was also inoculated intracerebrally into a strain of mice known to be susceptible to acanthamoeba, but amoebae were not isolated.

Dr Griffin also suggests that repeated nasopharyngeal specimens should have been examined for droplets of nasal secretions 3 weeks before and after patients went into hospital. This was possible, it seems, but not feasible.

Infection.

In these cultures of CSF and nasopharyngeal secretions were negative because the sulphonamide received by the patient for two days before the specimens were taken had inactiva-
ted the amoebae. However, the amoebae were seen to be still moving, although very sluggishly, in a specimen of CSF taken four days after the first, after the patient had re-
ceived both sulphonamide and amphotericin B.

The high cell count in the CSF is more typical of naegleria than of acanthamoeba infection. Dr Griffin suggests that N gruberi, which is sensitive to febrile temperatures, would cause little damage in a patient with a fever. In fact our patient had a fever of 39°C on admission, but thereafter his temperature never rose above 37°C.

There is thus no evidence for Dr Griffin’s theory that the N gruberi was not the primary pathogen in this case.

D C WARBURST
A P C H ROOME
S K R CLARKE

Public Health Laboratory,
Bristol

Squints

SIR,—As with the other papers in your series “Problems of childhood”, Mr Brian Harcourt’s article on squint (20 March, p 703) is commendable for its clarity, conciseness, and clinical relevance. He rightly stresses the importance of early diagnosis and treatment.

However, although glad to learn that squint surgery “rarely requires over three days in hospital,” I feel that it is insufficient to state that it is “the particularly uncomfortable or unsettling even for very young children.” Where preschool children have to be admitted to hospital, sadly it still seems necessary to emphasise the importance of their mothers being admitted with them. A recent paper by Douglas1 reveals not only that hospital admis-
sion without the mother can result in disturbed behaviour in preschool children on return home but also that there is a significant increase in problems of behaviour and learning during the adolescence of these children. Other writers2 3 have shown us how the concept of the child being “settled” in hospital can be misunderstood.

Where the mother cannot accompany the child Vaughan,4 who reported on 40 children (mean age 5-9 years) in hospital for five days for correction of strabismus, described a deliberate policy of discussing their fears with the children and explaining the procedures, which mitigated some of the adverse psycho-
logical effects of the experience. Other methods have also been described.4 Vaughan also reminds us that the psychiatric increase of squint, which were not referred to in Mr Harcourt’s article.

Anthony G Carroll

Department of Child and Family Psychiatry,
Regional Hospital,
Galway, Ireland

SIR,—With the help of her patient appointment list, her appointment patients often leave the vertical sections of skin with the opthalmologist. This system has resulted in much earlier diagnosis and treatment of real squints and spared many a mother the weariness and pointless business of having to attend hospital because her child has a broad nose. It also brings to light visual problems in siblings and the earlier diagnosis of conditions pre-
disposing to squints such as high hypermetro-
pia or anisometropia.

One other point which improves the defaulting rate at an early stage is the use of 0-1% hyoscine drops in place of several days of atropine. This is as powerful a cycloplegic and only requires one hour to work, obviating the necessity of a second visit and, in some cases, the destruction of a happy relationship be-
tween mother and baby.

Guy’s Hospital,
London SE1

P A Gardiner

Steroids and hypertopic eczema

SIR,—I want to thank Drs S Selwyn and P W M Copeman for their clarifying remarks on the treatment of patients with hypertopic eczema with Miot lotion and cream (14 Febru-
ary, p 399).

One explanation of the fact that I have seen adverse effects of treatment with strong steroids only in exceptional cases of this condition might, of course, be the choice of steroid. Approximately 90%, of my patients were treated with betamethasone valerate or betamethasone dipropionate. In controlled studies we also used other steroids, and noted a temporary erythema of the skin and a burning sensation after, for example, fluocinolone acetonide or flumethasone. horse Selwyn and Copeman are concerned about the use of antibiotics in skin medica-
ments without bacteriological monitoring. I entirely agree that antibiotics are very seldom needed, either in leg ulcers or hypertopic eczema. Fairly extensive investigations in our clinic have shown that not only an antibiotic may change the growth pattern entirely but also that healing progresses independently of the bacteriological flora. Skin conditions on the basis of venous incompetence of the leg should not be treated with antibiotics, either locally or systemically, unless there is a severe clinical
infection. In that case bacteriological monitoring is highly desirable and adequate treatment should be initiated according to Lord Fisher's famous principle: "Hit first, hit hard, keep on hitting."  

Knut Haeger

Slootsstaden Clinic, Malmö, Sweden

Occult perforations

Sir,—Your leading article on this subject (20 March, p 673) suggests that perforation due to tuberculosis has become rarer (our italics) in Britain. However, in a recent series of 15 patients with abdominal tuberculosis treated in Manchester1 we found three patients with perforated bowels: one had multiple free perforations in the small bowel leading to generalised peritonitis; another had chronic perforation at the ileocecal valve site leading to retrocaecal abscess formation; and in the third patient, who presented in a most bizarre fashion as a possible case of cholera with voluminous rice-water stools developing within days of her arrival in Britain, the symptoms were due to perforation of the diseased ileocecal valve into the third part of the duodenum.

Our experience leads us to suggest that abdominal tuberculosis can no longer be considered a rarity in our multiracial society, and an awareness of the diverse manner in which the disease can present is important if diagnostic delays are to be avoided.

B K Mandal
Regional Department of Infectious Diseases, Montsalvat Hospital

Philip F Schofield
Department of Surgery, Park Hospital, Manchester

1 Mandal, B K, and Schofield, P F, Practitioner, In press.

Specialist training

Sir,—At the start of the GMC conference on the implementation of the Merrison Committee's proposals (leading article, 6 March, p 546) the chairman, Sir John Richardson, asked for a show of hands on whether those present agreed with the first proposition in the discussion paper prepared by the GMC. It was, in my opinion, an impossible question to answer. It was a compound one, linking statements with which any reasonable person would agree to some of which I, for one, could never accept. It required the acceptance of the proposition that undergraduate, graduate clinical, and specialist training should all be supervised and co-ordinated by a reconstituted GMC. I am not alone in doubting whether, in the case of "specialist" training (whatever that is) such co-ordination would be effective; I hope I am even less alone in realising that co-ordination could be effective only if the opinions of the GMC were able to override the views of the relevant specialist body. Nevertheless, a number of hands went up: mine was not one of them. Looking around me I observed that I was far from being alone. Those who did not agree were not at all on show.

In the report of the meeting which the GMC secretariat has now circulated to participants I read: "The conference unanimously accepted the proposition that..." etc. This was a special conference and the participants will not have a chance to challenge the accuracy of this statement. It should therefore be placed on record that not only was it noisy notoriety that we did not even carry nem con, since the "cons" were never asked to signal their opinion.

M A Vickers
Department of Anaesthetics, Welsh National School of Medicine, Cardiff

Future of private practice

Sir,—Despite all the assurances of the Secretary of State it is clear that the very existence of private practice is in jeopardy. Although the phasing out of pay-beds is the most alarming and immediate threat, almost equally disturbing is the "possible Government restriction on private practice from health centres" (5 April, p 596). I trust that general practitioners will heed this warning of the dangers of moving into State-owned health centres, where they will be at the mercy of politicians. In your recent correspondence with Dr Richard Whittaker (the same edition (p 591), I was glad to see a tribute to his initiative in building the modern group practice premises in Guildford, which became known internationally; these premises are owned by his partners and not the State.

In its obsession with egalitarianism and its drive towards a total State monopoly in medicine, the Government shows little evidence of anxiety for a better National Health Service. I suggest that the private patient is a challenge to the NHS rather than a threat; inevitably the patient who is paying is more demanding and critical, but the standards and facilities accorded to these occupants of ordinary wards can never be allowed to lag far behind. With insurance private patient status is within reach of many; if the cost of private beds was slashed even more could afford them and much-needed finance would flow into the coffers of the NHS. The number of private beds would still be limited and would not affect the ghostly length of waiting lists in certain areas and in certain specialties.

At this time the unity of the profession is vital; consultants and GP's are equally under threat. Solzhynitsyn quotes the German proverb, "When courage is lost all is lost." Let us at least show courage in opposing the insidious spread of State interference. May I conclude with the words of a distinguished Irishman, John Philpot Curran, "The condition upon which God hath given liberty to man is eternal vigilance; which condition if he break, servitude is at once the consequence."  

Caleb Wallace
West Clandon, Surrey

Compulsory vocational training

Sir,—We are all trainees on a three-year vocational training scheme as approved by the Royal College of General Practitioners. We would like it recorded that, although we are fully in agreement with the royal college's aim of raising the standards of medical practice by means of training schemes, we do not feel that these should be universally mandatory; our reason being that several excellent and experienced medical registrars have been known to go into general practice with considerable success. Compulsory vocational training would have the effect of forming a rigid choice of specialisation on people either in or very shortly after their preregistration year. We do not regard it as axiomatic that this compulsory specialisation must of itself produce the best general practitioners.

Diversity and individuality are valuable features which, in medicine as elsewhere, are more easily lost than regained. The promotion of individuality in practitioners and areas is best preserved by allowing some flexibility in this matter.

Michael Martin-Smith
R A Pulton
G Foster
V Sanders
Stuart Calder
Clifton, York

BMA and HCSA

Sir,—Like Mr A H Grabham (3 April, p 851) I regret the failure of the Hospital Consultants and Specialists Association and the BMA to reach agreement on a solution to the perennial problem of the representation of hospital doctors. However, I find the arguments in defence of the BMA's attitude to be tortuous.

The facts are simple. The HCSA has about 5000 members, most of whom wish it to represent them. The HCSA has always been willing to enter into a partnership with the BMA to negotiate with Government. The Department of Health refuses to negotiate with any organisation not approved by the existing formal negotiating bodies, upon which the HCSA is not represented. The BMA, which claims to have more consultative support than the HCSA, controls the negotiating machinery, which it professes to be adequate. It was refused to form a partnership with the HCSA and instead has offered it seats upon one of its standing committees, the Central Committee for Hospital Medical Services. My council finds the offer unacceptable.

If the positions of the HCSA and BMA were reversed and we were to offer the BMA seats on one of our subcommittees I feel sure that the BMA reaction would be similar. Arguments about the constitution of the CCHMS or any other standing committee of the BMA are irrelevant. Our members want to be represented by our association. The straightforward question is whether or not their views are to be respected.

Federation of the Junior Hospital Doctors Association and the HCSA will exacerbate the problem. Unless the BMA changes its attitude an immensely powerful body representing thousands of hospital doctors will not be seated at the negotiating table and the feeling of resentment is bound to intensify.

Finally, may I say I was sorry to see Mr Grabham's complaint about alleged misrepresentation, distortion, and biased comment. One man's truth is another man's misrepresentation.

N A Simmons
President, Hospital Consultants and Specialists Association