uneventful pregnancies giving rise to unaffec-
ted infants. This programme has been offered to them: a tricky concept. (It is not
easy to see how that estimate of cost is obtained
from their abbreviated table III.) The cost
of permanent care of people born with Down's
syndrome would be considerable if all of an
assumed normal birth cohort is so low partly
because the estimated cost of permanent care
of 45-year-olds (the age at which 100%), of
Down's syndrome births are assumed to be
in permanent care) is low (about £250 per
person per annum) but principally because,
when discounted at 10%, per annum for 45
years, it gives a "present value" of only £3
per person per annum.

Distant benefit. This programme would be
needed to prevent each year eight uneventful pregnancies resulting
in eight normal births (after amniocentesis
and terminations for the eight affected).

This illustrates how a high discount rate
makes distant future earnings of the newborn
negligible compared with the present costs
of infant care and the near future costs of
schooling, even in the healthy. One of the
benefits that has to be taken into account
(even if it is not given a cash value) is the
value of life per se.1 The logical conclusion
drawn that their calculation is not to
screen the over-40s for Down's syndrome
but to prevent all births (whether "replacement"
or not).

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References

Effect of skin-cleaning agents on Dextrostix readings

SIR,—With the increasing use of reagent strip
tests for biochemical screening we would like
to report a potential cause of misleading results
which we have encountered in the use of
Dextrostix and which is illustrated by the
following case.

A 79-year-old insulin-dependent diabetic was
brought to the accident and emergency department
unconscious. Apart from increased muscle tone
and bilateral extensor plantar responses there were no
abnormal physical signs. An initial assessment of
glucose was made with Dextrostix reagent strips
by two independent observers from samples of
capillary blood obtained by finger prick. While
results were recorded as falling between 9.7
and 13.9 mmol/l (175 and 250 mg/100 ml). However,
formal laboratory estimation on a venous blood
sample taken at the same time gave a value of 1.67
mmol/l (30 mg/100 ml) and as a consequence 50%
glucose was then given intravenously, with rapid
improvement in the patient's condition.

The Dextrostix reagent strips were used from
a freshly opened bottle and when tested on venous
blood were found to give accurate and reproducible
results, indicating that the discrepancy was in
the technique used rather than in the Dextrostix
reagent strips themselves. Further inquiry
revealed that before the finger stick the skin had
been liberally swabbed with 70% isopropyl alcohol
(Sterets swab).

Ethanol or 70% isopropyl alcohol when added
to blood produces a sticky brown pre-
cipitate of denatured haemoglobin that will
adhere to the surface of a Dextrostix reagent
strip. Possibly residual alcohol on the skin
after swabbing may mix with blood to produce
this brown precipitate, which can impart a
brown colour to the test surface. This may
be interpreted by an uncritical observer as indicat-
ing a falsely high blood glucose level, par-
cicularly in poor lighting and when the true
blood glucose is low. More significantly,
Dextrostix reagent strips discoloured by the
brown precipitate also give falsely high readings
when used with a reflectance meter (Eyetone,
Ames Co.).

These misleading results may occur when
rapid determinations are being made in
emergencies with appreciable quantities of
alcohol remaining on the skin surface. This
appears to have been the explanation in this
case, for this phenomenon has not been
reported previously. We would therefore
recommend that any alcohol-based skin cleansing
preparation be allowed to evaporate completely
before skin puncture is performed and that
brown colour discolouration should be
treated with extreme suspicion. This will
avoid the potential danger of misdiagnosing
hypoglycaemia when using Dextrostix reagent
strips.

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Glucose absorption and diabetes

SIR,—Dr G Hatcher (6 March, p 571)
advocates adamant resistance to any milk feeds
being given to infants and children under
3 years of age. He describes the commencing
feeding of a mild diarrhoea because of
the risk of hyperosmolar dehydration.

It is essential to stress that this practice is
extremely hazardous and contraindicated in
whom there is any degree of undernutrition.
The BMI7 is read widely in many parts of
the world and it behoves those who review
problems of childhood to take into account all
the different conditions in which they may occur
and which may modify management con-
siderably.

A recent WHO guide1 to the management of
diabetes for primary health auxiliaries has
stressed the importance of early feeding, start-
ing not more than six hours after hydration
has been instituted. Hyperosmolar dehydra-
tion presents usually in infants on highly
concentrated feeds before the start of treat-
ment but should never develop during treat-
ment, in which adequate hydration is as
imperative as early calorie-protein intake.
Furthermore, it is not clear whether Dr
Hatcher's "guide to their feeding in the lasts"
I cannot believe he would.

Twenty-four hours' withdrawal of breast-
feeding would expose infants in many parts of
the world to further risk of the diarrhoea-
feeding circle, with the likelihood of total
termination of breast-feeding. In addition,
breast milk is highly unlikely to produce a
hyperosmolar state.

The further suggestion that milk should
not be recommended for the much longer
time of up to three weeks in severe diarrhoea
on account of the risk of temporary lactose
intolerance serves only to increase my
anxiety concerning the adoption of the practice
in areas of the world where only breast milk
and particularly in areas of the world
where low-lactose alternative feeds are not
available. Diarrhoea may increase slightly
when milk feeding is recommenced, but as
long as hydration is maintained this is of little
consequence compared with the necessity for
maintaining and improving the nutritional
state of the infant.

Finally, there is strong evidence2 that the
use of glucose-electrolyte solutions given orally
in adequate amounts restores appetite and
allows feeding to be started earlier, con-
sequently with less weight loss and more
rapid nutritional recovery. Water on its own
is less effective in this respect, especially if
it is unaccompanied by early feeding.

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References
1 World Health Organisation, Treatment and Prevention
of Dehydration due to Diarrhoea—Guide for Practitioners
562.
unabsorbable carbohydrates were added to a breakfast test meal containing 106 g of absorbable carbohydrate. The mean maximum rise of blood glucose between 15 and 120 minutes after the meal was only 40-68%, of the control.

Modification of food form may therefore be a useful therapeutic manoeuvre in controlling some diabetic patients.

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Prognosis of new and worsening angina pectoris

Sir,—The report of Dr Barbara Duncan and others (24 April, p 981) is clearly of great importance, but their conclusion regarding the prognosis of new angina may be unduly optimistic because they omitted from their series patients whose angina had already culminated in myocardial infarction or sudden death.

We have recently completed a study of 317 patients with angina in which we combined the prospective and the retrospective approaches by analysing the histories of the patients from the onset of their angina until death or myocardial infarction, or for an average of 6½ years. (As in the Edinburgh study we were dependent on general practitioners for referring the patients so that the material was not selected.) We found that the incidence of infarction or sudden death was at its highest in the first few days after the onset of angina and declined rapidly after the first week. Thus the incidence of acute cardiac episodes was 4% during the first week and 2½% per week during the next three weeks, falling to 0·6% per week during the next two months.

The other striking feature to emerge from our study was that the early prognosis was much worse in those patients whose angina had an abrupt onset than in those in whom the onset was insidious. In those with an abrupt onset the incidence of acute cardiac episodes was 18% during the first week and 5% per week during the next three weeks, falling to 0·5% per week during the ensuing two months.

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BMA and HCSA

Sir,—I have read with great sadness the report on the "Relationship between the BMA and HCSA" (3 April, p 850) together with the letters from Mr A H Graham (p 851) and Dr N A Simmons (17 April, p 963).

It has always been true that the Central Committee for Medical Services has appeared less powerful and less effective in negotiation with the DHSS and its predecessor, the Ministry of Health, than the General Medical Services Committee. When, many years ago, I first became interested in so-called "medical politics" I too believed that this was attributable to dominance by the BMA of the influence of the GMS, both within the BMA and hence the greater power of their autonomous standing committee, the GMSC, and the corresponding organization for the consultant practitioners, the Consultants and Specialists Association (the precursor of the HCSA), but fortunately I remained a BMA member. Subsequent experience as a member of the GMSC and later of the Council of the BMA totally convinced me that this was not so but that the weakness in negotiation of both the GMSC and the corresponding committee with the Ministry of Health and with the Review Body arose from an apathy and indifference of a substantial majority of consultants to the structure of the National Health Service and the details of the terms and conditions of service therein; from tensions between the so-called "teaching" and "non-teaching" staff and between members of the various disciplines within the hospital branch of the Service; and also from a lack of awareness or interest in the problems of the junior medical staff, which caused these doctors to organise and seek help outside the GMSC.

Far from membership of the BMA, with the presence within it of a strong GMSC, being an impediment in the presentation of the GMSC views and those of the hospital staff to the Ministry of Health and the Review Body, the very reverse proved to be the case in my fairly long experience as a member of the GMSC. I received nothing but unfailing courtesy and help from three successive GP chairmen of the BMA Council and from two GMSC chairmen. There were differences of opinion and points of interest which had to be discussed between the committees and sometimes such differences required their presentation to the Council or the Representative Body to arrive at a settlement, but it was not my experience in many years of membership of the RB and Council that a sound case which was presented by the hospital staff as a whole, was ever defeated by sheer weight of GP voting membership alone.

If it be true that the profession now faces a situation in which not only its own future but the whole form and ethos of medical practice for years to come is at stake is not the absolute priority that a united profession presents its case to the Government and the country? I am very well aware how sincerely the HCSA seeks the General Medical Service for its own sake, but if their present divisive policy persists and the future of private medicine is destroyed, or emasculated I believe that their successors will attribute that destruction to divisive and self-seeking action and will angrily denounce from unjustified suspicion of the motives of those who should be their colleagues.

It would appear that HCSA members should ask themselves four questions: (1) Are differences of opinion within the profession better resolved within the profession or by arbitration of the DHSS or the Review Body? (2) If the HCSA has 5000 members who are active and informed could they, through participation as elected members of regional and central HCSA ensure that their policies were those of the CHCMS? (3) Do they seriously believe that such a strengthened CHCMS, representative of all hospital staff, would be deliberately hindered in effectiveness in presenting its views to the DHSS by a hostile or antipathetic BMA? (4) If at any time a strong divergence of view between major branches of the profession develops would they consider that within the BMA organisation it can be resolved?

Members of the medical profession, because we are on occasion arbitrers in matters of life and death, can become and are rightly accused of unjustified suspicion. We would appear to be trying to motivate the HCSA in its claim that hospital staff views should be managed by itself and its own secretariat and presented to the authorities without their colleagues in other branches of the profession having the prior right to examine and seek to modify them.

Mr Grabham wisely says, "I believe basically that a single, efficient, democratically elected body is to be preferred rather than a 'marriage of convenience'—such marriages are rarely successful." This is wholly true not only in our own narrow interests but far more so if we are to create a body in which the DHSS and Parliament will respect and from which it will seek help and advice.

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Family planning in the hospital service

Sir,—Following a recent discussion with other gynaecological colleagues in the South-western Region it seems clear that many area health authorities find themselves unable to implement the scheme for sterilisation and contraception of the Royal College of Obstetricians and Gynaecologists (RCOG), which was agreed by the DHSS and the BMA, although various modified schemes are apparently under consideration.

Meanwhile, as gynaecologists, we are besieged by patients and doctors with requests for sterilisation under the scheme, and it would seem fair that the DHSS should make clear to patients and general practitioners that this scheme has not in fact been implemented. Evidently some of the objections to the scheme are financial, and on these grounds many gynaecologists are opposed to its introduction. I think we should remind ourselves that there are many ways in which savings can be made in the Health Service, and it would seem hardly sensible to expect one group in particular to bear the full brunt of economy measures. To be fair, vasectomy, contraceptive measures, and female sterilisation, other than on strict medical grounds, should be remunerated in a similar way in view of the fact that these procedures are extra to one’s normal commitment.

Therefore, I have deep concern about the waste of Health Service funds over the proposed scheme in letters to the national press no doubt have made sure that funds are not being used unnecessarily in other grades in the Health Service, such as over-prescribing, unnecessary investigations, and over- elaborate equipment. One would naturally assume that they have already refused to accept extra payments in the form of merit awards in order to help the Health Service in its financial crisis.

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* * * The text of a letter on this subject that has been sent to all consultants by the chairman of the Negotiating Subcommittee of the CHCMS was published in last week’s issue (p 1233).—Ed BMJ.

Hospital practitioner grade

Sir,—On behalf of this committee I write to express the mounting concern of hospital doctors in this region at the implementation of the hospital practitioner grade. Though this grade has been the subject of discussion for some years, recent developments in the Health