multifactorial causation then it is arguably the case that no single specialist is equipped with all the skills or resources required to effect adequate physical and psychological assessment, which may well be necessary in almost every case if the number of failed attempts at therapy is to be minimised. However, multidisciplinary approaches to health care and the facility of cross-referral could help to ensure that the patient receives appropriate assistance.

It is on these bases that we hold the view that any therapists engaging in the provision of help for sexually dysfunctional patients should be aware of the possibility that physical, pharmacological, and psychological factors, as well as others, may contribute to the onset and maintenance of the problems presented. Sex therapists should have access to facilities which will ensure adequate pre-treatment assessment and multidisciplinary therapy if appropriate. These views have clear implications for resource planning and the training of therapists, and we feel strongly that there are dangers in the currently popular concept of brief training in specific techniques to produce practitioners with skills limited to the treatment of discrete sexual dysfunction. The variety of settings outside the health services in which sexual problems may also be presented is of particular relevance to the question of adequacy of assessment and there are implications for the wider availability to varied referral sources of health care facilities for the treatment of sexual dysfunction.

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Out-of-hours calls in general practice

SIR,—Both Dr B T Williams and his colleagues (7 August, p 368) and Dr M G F Crowe and his colleagues (26 June, p 1582) give us examples of the way out-of-hours care is provided, but they state that we do not know quantitatively what happens in large areas of the country. I can confirm that this was so when, in January 1975, I examined several features of group practices, including out-of-hours arrangements, throughout the county of Wiltshire.[1]

Questionnaires were returned by 45 out of the 53 partnerships. This is a rural area and only two practices used a deputising service at any time. Of the 45 respondents, a duty doctor gave weekend cover in 44 evening cover in 42, and that partner also took emergencies after 10.30 am in 25 practices. Interestingly, in five instances the duty partner for the evening handed back the responsibility of each doctor for his own list at 11 pm. In nine practices the individual partners remained on call for their own obstetric cases at all times.

This survey was made primarily to examine the extent to which partners care for the patients on their own lists and it revealed that this was generally true for 12 practices (27%), whereas in the remainder patients attended any doctor. Those partners giving personal care to their lists during the day were just as likely to hand over to a duty doctor out of hours but were usually responsible for their own emergencies and late visits until evening surgery.

Your correspondents state that we know little about the acceptability to the public of the various methods of giving out-of-hours care. There is, surely, ample evidence that patients prefer to see a doctor whom they know rather than a complete stranger. Whether this is more *effective* care is much more difficult to establish except that a service given by doctors with little or no experience of general practice must have disadvantages.

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[1] Aylett, M J, *Journal of the Royal College of General Practitioners*, 1976, **26**, 47.

Marital urinary infection

SIR,—Sexual intercourse is a well-recognised cause of urinary tract infection (UTI) in women but has not been incriminated in men. Experience in this hospital over the past $2\frac{1}{2}$ years suggests that it is equally relevant.

Five married men aged 21 to 34 years presented with UTI due to *Escherichia coli* between 2 and 8 weeks after their wives had dysuria. Mid-stream specimens were obtained from four wives and showed *E coli* ($>10^5$/ml) in three, of whom two were pregnant. Sexual intercourse had occurred in the week preceding the husband's illness. Another man presented with epididymitis and *E coli* bacteriuria 2 weeks after his wife had UTI due to *E coli*.

Serotyping of organisms is desirable to confirm this hypothesis, but the evidence is suggestive. It is of interest that one of the five men was found to have a shrunken kidney and vesico-ureteric reflux. The next time his wife has a UTI perhaps he should be given prophylactic chemotherapy.

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Alpha-fetoprotein and amoebic liver abscess

SIR,—Dr E P Gétaz (8 March 1975, p 573) reports the occurrence of a positive test for α-fetoprotein (AFP) in the serum of a patient with a proved amoebic liver abscess. A similar case has been seen in Ibadan, Nigeria.[1]

A mass in the liver is a common diagnostic problem in northern Nigeria and in our hospitals we rely heavily on the results of serum AFP tests for the diagnosis of hepatoma. A positive test in a patient with a clinical picture strongly suggesting a malignant liver tumour is usually considered sufficient to establish the diagnosis of hepatoma. Serum AFP-negative patients are admitted to hospital for liver biopsy and further investigation. This policy spares many patients with hepatoma hospital admission and a potentially hazardous investigation. However, it is sometimes difficult by clinical signs alone to differentiate between an amoebic liver abscess and a hepatoma. If a positive serum AFP was a common feature of amoebic liver abscess our policy might lead us to make the serious mistake of diagnosing an amoebic liver abscess as a hepatoma. We have therefore reviewed the serological findings in patients with amoebic liver abscess seen by us during the past four years.

Fifty-three patients with an amoebic liver abscess were seen at Ahmadu Bello University Teaching Hospitals at Zaria and Kaduna, Nigeria, during the period January 1972-May 1976. Diagnosis of an amoebic liver abscess was based on a suggestive clinical picture accompanied by a positive test for amoebic precipitins. In many patients confirmatory evidence was obtained by liver aspiration or by a response to treatment with metronidazole. Serum from 45 of these patients was tested for AFP by counter-current immunoelectrophoresis with a locally prepared rabbit antiserum. All were negative. With the same technique sera from 80% of cases of hepatoma are positive.

Although a positive AFP test can occur in patients with an amoebic liver abscess our findings suggest that it is very unusual. All our serum samples were collected at the time that the patient presented at hospital. Perhaps positive tests would have been found at a later stage of the illness when hepatic regeneration was occurring. We believe that our policy of not fully investigating all suspected hepatoma patients with a positive serum AFP is still justified provided that patients with any suspicious feature are further investigated. These investigations should include amoebic serology and, perhaps, a trial of metronidazole.

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[1] O'Connor, G T, *et al*, *Cancer*, 1970, **25**, 1091.

Oral irritation with gentian violet

SIR,—In the past six months we have used gentian (crystal) violet to treat six neonates with oral candidiasis. All six babies developed oral ulceration, in one case within 24 hours. This resolved with cessation of therapy. Only those who received gentian violet developed ulcers; hence candidiasis per se was not the cause. A 0·5 or 1% aqueous solution of gentian violet was used and the manufacturers confirm the absence of additives. Applications were made twice daily. In all suspected cases *Candida* sp was cultured which was sensitive in vitro to nystatin, and only when this was clinically ineffective was gentian violet substituted.

We agree with John[1] that gentian violet is a potential irritant, but even complying with his dosage recommendations it is possible to produce ulceration. Increased mucosal sensitivity was a possible factor in our cases.

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[1] John, R W, *British Medical Journal*, 1968, **1**, 157.

Platelet and coagulation studies in patients treated with bromocriptine

SIR,—We were interested to read the letter from Dr A D B Harrower and others (10 July 1976, p 109). After the initial report by Karmali and Horrobin[1] on the shortening of the bleeding