vices Committee in its Annual Report to the Conference of Representatives of Local Medical Committees, circulated to all N.H.S. general practitioners, stated that it had been considering "for some time the design of medical records." It recommended to the conference that the future medical records should be "of a size to contain unfolded paper of A4 size and should be made available to those doctors who wish to use it." The conference approved the G.M.S. Committee's proposal on the condition "that a firm undertaking is given by the Department of Health to finance all consequent alterations to equipment and premises arising therefrom." The Department subsequently set up a joint working party—including representatives from the G.M.S. Committee—on the redesign of medical records and has accepted in principle the working party's recommendation that the A4 international paper size (210 mm × 297 mm) should be used for general practitioners' record sheets (*Supplement*, 19 May, p. 53). In its annual report this year also sent to all N.H.S. general practitioners—the G.M.S. Committee stated that it understood that the Health Departments were prepared to allocate funds to make some of the new record folders generally available to general practitioners some time in 1974. The committee commented that in the early stages of conversion the new size would be an alternative to the existing medical record envelope and that the two sizes would be in use during a transitional period of several years.—ED., *B.M.J.*

SIR,—The recent circular from the Department of Health (ECN 946) heralding the introduction of a new medical record for general practice is as welcome as it has been long delayed. The present medical record envelope is at best barely adequate and, if the current movement to raise the standard of general practice in this country is to continue, a much improved form of medical record is necessary.

An A4-size record will encourage a better standard of note-making and enable the doctor to refer at a glance to previous notes and letters. This is in marked contrast to the present envelope, which encourages cryptic and often indecipherable notes and from which any particular letter can be found only at the cost of several minutes' searching through tightly folded pieces of paper. Admittedly, there will be considerable problems in finding sufficient storage space in many practices, but the potential advantages are so great that the short-term difficulties must not be allowed to stand in the way of a useful and necessary reform.—I am, etc.,

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Ampicillin for Sore Throat

SIR,—I enjoyed Dr. H. Pullen's article on infectious mononucleosis (12 May, p. 350) and share his concern about the occurrence of ampicillin rashes. My partners and I took part earlier this year in an exercise in which 143 sore throats were swabbed. Forty-nine, or over one-third, yielded swabs positive for *Haemophilus* species while 66 yielded swabs positive for haemolytic streptococcus. Thus penicillin was not the antibiotic of choice in over one-third of these patients.

Published evidence suggests that, on balance, morbidity is reduced by the exhibition of antibacterial drugs in acute sore throat. The choice of drug is governed by the usual considerations, and I think ampicillin must be considered one of the front runners.—I am, etc.,

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Antibiotic Sensitivity of Klebsiella

SIR,—In the interesting account by Dr. Eunice Lockey and others (19 May, p. 400) of a *Klebsiella aerogenes* blood infection from E.C.G. electrode pads one was surprised to read—"On routine disc sensitivity testing the organism appeared sensitive to ampicillin . . ."—though it is later stated that the minimum inhibitory concentration of this drug was 32 μg/ml. Is it possible that the method or interpretation of their disc-plate test is in need of a little review?—I am, etc.,

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Thrombocytopenic Purpura and Haemolytic Anaemia after Influenza Vaccination

SIR,—Dr. R. C. Brown and his colleagues (5 May, p. 303) report thrombocytopenic purpura and haemolytic anaemia after inoculation against influenza. But why diagnose *thrombotic* thrombocytopenic purpura (T.T.P.)? Admittedly, an acute illness with thrombocytopenia, purpura, haemolytic anaemia, coma, and uraemia constitutes a syndrome that suggests T.T.P. (the only classic features of T.P.P. that were missing are fluctuating focal neurological signs and death). T.T.P.—a very rare disease (there are about 300 acceptable published cases)—is the likeliest cause of an association of thrombocytopenia, purpura, and haemolytic anaemia; there are others, and different mechanisms may account for the haematological changes. The pathognomonic feature of T.T.P. is a distinctive form of thrombosis in arterioles and capillaries: without its unequivocal demonstration the diagnosis is only presumptive—in the case in question this histological proof was lacking.

When treatment is credited with cure of so fatal a disease, presumptively diagnosed, it is important that the diagnosis be recognized to be unproved, and therefore possibly incorrect. In contrast to other conditions with peripheral thrombocytopenia, T.T.P. is commonly associated with increased platelet production, though the increased output fails to keep up with consumption in the formation of the myriad platelet thrombi. The observation in the case under discussion that the megakaryocytes showed little platelet budding is not inconsistent with T.T.P., but it is contrary to what is usual. Similarly, it is relatively uncommon in T.P.P. to see the deformed red blood cells that were found in this case. Such less than typical findings reinforce the need for histological proof of a diagnosis of T.T.P.

Terminological ambiguity has led to confusion between T.T.P. (Moschcowitz's syndrome) and the less rare and prognostically quite different haemolytic-uraemic syndrome (H.U.S.). Both T.T.P. and H.U.S. are described as characterized by "microangiopathic haemolytic anaemia." In relation to H.U.S. this term indicates that the anaemia is due to damage to red cells during circulation through diseased small vessels (microangiopathy), particularly glomerular capillaries but occasionally abnormal vessels in other conditions (angiolipomas, for instance, and some cases of T.T.P. itself). This usage differs from the sense of "thrombotic microangiopathic haemolytic anaemia," coined as a synonym for T.T.P. by an unseasoned pathologist[1] who thought T.T.P. an inadequate name because neither thrombocytopenia nor purpura is as frequent as haemolytic anaemia; to acknowledge the pathognomonic thrombosis in the smallest blood vessels he thought up the term "thrombotic microangiopathy"—the rest followed. If the terms "thrombotic microangiopathic haemolytic anaemia" (a synonym of T.T.P.) and "microangiopathic haemolytic anaemia" (the anaemia of H.U.S.) are compared, it may be recognized that in the latter "haemolytic anaemia" is qualified by "microangiopathic" to indicate its vascular cause; in the former, "microangiopathic" is qualified by "thrombotic" (indicating that the microangiopathy is characterized by thrombosis) and the epithet "thrombotic microangiopathic" merely stresses that the anaemia is accompanied by the thrombotic microangiopathy.

T.T.P. and H.U.S. are not the same disease. Is it too late to make this point? Experience at the International Congress of Haematology last year was discouraging; the discussion after a presentation of 41 previously unrecorded cases of T.T.P.[2] revealed an almost unanimous failure to distinguish between T.T.P. and H.U.S.—thus far have confused concepts and neoteric imprecision obscured the differences in pathology, manifestations, and prognosis. Disseminated intravascular platelet thrombosis is not a feature of H.U.S.; it is characteristic of T.T.P. H.U.S. is a serious but by no means regularly fatal disease; T.T.P. is fatal. Haemolysis and uraemia are essential features of H.U.S.; neither is invariably part of the syndrome of T.T.P.

Has any patient with histologically confirmed T.T.P. recovered?—I am, etc.,

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1 Symmers, W. St. C., *British Medical Journal*, 1952, **2**, 897.
2 Symmers, W. St. C., *Lectures, 14th International Congress of Hematology, São Paulo*, 1972, p. 62.

Is Your Pain Really Necessary?

SIR,—One of the more distressing conditions experienced by women of childbearing and pre-childbearing age is spasmodic dysmenorrhoea (see leading article 12 May, p. 323). While seldom if ever permanently disabling, spasmodic dysmenorrhoea is extremely painful and can cause great distress to the patient and her immediate family. The patient who suffers from this condition frequently consults her G.P. to seek relief from the pain, but all too often, as the result of years of indoctrination during adolescence,