many other oral lesions and rarely is tuberculosis at the top of the list of differential diagnoses. In the older texts, when tuberculosis was more common, the ulcers were described as being painless and found mainly on the tongue and occasionally on the gingivae. Patients seem to be taking longer to seek advice for such lesions and the pain is probably related to further infection of the ulcer with normal oral commensals.

Finally, I would stress that, although this case was reported from Nigeria, such cases are still to be seen in Britain in both natives and immigrants, and the incidence is even higher. In my thought, as oral lesions are rarely sought in patients with active tuberculosis. Such patients with covert tuberculosis and dental pain may well be given a general anaesthetic during treatment and investigation, with the resulting danger of infecting the anaesthetic apparatus.

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Genetic counselling in Huntington's chorea

Sir,—We are concerned at the increasing publicity and the changing attitudes towards genetic counselling in Huntington's chorea. Under the guise of “help” a major diy is developing to discover all the families with the disease. Before all this becomes too public, and therefore out of the control of medical ethics, we feel several points need to be emphasised.

(1) It is a rare disease which has involved a few families for many generations. (2) To eradicate the disease from a family the family itself must be eradicated. This is idealistic medicine, but is it the best medicine here? (3) The only “help” that can be given at present is advice against having children. (4) Particular gentleness and care are needed in genetic counselling in these families because one is advising people who have not yet displayed symptoms of a disease they may have inherited. The foremost responsibility of doctors is towards living patients and not possible future generations. (5) In some patients the disease is not as terrible as it is usually described. This should not influence genetic counselling but is a useful solace when advising those at risk. There seem to be familial traits in the clinical picture. In a family which we have studied seven out of 20 members have had mild chorea with no dementia for many years. The average age at death of affected members in the family has been forty years older than that of the unaffected members in the last three generations. Therefore we suggest the following: (1) Only doctors should be made aware of this disease, otherwise there is a danger of the general public becoming over-involved. Chorea-hunting and persecution of witches in choreic families was common in America last century. This was done in the name of religion. We do not want a recurrence in the name of genetic counselling. For this reason we suggest that the use of the media to publicise Huntington's chorea is foolhardy. (2) Affected families should be approached through their general practitioners, who are the only professional people in a position to advise which members of a family should or should not be contacted.

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Outpatient laparoscopic sterilisation

Sir,—I note with interest Mr J H Brash's conclusion (5 June, p 1376) that in his hospital outpatient laparoscopic sterilisation has proved highly acceptable to both patients and staff. I would like to sound a cautionary note from the anaesthetic viewpoint.

Since laparoscopy was first performed on dogs by Kelling1 in 1902 the deliberate production of a pneumoperitoneum with carbon dioxide has been constantly observed to result in a decrease in the patient's tidal and minute volumes, an increase in arterial carbon dioxide tension, a decrease in cardiac output and central venous pressure, and the possibility of silent regurgitation of stomach contents. These problems led Hodgson et al2 to conclude that the anaesthetic technique should include controlled hyperventilation via an endotracheal tube and that laparoscopy should not be regarded as yet another minor procedure.

My own experience bears out their views, and indeed authorities such as Lee and Atkin-son3 state that controlled ventilation is mandatory during anaesthesia for this procedure. Since the use of muscle relaxants is contra-indicated in day-case anaesthesia I would suggest that it is, to say the least, doubtful if laparoscopy should be undertaken on a day-case basis.

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Prevention of coronary heart disease

Sir,—Dr M A Crawford's belief (19 June, p 1532) that degeneration of human coronary arteries is caused by the intensive feeding of farm animals finds no support at all in the facts of agriculture. Stal-fed animals make up only a very small proportion of the total population of cattle and sheep, which graze on fields and hills. In dairy herds the tendency has been an increased dependence on grass feeding. This has had the effect of reducing the consumption of concentrates per cow rose by only 153 kg; during the same period the figure for silage was 742 kg. In any case, according to Dr Crawford's own figures the most underexercised and intensively fed of all domestic animals, the pig, has a far higher percentage of unsaturated fat than the beasts which roam the fields.

The last paragraph of Dr Crawford's letter is wholly inaccurate. I find it difficult to believe that his reference to “saturated high teas” and implies that I am uncaring about the health of future generations. Unlike Dr Crawford, who has no clinical experience and who works among animals, I live and work among people; they are my friends as well as my patients. For over 25 years I have observed their diseases, their way of life, and their nutrition, and like most general prac-titioners I share in their agonies and ecstasies. Because I care a great deal about the dreadful effects of the high incidence of diseases such as dementia, obesity, coronary heart disease, peptic ulcer, diabetes, diverticular disease, and, above all, cancer I have repeatedly campaigned against such “sugar high teas” which are so popular in Scotland and which I believe to be the cause of these very diseases. Any possible “saturation” of my high tea will be corrected by the wheat germ oil in my whole-wheat bread.

Coronary heart disease is, I am convinced, but one wave in a whole tide of degenerative diseases which, since the turn of this century, has steadily risen in industrial societies. Changes which have occurred in the quantity or quality of fat cannot, in my own experience explain this pattern of disease. I am sure, however, that, in elaborating the role of refined carbohydrate foods as the cause, the work of Cleave will stand as a landmark in human affairs.

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One-day treatment of hypertension

Sir,—Dr S P Douglas-Jones and J M Blackshank (24 April, p 990) claim atenolol to be effective in one-day dosage in controlling blood pressure in patients with mild or moderate hypertension. However, their conclusions appear to be drawn from an analysis of evenly divided treatment groups, each taken once every two weeks and as a result no information is available concerning within-day blood pressure variation; also their patients did not perform an exercise test.

I have undertaken a pilot study to determine whether once-daily therapy with the beta-blocking drug sotalol would have a satisfactory 24-hour effect in lowering blood pressure in eight patients suffering from mild to moderate hypertension. The pharmacokinetics of sotalol and its relatively long plasma half-life of 12.7 hours1 suggested its use for this purpose. Blood pressure and heart rate were measured in each patient's home at 7 pm, 11 pm, and 7 am. On each occasion recordings were made at rest in the lying and standing positions and repeated after three minutes' exercise. After a 4-day run-in period once-daily therapy with 80 mg of sotalol was taken for 7 days. Readings were then taken weekly for a further six weeks with the same thrice-daily routine.

Preliminary analysis of the results shows the following features: (1) Beta-blockade with sotalol showed a dose-response relationship. Blood pressure was reduced by 12-20%