Fluorescent Staining and Human IgM

SIR.—When antibody is united to an insoluble antigen, the class of globulin attached may be ascertained readily by the fluorescent antibody technique, using conjugated antiglobulins of appropriate class-specificity.

In human serum, during and after acute infection, a rising and falling titre of specific IgM fluorescent staining against a virus system may indicate reliably the amounts of virus-specific IgM, but, according to the results shown in the Table, IgM-specific fluorescence given by random human sera not associated with recent virus infection is of more doubtful significance. The Table represents mostly the incidence of IgM-specific staining given by individual sera from rheumatoid arthritis and also by normal sera, when these are applied to HEp cells, infected with herpes-simplex virus.

<table>
<thead>
<tr>
<th>Source of Sera</th>
<th>Number Tested</th>
<th>Before Absorption with Aggregated IgG</th>
<th>After Absorption with Aggregated IgG</th>
</tr>
</thead>
<tbody>
<tr>
<td>RF-positive Rheumatoid Arthritis</td>
<td>35</td>
<td>31 (1)</td>
<td>3 (5)</td>
</tr>
<tr>
<td>RF-negative Rheumatoid Arthritis</td>
<td>10</td>
<td>3 (0)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>RF-negative non-Rheumatoid Patients</td>
<td>41</td>
<td>4 (0)</td>
<td>0 (6)</td>
</tr>
<tr>
<td>Acute Virus Infection (Hepatitis, Measles, Mumps, Rubella)</td>
<td>29</td>
<td>28</td>
<td>27*</td>
</tr>
</tbody>
</table>

Figures in brackets faint, but specific, additional reactions. RF—rheumatoid factor. Tested by IgG-coated latex on serum diluted 1:3.

* One weekly positive rubella serum negative after absorption.

Source: British Medical Journal, 1971, 3, 5776-5776. b on 18 September 1971. Downloaded from http://www.bmj.com/ Br Med J; first published as 10.1136/bmj.3.5776.707-b on 15 September 1971. Copyright © BMJ Publishing Group Ltd. All rights reserved.
Points from Letters

Anxiety and the G.P.
Dr. C. W. D. PHILLIPS (Huddersfield, Yorks) writes: The accessibility of the general practi-
tioner is a topic that needs to be discussed openly now that many doctors have (quite rightly) intro-
duced appointments systems. The problem arises when enough time is not allocated for appoint-
ments. One of our main tasks is to alleviate anxiety, and we may fail to do this if the patient has
to wait too long to get an appointment to see us. The question of what is urgent in general prac-
tice is a vexed one. How long should a middle-aged man with a vague pain in his chest have
to wait before he can see his doctor? Dr. C. A. H. Watts (14 August, p. 419) says that all
patients in general practice, apart from those
clearly not urgent, should be seen within 24 hours. The objection is being expressed at the vast
quantities of medication, especially hypnotics and tranquilizers, consumed by the British populace.
Most of this medication is presumably prescribed by us general practitioners. Do we sometimes
take the easy way out, and continue to sign prescriptions for these drugs without seeing the
patients, rather than spend a few minutes with the patients to see if the prescription is really
necessary?

General Practitioner Obstetricians
Dr. M. B. CLYNE (Southall, Middx) writes: Mr. R. M. Burton (28 August, p. 532) is one of our
local consultants with whom we general practitioners in the area of Hillingdon Hospital and
Perivale Maternity Hospital work so well
together in shared antenatal care. The benefits of
this shared care are immeasurable, both for patients and for general practitioners. The
patients benefit not only by saving waiting time and long journeys, but also because they are
always aware that their general practitioner is taking ultimate care of them during pregnancy.
General practitioners benefit because the shared system of care is bound to raise their level of
antenatal care and because they are never ignorant of their patient's condition during preg-
nancy, as is apt to happen when the patient is taken over by an antenatal department. . . .

Scotland's Anaesthetists
Dr. C. S. JONES (Worcester, C.P., South Africa) writes: Dr. P. R. D. Dodds's interesting report
on anaesthetic staffing and training requirements in Scotland (31 July, p. 293) is apparently based
upon the premise that all anaesthetics in Scotland should be given either by consultants or by
anaesthetists in the specialist training programme. I feel that the evidence is not as strong as
Dr. P. R. D. Dodds suggests, and I am of the opinion that the establishment of a group of
anaesthetists who would be willing and able to work with the consultants in individual cases will
lead to a more favorable situation. . . .

Oncolytics and Enzyme Detergents
Dr. H. R. VICKERS (Department of Dermato-
logy, Radcliffe Infirmary, Oxford) writes: I have been trying to find the incidence of skin
damage caused by enzyme detergents, and from replies received to a questionnaire sent to all
British dermatologists, it appears that the incidence of skin damage is extremely small. One interesting feature about the
case reported by Drs. G. Hodgson and R. T.
Mayon-White (7 August, p. 352) is the fact that in the region in which the patient was treated,
the case is missing, as is implied in naming them "consultants"? . . .