists. We stand corrected. We are now informed that we are to work a "standard week" of 40 hours. As no extra payment is forthcoming until 44 hours have been worked we regard the term "standard 40-hour week" as not only inaccurate, but dishonest.

Of greater significance is the proposal for a two-tier system of payment. It is obviously fairer and more just that those working in a hospital should earn more than those merely standing by at home. This vital principle has, however, never been openly discussed and yet has the most serious repercussions not only for juniors but also for consultants.

We were not aware that our negotiators had at any time any mandate whatsoever to negotiate what amounts to a rise in salary for some doctors at the expense of others. Our negotiators have negotiated not a penny more to cover the increased cost of our new 44-hour week but in fact have negotiated only the right to redistribute the existing sum. It will not be impossible for a busy houseman on "A" units to earn more than his registrar on "B" units. We believe that the time will come, after suitable consultation, for this differential system of payment to become part of contracts for both junior and consultant. That time is not now. Prospectively determined differential rates of payment introduce a totally new concept into hospital practice and this concept, fair though it may be, cannot be accepted without wider consultation.

We urge our negotiators to disregard consideration for the majority who will benefit and think of those who will suffer a reduction in salary. A "no detriment" clause is no answer if a new appointee gains a salary less than he might have expected under existing arrangements. Our negotiators at all levels of the profession have repeatedly stressed the need for unity. Let them now practise what they preach and reject this arrangement, which will cause nothing but division.

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SIR,—Since hearing of the Government's proposals to pay overtime for work in excess of 44 hours a week the following points have occurred to me that I did not include in my previous letter (20 September, p 707).

One assurance we have heard regarding the new "closed" junior contract is that it places us in a stronger bargaining position.