pyrexia for 24 hours with reluctance to feed and the passage of one loose stool. During the previous three weeks he had been fed undiluted, unmodified cows' milk ("milkman's milk") with an added protein-rich cereal. He was desperately ill but recovered only to be left with evidence of severe brain damage. It seems likely that this high-solute feeding regimen was the major factor in the production of his hypernatremia. His mother's explanation for such an unusual feeding regimen in a young infant was that she could not afford the prepared dried milk powders.

I believe that a major campaign is required to alert mothers to dangerous feeding practices and this could be part of a national drive to encourage breast-feeding. There may also be a case for further subsidies on low-solute milk powders when breast-feeding is impracticable.—I am, etc.,

BARRY LEWIS

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The Disc Sensitivity Test

Sir,—Your leading article on this subject (13 July, p. 74) has come to our attention. It contained a number of misapprehensions about the system of diffusion testing (F.D.A.) and International Collaborative Study (I.C.S.) recommendations for diffusion susceptibility testing. The most important is the statement that these procedures are "uncontrolled." Specific recommendations for the use of two recognized control strains and the statistical limits of acceptable results with them have been published in several places.1,2 The question of quality control has also been broadly reviewed.3 Medium control at the manufacturer level is feasible to resolve finally the problem with Pseudo-

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| 7 Roller, L. B., et al., Journal of Infectious Diseases, in press.

• Our correspondents are themselves under at least one misapprehension. Naturally if the type of test advocated in our leading article were to be commended by any authority for general use the test conditions (including the plates) should come as close as possible by a simple method not involving turbidimetry, and indeed its every feature except the composition of the culture medium would require definition. If a small fraction of the effort which has gone into the evolution of the F.D.A. and particularly the I.C.S. method were devoted to this task it should not present difficulty. Indeed, a description of one such method adequate for its performance without risk of any serious error already exists.2 It will be little con-

Quality Evaluation in Histopathology

Sir,—Opinions have recently been expressed about the desirability of a quality control test in histopathology. Many factors affect the quality of histopathology and not the least of these being the quality of the surgical specimen, the technical processing of the tissue, and clinicalopathological con-

1 Pelminger, D., and Stone, J., Medical Laboratory Technology, 1972, 29, 196.

1 BMJ: first published as 10.1136/bmj.1.5950.149-a on 18 January 1975. Downloaded from http://www.bmj.com on 25 April 2022 by guest. Protected by copyright.
been obtained in all but eight of the first 300 cases reviewed. Differences between the consensus diagnosis and the participants' diagnoses are placed in two categories: (a) a diagnosis that gives a misleading prognosis or one that would lead to inappropriate treatment, and (b) a minor diagnostic difference of no clinical relevance. The consensus diagnosis has been compared also with the original 1970 diagnosis. Nine pathologists participated. These have been divided into two groups, senior pathologists who have obtained the M.R.C.Path. diploma and junior pathologists without this diploma. The results of the 295 out of 300 cases are presented in the table. Since clinical information was minimal and since consultation between pathologists before diagnosis was not permitted, the figures may be interpreted as the maximum for incorrect diagnosis.

The benefits of this on-going system are as follows. (1) It has proved to be a valuable educational exercise for consultant and trainee pathologists. (2) Uniformity of nomenclature and diagnostic criteria in the field.—We agree. (3) It is a valuable guide to the suitability for delegation of responsibility for reporting. We can see that a comparable system may have advantages in the clinical field.—We are, etc.,

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J. R. Tighe

Department of Surgical Pathology,
St. Thomas's Hospital Medical School,
London S.E.1


Disclosure of Medical Records

Sir,—Since August 1971 the Rules of the Supreme Court have provided (Order 24 Rule 7A made under the Administration of Justice Act 1970) that before commencing proceedings a potential plaintiff in a personal injury case may apply to the court for an order requiring a medical practitioner who is a potential defendant to disclose his clinical records. Similarly, once proceedings have been started to which a medical practitioner is not a party (case example below) a medical practitioner who would be a material witness in the case can be required by order of the court to disclose his clinical records at an early stage in the proceedings rather than delaying this until he is in the witness box. It is worth pointing out in general terms that an order of the court is not made automatically and that if the practitioner chooses not to submit his records voluntarily (as is his absolute right) the court will consider the merits of each application and restrict the disclosure of records to that which Justice requires.

This case has been dealt with in detail on more than one occasion in the medicolegal columns of your journal2 as well as in a letter from Dr. P. H. Addison, past Secretary of the Medical Defence Union,4 and there is no need to go over the same ground again. What we wish to do now is to bring to the notice of members of the profession a particular aspect of the problem.

Two recent cases4 heard before the Court of Appeal and supported by the M.D.U. have established that when a court orders disclosure of medical records they shall normally be produced only to another medical practitioner, acting as medical adviser to the party that obtained the order for disclosure, and not to solicitors. A practitioner's records may well include letters written to him by another practitioner—for example, a general practitioner may have bad letters from a hospital consultant about the patient. The precise description of the documents the production of which may be ordered will be set out in the order, but it should be assumed that when the order specifies "all the medical records of Dr. X relating to . . . this will include not only the practitioner's own notes but all consultants' letters and other clinical documents which are relevant to the case.

Our purpose is to point out to all practitioners in the United Kingdom that letters to other doctors about patients should always be written in the knowledge that they may be subject to detailed scrutiny by other practitioners prior to any court hearing, as well as by the judge and lawyers when the case gets to court; and that accordingly their tone should be serious and precise, even though this may mean the loss of the "personal touch" which have in the past lightened correspondence between colleagues.

—We are, etc.,

James Patterson
Joint Secretary,
Medical and Dental Defence Union of Scotland
Glasgow

J. Leacy Taylor
Secretary,
Medical Protection Society

J. W. Brooke Barnett
Secretary,
Medical Defence Union

London W.1

1 British Medical Journal, 1972, 1, 577.
3 Addison, P. H., British Medical Journal, 1972, 1, 365.
4 Davidson v. Lloyd Aircraft Services Ltd., The Times, 15 May 1974, p. 20.

Retinitis Pigmentosa

Sir,—The leading article on this subject (17 August, p. 429) is misleading with regard to the genetic advice to be given to a family with affected members and also the visual prognosis to be given to an affected individual.

You state that the disease is usually transmitted as a recessive condition without differentiating between X-linked and autosomal recessive forms. In a family with X-linked disease the chances of affected individuals appearing in future generations is high, while in autosomal recessive disease it is low if cousin marriages are avoided. This differentiation is particularly relevant when a heterozygote seeks advice. You correctly point out that heterozygotes for the X-linked gene (female carriers) show some phenotypic expression of the abnormal gene by early adult life,1 but it should also be emphasized that heterozygotes for the autosomal recessive gene rarely if ever have recognizable ocular changes. Therefore, these two forms of the disease, which are equally common in south-east England,2 must be distinguished from another before genetic advice is given.

Your statement that retinitis pigmentosa, once recognized, leads to blindness within a few years is quite wrong. There is no doubt that patients with severe recessive forms of the disease may be blind in early life, though such cases are rare. Even males with X-linked disease who notice loss of dark adaptation in the first decade of life are not severely handicapped until the third decade and may retain some useful vision until they are 50 or 60 years old. Autosomal dominant retinitis pigmentosa, which represents 25% of all cases in our practice, is mild and may give rise to little disability even in late life.3

—We are, etc.,

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Barney JAY

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* * *

We did not expand on the various patterns of retinitis pigmentosa inheritance as this was not the aspect with which our article was primarily concerned, but we deemed it sufficient to refer readers to a recent genetic analysis—indeed, by the authors of this letter. We said that retinitis pigmentosa "usually . . . leads to blindness within a few years." We readily accept these authors' findings that this was unduly pessimistic.—Ed., B.M.J.

Diagnostic Test for Multiple Sclerosis

Sir,—The degree of inhibition by linoleic acid of the response of human lymphocytes to antigens has been claimed by Field et al. to be much greater in patients with multiple sclerosis (M.S.) than in other neurological disorders and could be used as a diagnostic test. Merrin et al.2 failed to confirm that the test was diagnostically useful in double-blind trials on M.S. patients selected according to the criteria of Allison and Miller (see MaAlpine et al.). Without wishing to take sides we would like to suggest that this new factor which we believe should be taken into account in patient selection if an effect of linoleic acid is to be tested on the patients' macrophages.

Linoleate levels were demonstrated in 19661 in patients with M.S.; early in 1973 Miller et al.2 published evidence that sunflower seed oil might act as a remission agent. At that time we were including M.S. patients in a study of blood fatty acids. However, considerable press and television publicity was given to these findings of Miller et al. and by the autumn of 1973 most of the M.S. blood samples we