that the first phase of any compulsive action which the doctors take must be mild but definite. I would advocate a graded strike consisting of refusal to sign death certificates, sick notes, and Health Service prescription forms. I have no doubt that the Government has already plans in hand for lay officials to take over these duties, and some little time would elapse before their incompetence became fully evident. During this time doctors could achieve the cohesion that is required and the knowledge that all were taking part in the action.

The next step would be to close down all the non-emergency treatment—clinics, investigation, and diagnosis would continue. It is a dreadful thing to find myself, a doctor who willingly put life and freedom at the disposal of the R.A.M.C. in 1939 on behalf of my country, so disgusted by the treacherous and vote-grabbing manner in which politicians have handled the National Health Service that I am prepared to advocate the abandonment of this service in favour, once again, of total private medicine.

The present stage is climactic and only a return of the Ministry to loyal and truthful adherence to the original conditions of service should persuade us to continue to deal with it. But it must be remembered that we can deal with it only from a position of strength which it will resound and indeed fear.—I am, etc.,

RANDLE LINT
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Metaclopromide and Prolation
Sir,—The report by Dr. A. S. McNell and others (29 June, p. 729) that metaclopromide is a potent stimulator of prolactin release may be a matter of serious consequence in the treatment of patients with breast cancer. It has been shown that the growth of breast cancer is sometimes dependent upon the presence of prolactin. Metaclopromide is often used to treat the side-effects of radiotherapy or cytotoxic chemotherapy in patients with breast cancer. It now appears that by releasing prolactin this drug could stimulate the growth of the cancer. I suggest that this drug should not be used in patients with breast cancer. It has previously been reported that chlormethazine is equally effective in treating radiation sickness.—I am, etc.,

H. W. C. WARD
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Drugs for Gastric Ulceration
Sir,—Your leading article on the above subject (27 April, p. 186) leaves one with an impression that a vast number of combinations are available for the treatment of gastric ulceration either suffer from side effects or are not very effective in accelerating ulcer healing. The reference to a “carefully conducted Scandina vean” (1) which showed no demonstrable effect at all® with cinnarvonol is interesting. A recent clinical trial with this compound carried out on Chinese subjects in Singapore resulted in a similar conclusion. It appears likely that once again the ubiquitous prostaglandins might fill the gap. The gastric antiseptic effect of naturally occurring prostaglandins E1, E2, and A1 in man has been recognized for several years. However, these compounds are effective only when administered by continuous intra-muscular or inhaled administration. An inhibitory effect is accompanied by unacee ptable side effects. Of all the naturally occurring prostaglandin only PGF2a is active by mouth, but inhibition of gastric secretion is transient. In a laboratory study of 10 patients suffering from gastritis ulcerating prostaglandin have an ulcer-sparing effect, but the drugs have to be given by subcutaneous infusion for many hours. The lack of effect of orally administered natural prostaglandin is most likely due to their rapid metabolism and inactivation. Results obtained with some synthetic analogues of prostaglandins are more encouraging; 15 (R) 15-methyl prostaglandin, 7, 10-methylene PGF1a, methyl ester, and 16, 16-dimethyl PGE1, methyl ester and free acid are all potent inhibitors of gastric secretion in man.5 When given by mouth. Of all these analogues 15 (R) 15-methyl PGF1a ester appears to be the most promising, and six-hourly oral doses of this compound for two weeks in normal volunteers are well tolerated. Repeated administration of the other analogues is associated with gastrointestinal side effects.3

Some of the interesting and useful properties of 15 (R) 15-methyl PGF2a methyl ester are: (1) a single oral dose of 1200-1500 µg of this compound results in complete inhibition of acid secretion in man. The volume of gastric juice does not alter significantly but there is a marked elevation in pH of gastric juice from around 2 to 7. (2) A similar inhibition of peptic secretion has been observed.6 (3) After a single dose the inhibitory effect on acid and peptic secretion lasts for over three hours. (4) Given orally, it is a potent stimulant effect on mucus-secreting cells.3

Inhibition of peptic and acid secretion and increase in mucus production could provide an ideal milieu for the growth of gastric ulcers. Twenty-one cases with this compound in ulcer patients have been carried out so far. (a) In eight out of 10 subjects with gastric ulcers oral administration of a single dose of 150 µg 15 (R) 15-methyl PGF2a methyl ester resulted in elevation of gastric pH from 4.5 to 7 accompanied by a reduction in epigastric pain and tenderness lasting for over three hours.6 (b) In another study the effect of this compound on the healing of gastric ulcers in 10 patients was evaluated and compared with that in a similar group prescribed an antacid and bed rest. It was given orally in doses of 150 µg 15 (R) 15-methyl PGF2a methyl ester to two volunteers. Gastric ulcer healing in both groups was assessed endoscopically with a duodenoscope. In the prostaglandin group complete healing was seen in three cases, considerable healing in six cases, and no healing in one case. In the control group complete healing was seen in none, considerable healing in two cases, slight healing in four cases, and no healing in three cases. The difference was statistically significant.5

These preliminary encouraging results warrant further clinical trials with 15 (R) 15-methyl PGF2a methyl ester which may provide a much-needed compound for the treatment of gastric ulceration.—I am, etc.,

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Hepatitis B Antigen in Papular Acrodematitis in Children
Sir,—In your leading article (9 March, p. 407) you suggested that there were alternative interpretations to my observations2 on the association of hepatitis B antigen (HBAg) with papular acrodematitis in children. I must emphasize that diagnostic of the disease depends on the presence of (1) non-relapsing, non-itching erythematous papular dermatitis localized to the face and limbs and lasting 20-25 days; (2) a reactive reticulohistiocytic lymphadenopathy; (3) an acute hepatitis, usually anicteric, which lasts for at least two months and may persist for several months or years; and (4) HBAg in the serum after two to four weeks of the illness. These diagnostic criteria distinguish cases of P.A.C. from those of papular-vesicular-acralcoidated syndrome.

HBAg can be shown in the serum of all cases of P.A.C. by immunodiffusion, electro-synthesis, or radioimmunoassay and may be seen on electron microscopy as pleomorphic spherical, tubular, and double-shelled particles identical with those found in the serum of patients with serum hepatitis or polyarteritis nodosa. We and others3 have seen cases of P.A.C. where one or more members of the family were HBAg carriers. We and others4 have also seen cases where a few weeks before or after a child had developed P.A.C. another member of the family showed symptoms of icteric hepatitis.

We believe that P.A.C. is a common disorder than it is thought to be. The diagnosis is often missed because neither the relatives nor the doctor pay much attention to the common symptom—the non-itching eruption of a few papules in hepatitis, usually anicteric, is unsuspected, for there is little constitutional upset and only moderate hepatomegaly. We consider P.A.C. to be the clinical manifestation of the primary infection of HBAg (the causative virus of long incubation hepatitis) in childhood via the mouth or mucous membranes. It is true, as your leading article pointed out, that the characteristic rash and lymphadenopathy of

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P.A.C. are not seen in serum hepatitis. But there are other examples of this. For instance, it is well known that herpes simplex infection affects almost everyone during childhood and adolescence but few present the cutaneous, mucosal, lymph-node, visceral, and general symptoms of the primary disease.

We suggest that the cycle of HBAg infection (see fig.) is such that when it occurs in children it is asymptomatic in most cases but in adults it causes P.A.C. When an infection is acquired by parenoreal inoculation (blood transfusion or subcutaneous or intramuscular injections) the popular dermatitis and lymphadenopathy do not develop, either because the infection begins directly in the blood or because the subject has already experienced primary HBAg infection. For these reasons HB antibody is not found in the serum of children with P.A.C., whereas HBAg is always detectable in the dermatitis phase, while HBAg is not always found in long-incubation hepatitis and polyarteritis nodosa, in which HB antibodies or immune complex are present. The presence of icterus in P.A.C. and its frequent presence in long-incubation hepatitis should be noted.—I am, etc.,

F. GIANOTTI

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1 Gianotti, F., Giornale Italiano di Dermatologia, 1955, 96, 678.
2 Gianotti, F., Archives of Disease in Childhood, 1973, 48, 794.

Doctors, Drivers, and Confidentiality

Str.—I certainly had no wish to slander Dr. R. MCL. Archibald (22 June, p. 670), nor to cast any kind of slur on all who work in occupational medicine. But, yes, I have myself been approached by telephone by firms’ medical officers asking for information about my patients without the patient himself having given his consent. I have never thought that these doctors were villains, but simply ordinary, honourable doctors doing a routine job and—I like most of us—not considering the ethical implications of every little act.

Dr. Archibald invites me to examine my motivation in writing. One would have thought that this subject is worthy of discussion in your columns for two reasons. Firstly, doctors who seek information in this roundabout manner may welcome the chance to consider its ethical implications. Secondly, young general practitioners may wish to be forewarned and forearmed against this sort of irregular inquiry. Speaking—as Dr. Archibald would wish—from my own experience, I know how routine and normal such a request for information can sound when it comes from a genial, honoured, and senior medical colleague.

To end peditantically, the doctor technically in breach of our ethical code would be the one giving information without the patient’s permission, and not the one seeking this information.—I am, etc.,

M. G. KREMER

Bracknell, Berks

Abdominal Decompression in Pregnancy

Str.—The investigation and treatment of infertility are fraught with disappointments for both patient and doctor. Any pregnancy finally conceived brings both a sense of achievement and relief to all concerned.

Maternal rubella infection, even at a subclinical level, undoubtedly carries some risk of fetal malformation. It might be thought desirable to justify a couple to request and the doctor to grant termination of pregnancy. For this to occur in an infertile patient is an immense tragedy and waste. Two such infections in patients attending the infertility clinic at this hospital recently has brought this to our attention. We therefore suggest that, though as an ideal every woman of child-bearing age should have been tested for rubella infection and if necessary vaccinated, at the very least such measures should be carried out before referral to an infertility clinic. This would avoid any delay caused by the necessity to make additional tests and treatment having to be carried out later in the infertility clinic. A test for rubella anacibodies should be available to all practitioners and will indicate if vaccination is required.

Vaccination will give the necessary protection, but contraceptive measures should be used to prevent pregnancy and possible teratogenesis for three months afterwards. Only by such prophylactic measures can our patients be best served and potential heartbreak avoided.—We are, etc.,

GEORGE WYNN-WILLIAMS

ROBERT F. HARRISON

Chelsea Hospital for Women, London S.W.3

Vitamin A and the Teratogenic Risks of Oral Contraceptives

Str.—Dr. Isabel Gal (8 June, p. 560) comments on the results of the high level of vitamin A (retinol) found in the serum or plasma of women taking oestrogen-containing oral contraceptives. Such a finding may constitute a teratogenic hazard to women who become pregnant during or shortly after stopping treatment—Dr. Isabel Gal.

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