

until the morning. Just before discharge a smartly attired young doctor entered our room with an entourage of students. He was somewhat taken aback to find two foreigners with whom he could not converse and left after a short while. I was given a pill and left the hospital in a car provided by Intourist. Thus ended my brush with the Soviet health service. My fellow patient received some aftercare as he vomited blood during one of his bouts of sickness and an ulcer was, I believe, suspected. His request to travel by air instead of by coach as scheduled was acceded to and he was afforded every facility and help until we reached our next destination.

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Points

Financial incentives of subregional RAWP

Dr L J OPT (Health Services Research Unit, University of Kent, Canterbury CT2 7NF) writes: Messrs Gwyn Bevan and John Brazier (3 October, p 836) make clear the absurdity of attempting to operate two separate criteria of fairness in dealing with the financing of district health authorities with large cross boundary flows. The logic implies strongly that new methods of capitation funding or cross boundary charging will not deal adequately with the problem of heavy use of services by district residents. Even if such methods guarantee more funding for inner London districts this money will be removed "unfairly" from other districts that are more self contained in their management of resident populations. One solution to the problem could be to redefine district health authorities' boundaries in such a way that they recognise the reality of this interdistrict traffic. This could even mean the development of London health authority(s) whose administrative boundaries would cause much of the cross boundary traffic to disappear and thus allow a return of funding per head as the model for redistribution.

Undescended testes in low birthweight infants

Mr H H NIXON (Hospital for Sick Children, Great Ormond Street, London WC1N 3JH) writes: Drs R Morley and A Lucas comment on the rising incidence of undescended testes (26 September, p 753). Perhaps one reason is implicit in their definition of an undescended testis as "one that could not be brought down to the bottom of the scrotum by manipulation." The late Sir Denis Browne taught that any testis that could be manipulated into the scrotum—whether or not it reached the bottom—was a normal variant ("high" and "low" retractile testes).¹ A follow up in 1977 of patients so diagnosed between 1953 and 1960 by Sir David Innes Williams or myself showed that in all cases traced the testes were in the scrotum.² Also it has become common to measure descent by the distance in millimetres below the pubic tubercle. This seems to me less important than the relation of the organ to the scrotum, as it is sometimes possible to coax a testis quite a distance down alongside the scrotum without entering it.

1 Browne D. Treatment of undescended testes. *Proc R Soc Med* 1949;42:643.

2 Puri P, Nixon HH. Bilateral testes—subsequent effects on fertility. *J Pediatr Surg* 1977;12:563-5.

Radiological diagnosis of deep vein thrombosis

Dr I M AL-KHAWAJA (Oldchurch Hospital, Romford RM7 0BE) writes: Particulate radionuclide venography has many advantages for thrombophlebitis detection (Professor Graham Whitehouse, 3 October, p 801). Phlebitis and pulmonary embolism may coexist in half of all patients. Thus it is useful to

combine perfusion lung scanning and radionuclide venography in one procedure. Instead of the routine antecubital injection for the lung scan the injection is made into a dorsal foot vein. Both legs should be injected simultaneously for comparison. Sequential images of the tracer flow through the calf, thigh, and iliac regions are recorded. Normally, a single deep channel is visualised.¹ The presence of obstruction, collateral circulation, or slow flow suggests venous thrombosis. The sequential images can be followed immediately by the routine perfusion lung scan images. Therefore, radionuclide venography separates the low risk non-phlebotic patient from the high risk group with venous disease. It also differentiates myositis from phlebitis, a distinction not usually possible with labelled fibrinogen.² Radionuclide venography yields 95% correlation with Doppler and contrast venography for detecting disease below the thighs. It is also more accurate than these procedures in non-obstructive phlebitis.

1 McDonald GB, Hamilton, GW Barnes RW, et al. Radionuclide venography. *J Nucl Med* 1973;14:528-30.

2 Webber MM, Pollak EW, Vitrey W, et al. Thrombosis detection by radionuclide particle (MAA) entrapment: correlation with fibrinogen uptake and venography. *Radiology* 1974;111:645-50.

AIDS and tuberculosis

Dr IVAN A D'CRUZ (VA Medical Center, Augusta, GA 30910, USA) writes: Dr K P Goldman (29 August, p 511) called attention to the frequent incidence and varied forms of tuberculosis reported in patients with the acquired immune deficiency syndrome (AIDS). The latter included involvement of lungs, lymph nodes, bone marrow, genitourinary tract, liver, peritoneum, meninges, and brain. To this list may be added tuberculous pericarditis, which in our case caused a large effusion.¹

Cardiac disease in AIDS has been well documented^{2,4} but is usually overshadowed by pulmonary and other manifestations. These few reports of myocardial and pericardial disease tend to be submerged into obscurity by the flood of reports on all other aspects of AIDS. However, if sought by echocardiography cardiac manifestations may be detected more often than is now the case and when present prove an important factor in prognosis.

1 D'Crúz IA, Sengupta EE, Abrahams C, Reddy HK, Turlapati RV. Cardiac involvement, including tuberculous pericardial effusion complicating acquired immune deficiency syndrome. *Am Heart J* 1986;112:1100.

2 Fink L, Reichel N, Sutton MG. Cardiac abnormalities in acquired immune deficiency syndrome. *Am J Cardiol* 1984;59:1161.

3 Cammorosano C, Lewis F. Cardiac lesions in acquired immune deficiency syndrome. *J Am Coll Cardiol* 1985;5:703.

4 Cohen IS, Anderson DW, Virmoni R, et al. Congestive cardiomyopathy in association with the acquired immunodeficiency syndrome. *N Engl J Med* 1986;315:628.

Breast cancer

Mrs PATRICIA MOORE (Sevenoaks, Kent TN13 3XH) writes: Like Dr Angela Prior (10 October, p 920), I too have breast cancer and very positive ideas about what should be done with my body. It is now 10 months since I turned up at the surgery with a tumour 3.5 × 2.5 cm on the left breast. It had burst and was discharging smelly colourless fluid. I had let the lump develop until it burst for no other reason than a determination not to go through the cancer "sausage machine." For many years I had watched with dismay the treatment meted out to friends and close colleagues. In every case there was a fatal outcome within a year or two. I said straight away that I would not consider surgery or radiotherapy. Tamoxifen 10 mg twice daily is the only treatment I have had. A year ago I looked haggard and had a general malaise which made me feel much more than my 64 years. Since the discharge started (it has sometimes been quite unpleasant) my health has improved steadily. I now look and feel fit and have regained my old fighting style. During the past few weeks the tumour has granulated and shrunk, the breast has taken up its proper contours, the mass around the tumour and the node in

the axilla have gone, and the discharge has all but stopped. I have been fortunate in that neither my general practitioner nor the consultant, a radio-therapist, has tried to make me agree to any other treatment. This treatment would probably not be adequate for all patients with breast cancer, but it is neither destructive nor irreversible and could be tried first.

Growing up with chronic renal failure

Dr S SINGH (Child and Family Health Unit, South Western Hospital, London SW9 9NU) writes: Dr M H Winterborn rightly emphasises the multi-disciplinary approach to the care of children in the community (10 October, p 870), but he fails to mention either the school doctor or the school nurse. Not only does the school health service assess the child's educational needs (Education Act 1981) but the medical officer can contribute to the continuing support of the child and family as well as tackle some of the practical problems (enuresis) which can take on magnified proportions in a school environment. Since mainstream schooling can only enhance a uraemic child's educational and social development this aspect of care should not be neglected.

Alcohol and accidents

Miss M A HOCKING (Accident and Emergency Department, Lewisham Hospital, London SE13 6LH) writes: In your report of the Central Committee for Hospital Medical Services' discussion on alcohol consumption (3 October, p 866) you quote Dr J M Cundy as saying that among the 450 people injured by assaults and attending Lewisham Hospital in the past three years, alcohol had been found to be the provoking factor in 60% of them. I do not know exactly what Dr Cundy said but the true figures are as follows. Over three months 425 patients attended the accident and emergency department after an assault. In 348 cases the casualty officer had recorded whether or not alcohol was a factor and it appeared to have been implicated in at least half of these patients.

Intellectual performance of children after whooping cough

Mr R W PORTER (Doncaster Royal Infirmary, Doncaster DN2 5LT) writes: The Swansea Research Unit shows an interesting association between the serious complications of whooping cough and the subsequent intellectual performance of children (24 October, p 1044). It concludes that this may be related to apnoea, fits, or other factors. Our studies of the vertebral canal have shown some evidence for a relation between the development of the neuro-ossesous and the immune systems, populations with small vertebral canals also having some impairment of the immune and central nervous systems.¹ Only a prospective study would have shown whether the Swansea children had both intellectual and immune impairment predating their whooping cough infection. It would then not be surprising that they had previously suffered significantly more recurrent bronchitis and ear infections than the controls.

1 Porter RW, Drinkall JN, Porter DE, Thorp L. The vertebral canal—part 2: Health and academic status: a clinical study. *Spine* (in press).

Correction

The fertility debate and the media

We regret that an error occurred in this letter by Professor Ian Craft and others (31 October, p 1134). At the end of the fifth paragraph it was stated that the first UK twins and triplets were approaching 4 and 3 years of age respectively. This should have read 6 and 4 years respectively.