

on four occasions and at 38 weeks a healthy 3180-g baby was delivered. Insulin requirements during the period of treatment rose to a maximum of 112 units daily, twice the original dose. The uterine activity was on each occasion preceded by a period of hyperglycaemia and ketonuria, probably due to infection in the first instance. To use a hyperglycaemic agent to suppress premature labour in a pregnant diabetic already out of control presents obvious problems, but this case and those reported from Edinburgh show that these can be overcome by adjustment of insulin dosage.

In the current ritodrine data sheet diabetes appears as a contraindication to use in premature labour. It might more appropriately be regarded as a condition in which the drug may be used, but cautiously and with frequent blood sugar estimations. Ritodrine may then contribute towards a reduction of the increased perinatal mortality associated with diabetes.

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Increased serum growth hormone levels in absence of acromegaly

SIR,—I read with interest the report by Dr J A H Wass and others (2 April, p 875) of the long-term treatment of acromegaly with bromocriptine. I should like to point out another condition in which a discrepancy occurs between serum growth hormone (GH) levels and the clinical state of the patient. In 24 heroin-dependent subjects there were very high fasting levels of GH which failed to suppress in response to a 50-g oral glucose load, although there were no symptoms or signs of acromegaly. In 11 addicts abstinent from heroin for a mean period of six months GH levels, although lower than in addicts still "on" heroin, were still significantly higher than those of normal controls during the latter part of an oral glucose tolerance test.

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Truncal vagotomy and cholelithiasis: plea for a controlled study

SIR,—There is not complete agreement regarding the relationship between truncal vagotomy and cholelithiasis.^{1,2} Vagotomy in man produces reduction in bile flow,² increase in the gall bladder volume,^{3,4} delay in its emptying,⁴ and diminution in the response to cholecystokinin-pancreozymin.⁵ Retrospective studies are available, some of them⁶⁻⁸ showing an increase in the incidence of gall stones after truncal vagotomy, others failing to show this.⁹⁻¹¹ Unfortunately, in none of those series were postoperative insulin tests or any others performed in order to demonstrate the functional completeness of the vagotomy. Furthermore, in some of them the normality of the biliary system was not properly assessed before the vagotomy.

In 1970 Bouchier² stated the need for a "well-designed, well-controlled prospective study" to clarify this matter. The same request had been made earlier that year by Costello.¹¹ A review of the literature in English from

January 1970 to January 1977 has failed to show that any such study has yet been done. I feel strongly that it should be.

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- ¹ *British Medical Journal*, 1973, 2, 256.
- ² Bouchier, I A D, *Gut*, 1970, 11, 799.
- ³ Johnson, F E, and Boyden, E A, *Surgery*, 1952, 32, 591.
- ⁴ Nyhus, L M, *American Journal of Surgery*, 1976, 131, 3.
- ⁵ Malaselada, J R, Go, V L W, and Summerskill, W H J, *Gastroenterology*, 1974, 66, 22.
- ⁶ Nobles, E R, *American Surgeon*, 1966, 32, 177.
- ⁷ Tompkins, R K, et al, *Surgery*, 1972, 71, 196.
- ⁸ Clave, R A, and Gaspar, M R, *American Journal of Surgery*, 1969, 118, 169.
- ⁹ Mujahed, Z, and Evans, J A, *Surgery, Gynecology and Obstetrics*, 1971, 133, 656.
- ¹⁰ Fletcher, D M, and Clark, C G, *British Journal of Surgery*, 1968, 55, 895.
- ¹¹ Costello, C, *Postgraduate Medicine*, 1970, 47, 141.

"The cholecystogram is normal" . . . but . . .

SIR,—Mr M H Gough's excellent review of the problem of "falsely normal" cholecystograms (9 April, p 960) did not include the context of recurrent acute pancreatitis. Gall stones are a common cause of this syndrome, and all patients normally undergo cholecystography and/or intravenous cholangiography in the recovery phase. During the past five years we have investigated 135 problem patients who have continued to have recurrent attacks of pancreatitis. Many abused alcohol, but no fewer than 13 were found (usually by endoscopic retrograde cholangiography) to harbour gall stones which had escaped detection by conventional biliary radiology at the referring hospitals.

In Britain a woman with pancreatitis is likely to have gall stones whatever the cholecystogram shows.

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SIR,—Mr M H Gough's refreshing reconsideration of a radiological procedure that is not as helpful as we radiologists like to assume (9 April, p 960) prompts me to report observations made many years ago.

In a military hospital in Italy towards the end of the war we had no "fatty meal" supplied as part of the standard equipment of the x-ray department. At that time an egg in milk was the standard form of "fatty meal." Though no biochemist, this seemed to me to be a singularly poor way of getting fat administered. The milk in any case was prepared from powdered milk rather than direct from the cow. The advantage of holding field rank enabled me to arrange for all our cholecystogram patients to go at the appropriate time to the hospital kitchen, where they were given fried bread nice and hot and appetising. The results were wonderful and even with the sodium tetraiodophenolphthalein then used I obtained visualisation of the cystic and common bile ducts superior to anything I have seen since.

The nauseous cold preparation, based I believe on peanut butter, is as unappetising as can be imagined but it is convenient to the radiographer. In neuroradiology cholecystography is rare and I abandoned the attempt to

fight the commercial pressure. But if my own gall bladder gave trouble . . .

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Administrative staff in the NHS

SIR,—The letter of Mr N H Harris (26 March, p 842) exhibits a complete lack of understanding of the nature of the National Health Service. The aim of this service is surely to provide comprehensive health care which is spread as uniformly as possible over all parts of the United Kingdom. This objective for its "administrators," of whatever discipline, goes far beyond facilitating the "work of medical and nursing staff who treat patients."

Would clinical disciplines really be prepared to take on the professional (let alone the lay) aspects of the employment of staff, of ensuring the correct preparation and conduct of advisory appointment committees, the intricacies of the junior hospital doctors' contracts? To co-ordinate the conflicting views of clinical colleagues and provide advice to health authorities on which decisions relating to the allocation of scarce resources are taken, and then to accept the recriminations when some services go without while others appear to prosper? To face community health councillors and local government members to discuss plans and explain the existence of waiting lists and breakdowns in the Service and the postponement of very desirable developments?

If the absence of porters, orderlies, and catering and clerical staff on strike makes no difference to the treatment of patients, am I to believe that they are no longer required in the hospitals in which Mr Harris works? If so why do clinicians in my health authority continue to urge increases in the establishment of these staffs in order to support operating theatres and give secretarial assistance to consultants and nurses?

Each clinician is responsible in detail for a small part of the NHS; each community physician sees a much larger section of the service in much less detail, but comes to know and procure the interrelationship of each clinical firm, division, and discipline. This requires completely different skills from those practised by a clinician. Should each not stick to his own and avoid denigrating the other?

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SIR,—I fear that Mr N H Harris (26 March, p 842) doth protest too much. His reply to Mr L C Crane's letter (5 March, p 644) is like the proverbial curate's egg, and where it is bad it is very bad.

Let me take two examples. Firstly, it is claimed that there are now 400 physicians doing administrative work for a total salary of £1m. One must allow for printing errors, but if Mr Harris's figure was anywhere near correct these 400 should be the standard bearers to the medical fraternity for voluntarily taking up to a 75% reduction in salary! Mr Harris also does not make it clear whether these 400 are in addition to those who were already doing "administrative" work before reorganisation—MOHs and their deputies,