delayed the summary being typed and sent for up to six months after patients had been discharged. Such problems are not unique to our hospital.

We decided to produce short computerised summaries as close to the time of discharge as practicable using purely medical input. This was achieved with a 16 bit MSDOS computer (RML Nimbus) with a hard disk, using the database language dBASE II programmed by MLJ. A computer novice (JHP) takes some 15 minutes (on average) to produce a complete printed summary. This compares favourably with the 10 minutes of purely medical time spent with the system described by Dr Llewelyn and others.

Our database includes a current alphabetical list of local general practitioners as well as data on previous patients, which saves re-entering data on each admission. It permits searches of any data field and generation of Körner statistics and has resulted in the identification of duplicate case records missed by the hospital patient administration system computer.

Our main current problem is the necessity for medical staff to enter the data, for which they need to be reasonably proficient with the keyboard. This would be solved by adequate secretarial staffing and helped by integration with the database of the hospital patient administration system computer. Fortunately, an increasing percentage of medical staff are gaining keyboard skills.

Although junior staff may well think that computer generated summaries are an imposition on their already overworked schedules, direct experience of the problems, delays, duplications, and even dangers associated with seeing a recently discharged patient with a blank set of notes provides overwhelming evidence of the advantages.

With increasing difficulties in secretarial staffing, which are expected to become worse, hospital administrators should provide the necessary computer terminals, software, and printers to allow hospital doctors to produce immediate discharge summaries and effectively communicate with their colleagues.

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1 Llewelyn DEH, Edwins DL, Horn J, Evans TGR, McGregor AM. Computerised updating of clinical summaries: new opportunities for clinical practice and research? *Br Med J* 1988;**297**:1504-6. (10 December.)

Pituitary apoplexy

SIR,—The case report and discussion of pituitary apoplexy by Dr I G Lewin and others[1] is a timely reminder of the need to consider this comparatively unusual diagnosis, even in patients with little or no previous evidence of pituitary disease. We report a case in which pituitary infarction was precipitated by hypoglycaemia induced by insulin, which was used to test anterior pituitary function.

A 50 year old man was referred with a diagnosis of probable hypothyroidism, on the basis of a serum thyroxine concentration of 34 nmol/l and a raised thyroid stimulating hormone concentration of 10·0 mU/l (reference range 0·35-3·3). His only complaint was of flushing attacks six months previously, but on further questioning he admitted that he needed to shave only every three days and was sometimes troubled by impotence. He denied headache or visual disturbance. He was clinically euthyroid, with a small firm goitre. Funduscopy gave normal results, and eye movements, pupillary reactions, and visual fields by perimetry were all normal.

Thyroid microsomal antibodies were present at a titre of 1/6400. Serum testosterone concentration was low at 1·9 nmol/l and gonadotrophin concentrations were inappropriately low (follicle stimulating hormone 3·4 U/l, luteinising hormone 1·9 U/l). Lateral skull *x* ray films and coned views of the pituitary fossa showed no abnormality. During insulin stress testing (0·15 U/kg) the patient complained of severe retro-orbital and occipital headache and became symptomatically hypoglycaemic and hypotensive, requiring intravenous dextrose and hydrocortisone; he was subsequently given oral hydrocortisone and thyroxine in replacement doses. He continued to complain of headache, nausea, and photophobia, although there was no meningism, and developed a right afferent pupil defect, a right temporal field cut, and a diminution in visual acuity to 6/36 in the right eye. A computed tomogram with coronal sections showed a tumour of 2 cm in the pituitary fossa extending 12 mm above the diaphragm sellae; pituitary function tests confirmed panhypopituitarism, apart from an apparently normal thyroid stimulating hormone response to thyrotrophin releasing hormone. At trans-sphenoidal operation a necrotic pituitary adenoma was removed, and there was evidence of recent haemorrhage within it. Histology confirmed a necrotic haemorrhagic tumour. After the operation and radiotherapy the ophthalmological findings returned to normal but the hypopituitarism persisted.

We have not found any previous reports of pituitary apoplexy occurring as a complication of insulin stress testing, but this case illustrates the need to consider it in appropriate circumstances. Our patient suffered damage to the optic pathways and required both urgent resuscitation and neurosurgical decompression.

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1 Lewin IG, Mohan J, Norman PF, Gibson RA, Francis JRC. Pituitary apoplexy. *Br Med J* 1988;**297**:1526-7. (10 December.)

Children and apartheid

SIR,—I find Dr Peter Arnold's logic regarding the presence of doctors in South Africa[1] extremely difficult to follow. Of course, some South African doctors are impelled to leave because of the dictates of their conscience. For others there may be a genuine lack of an adequate career in South Africa.

Yet if all South African doctors followed Dr Arnold's advice, and their demands as human beings took precedence over their calling as doctors, they would all leave the country. In their hundreds of thousands they would lead the good life on offer in the United States, the United Kingdom, Canada, and elsewhere. As the economy in South Africa declines all that is left of the so called enjoyable fruits of the South African apartheid system is a decreasing standard of living and an increasing number of patients needing treatment in the public sector.

When I visit the United Kingdom, Canada, and the United States I am impressed by the superior standard of living of emigrant South African doctors. Could Dr Arnold (or anyone else) please tell us who would serve the vast medical needs of the black and coloured populations if all the doctors left? At Groote Schuur Hospital we are now completely integrated, and the most modern facilities can be offered to all patients, irrespective of ethnic group, at a modest cost. Does Dr Arnold seriously suggest that the doctors who keep these largely altruistic services running should emigrate and leave the patients to look after themselves?

The Declaration of Geneva of the World Medical Association binds the physician with the words: "The health of my patient will be my first consideration."

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1 Arnold P. Children and apartheid. *Br Med J* 1988;**297**:1130. (29 October.)

An inadequate questionnaire on premature births

SIR,—We are writing to express our concern at a "premature baby survival project" currently being undertaken by Nicholas Winterton MP on behalf of the House of Commons social services committee's inquiry into perinatal and neonatal mortality.

As part of this project a questionnaire is being circulated to all neonatal units requesting the number and exact gestational age of all babies born at or under 25 weeks' gestation who have survived. There are, however, major deficiencies in this questionnaire which will limit the scientific validity of any findings reported or conclusions drawn from this project.

Firstly, details of gestational age have been requested, but not birth weight. No information has been sought on the methods used to ascertain gestational age, despite the fact that this may be difficult to ascertain with precision in extremely premature babies. Birth weight may be simply and reliably measured and is routinely included on the death certificates of premature babies. We are therefore surprised to see that it has not been included on Mr Winterton's questionnaire.

Secondly, no definition of survival has been given and this crucial aspect of the project is thus open to individual interpretation; nor has information on the length of survival been requested.

Thirdly, it is the proportion surviving and not just the number who survive that is needed if comparisons are to be made over time and between different units. Details of the total number of babies delivered at this gestation irrespective of outcome have not, however, been requested.

Finally, no period of time has been specified and it will therefore be impossible to state whether the resulting information relates to the past month, year, or five years.

We therefore suggest that any data eventually quoted from the questionnaire should be recognised as being without scientific validity. It cannot possibly increase knowledge about the survival of premature babies.

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Corrections

Postnatal depression of coeliac disease

An editorial error occurred in the title of this letter by Drs Simon Travis and Paul Ciclitira (7 January, p 47), which should have been, "Postnatal presentation of coeliac disease."

Merit awards

A printers' error occurred in this letter by Dr B A Evans (7 January, p 52). The penultimate sentence should have read, "Now even the review body expresses its concern."

Monitoring the acute phase response

An editorial error occurred in this letter by Dr Anthony G Freeman (7 January, p 50). Reference 1, at the end of the first sentence of the third paragraph, should have been reference 2, and the subsequent references should have been renumbered sequentially.