is accepted that the way history, examination, and investigation are applied must also alter, we become aware of yet another difference between general and geriatric medicine, and the failure of many teaching hospitals to provide adequate (or sometimes any) instruction on the management of old people becomes even more absurd.—I am, etc.,

C. REISSNER

The London Hospital (Mile End), London E1

The Suicide Profile

Sir,—I was interested to read your leading article on suicide (7 June, p. 525). The feature of the great doctor may well have fallen, but the coroner today bends over backwards to avoid the verdict of suicide, so that the statistics are an underestimate of the true state of affairs. A woman patient of mine drowned herself in a foot of water. She was a known case of depression with a strong suicidal urge and she had spent a good deal of time in a psychiatric hospital. Because there was no note to indicate her intentions, accidental death was recorded. There are many cases like this.

You were right to stress the importance of the doctor-patient relationship. Surely one of the most enhancing rapport situation is to inquire tactfully about the presence or absence of suicidal ideas. It usually gives the patient great relief to be able to share such a guilt-laden secret with his doctor, and the suggestion morale can be boosted by remarks to the effect that such feelings are an indication of how ill he must have felt and how wise he is to seek advice. He is told that today depression is the result of a disease, that he should know how to assess the suicidal risk of the depressed patient.—I am, etc.,

ASHBY DE LA ZOUCH, LEICS

C. A. H. WATTS

Secondary Syphilis and Hepatitis

SIR,—May I support the reminders in your leading articles (31 May, p. 460 and 18 January, p. 112) that abnormal liver function tests and pyrexia of unknown origin may be present in patients with great prominence in the history of both patients with these features in whom we initially omitted to consider syphilis?

An unmarried 48-year-old artist, admitted under the care of Dr. J. H. Baron, gave a three-week history of recurrent headache and drenching night sweats, having recently returned from three weeks in South Africa, where he had a week's influence illness of headache, cardiac stiffness, and sweating. He was febrile, with large axillary and inguinal nodes, a large tender spleen, and a smoothly enlarged and slightly tender liver, but no rash. Haemoglobin was 12.6 g/dl, white cell count 4.8 x 10³/l (4800/mm³) (normal differential), E.S.R. 60 mm in 1 hr, alkaline phosphatase 171 U/l (normal range 20-95), aspartate transaminase 27 IU (normal range 1-47), Paul-Bunnell negative. No malarial parasites were seen on thick and thin films. Foul-bred cultures were negative.

Because he drank unpasteurized milk bruellnosis was suspected, but agglutination tests were non-dilution and rose test was negative (cross-over electrophoretic method) was negative.

Histological examination of multiple sections of a liver biopsy specimen revealed an intact overall liver architecture, slightly oedematous portal tracts

infiltrated by chronic inflammatory cells, and a few polymorphs, scattered microfoci of inflammatory cells in the parenchyma, scanty doubtful areas of focal reticulum collapse, and an area showing prominent Kupffer cells. Subsequent special staining failed to reveal patho.

These findings are similar to those described by Lee et al.1 His intermittent pyrexia persisted throughout his four weeks in hospital. When we reported our lack of a diagnosis to his general practitioner he mentioned that he had obtained a V.D.R.L. test on this patient regularly and that this had been negative when last done, three months previously. On being repeated, the V.D.R.L. test was now positive, as was the cardiolipin W.R. and the fluorescent treponemal antibody test. He became well, free from symptoms and signs, following penicillin therapy.

Several recent reviews of differential diagnosis in pyrexia of unknown origin do not mention testing for syphilis,2,4 which, if done initially, would have saved our patient unnecessary investigation in hospital.—We are, etc.,

JOHN SEWELL

Department of Medicine, St. Charles's Hospital, London W.10

M. A. AHMED

Department of Histopathology, St. Mary's Hospital, Harrow Road, London W.9

Abortion (Amendment) Bill

Sir,—We, the undersigned, are general practitioners who wish to record our general support for the Abortion (Amendment) Bill 1975.

The change proposed in clause 1 is valuable because it would discourage the interpretation of the law for sanctioning abortion on demand. We welcome the provisions of clause 7, which further restrict the period of gestation during which termination is permissible—in the interests of both mother and child. We feel that the way clause 11 has been drafted has given rise to misinterpretation. We would suggest that the wording be changed to clarify the intentions of the sponsors.

We regard the whole Bill as an important measure for eliminating abuses of the present Act without restricting the grounds for abortion originally agreed by Parliament in 1967. We believe that the Bill thus clarified will reflect the true desires of the great mass of British opinion rather than those staked up temporarily by the pro-abortion lobby who showed unnecessary anxiety at the appearance of the Bill.—We are, etc.,

J. BEATON HIRD

R. TODMAN

D. L. KIRK

Birmingham

Picking a Diuretic

Sir,—Your leading article on diuretics (7 June, p. 521) concludes that there is a substantial degree of inappropriate prescribing. This is stating things rather gently. Some of my work has merit. It is elderly handicapped patients, many on treatment for cardiac failure and oedema. The proportion on frusmide is surprisingly high. Surprising and distressing when one considers the efficacy of thiazides and the extraordinarily high cost of frusmide. Distressing to the handicapped elderly patient who has difficulty hobbling to the lavatory or commode fast and often enough to ensure diuresis. For such patients the drug is an unintentionally unpleasant and embarrassing prescription.

Frusmide is splendid when urgent diuresis is needed. It is acceptable also if the patient has abnormal facilities to obey abnormal bladder messages. This perhaps is why it is so much used in hospitals. But once the patient is discharged he could be given tablets which have a paralyzing and correcting effect on French itself. I think that the main danger here comes from scientific terms as such, and the fact that they may be foreign, though no doubt making their effect worse, is, in the end, probably scientific terms by their very nature are superficial and "quantitative," and it seems to me to be "vulgar" to use them, even if they are in one's own language, outside a strictly defined scientific context. The beauty of a language resides in its poetic and "qualitative" overtones, and it is precisely these which are lost when scientific jargon usurps normal speech.

I agree most strongly with Professor Meyer's final point—namely, that in spite of all utilitarian arguments in favour of developing English in France as an energetic diuretic, the French language is still the real language really called for. The "gift" of French or English, as the case may be, to a variety of "colonial" peoples was unquestionably a "caude empoisonne." Such a gift amounts to cultural genocide. (This is why, incidentally, the indirect rule of British colonialism was so infinitely preferable to the "assimilationism" of French colonialism.) English words in French are thereby a poisoned gift, but the biggest poison of all is the infiltration into a language of scientific jargon and the mode of thought that goes with it.—I am, etc.,

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