Cause of Unexplained Anaemia

Sir,—There is a high incidence of thalassaemia trait in large areas of the Indian subcontinent. This should always be borne in mind when investigating apparently simple iron-deficiency anaemias in the immigrant population. The diagnosis of thalassaemia trait is easily missed if the history is not sought. A patient will be labelled 'anaemic' but will not be investigated further unless the history is taken. This should always be borne in mind in the evaluation of the iron-deficiency anaemia patient. The parasites of the Thalassaemia trait may be a red herring, as the unsatisfactory response to iron therapy (oral or intravenous) will soon or later reveal.

We have recently picked up four such cases in patients whose faces contained eggs of the parasite. They were admitted for various conditions such as cerebral vascular accidents, appendicitis, pregnancy, and pneumonia. Despite a low serum and stainable bone marrow iron content, after iron medica-
tion the haemoglobin values showed no significant improvement and the morphologi-
ical changes in the red cells remained largely unaltered. However, the number of cells with punctate basophilia increased, and the diagnosis of thalassaemia was subsequently confirmed by the presence of abnormal amounts of HbA0 (4.2 to 6.3%).

These observations underline the importance of quantitating haemoglobin A0, especially in immigrants originating from the northern regions of India and West Pakistan, particularly the Muslim section, in whom the incidence of the beta-thalassaemia trait would seem to be highest. —We are, etc.,

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Lung Transplantation

Sir,—Your leading article on lung trans-
plantation (28 September, p. 755) states that one of the difficulties that will arise when the lungs are denervated is slow, deep respiratory activity that is perhaps analogous to complete heart block. Section or block of the cervical vagi in animals does produce slow, deep breathing, but this is not true in man. The evidence for this is as follows.

In anaesthetised normal man, block of the cervical vagus nerves by ligation causes no change in tidal volume, respiratory rate, or pattern of air flow. In conscious normal man ligation block of the glosopharyngeal and vagus nerves at the base of the skull produces no change in tidal volume, respiratory rate, or pattern of air flow. This information is now included in recent reviews and in standard textbooks.

It can be predicted, therefore, that total lung transplantation in man will not result in slow, deep breathing as a result of denerva-
tion. —We are, etc.,

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REFERENCES

Psychiatric Interviews in General Practice

Sir,—I submit that Drs. B. Blackwell and D. P. Goldberg (12 October, p. 99), having at first set a fair course, subsequently steer into stormy seas in two areas. Firstly, they advocate that “at least a third of the available time at the first interview needs to be spent on this task” (that is, in obtaining treatment). Why are they so keen to institute treatment so soon, and to spend so long in a very short interview in explaining it? My own experience is that two or three interviews may be necessary before the real illness emerges, and that more often than not explanations are neither sought nor needed by the patient. The second stormy area is that in which the authors assume that treatment required involves tablets. The setting in which they have placed the doctor, as offering treatment, anticipating side-effects, predicting the likely duration of treatment, and warning patients against stopping treatment abruptly attributes to him overmuch authority and omniscience. It is unnecessary to become involved in arguments about the therapeutic value of antidepressive drugs, but not all doctors deny the significance of environmental influences in the causation of mental illness. These influences always demand careful and sometimes detailed con-
consideration before the illness can be success-
fully resolved, and the fact that the authors omit any reference to them is a very serious deficiency.

Medical students are taught that the aim of treatment is to remove the cause of the illness. A patient who is allowed by escaping gas removed from the room. A patient with pneumonia is treated with antibiotics, which by killing or reducing the bacterial population allows natural recovery. Similarly, the cause of patients’ mental ill-
ness may frequently be removed or modified. The notion that mental illness results from an undefined intrinsic biochemical disturbance has little evidence to sustain it.

General practitioners take place of their closest contact with families should have a specialized knowledge of family relationships, will be wise to think very carefully before they grasp at supports which appear to offer them a simple solution. Sooner or later the patient will Avise, and should be willing to explore the complex areas.

A G. P. Obstetric Units

Sir,—Not only your leading article (7 September, p. 567), but also the many con-
tributors to your correspondence columns all wish to agree that the general-practitioner obstetric practice in this country is moving towards an institutional era. Unfortunately there are widely differing views as to which institution.

There are some consultants who believe that all deliveries should take place in obstetric units only (perhaps with some general-practitioner beds attached)—possibly an interesting belief, but unquestionably unrealistic and impracticable. It is well known that in Britain there are many big towns situated many miles from the obstetric units, and therefore it is obvious that these areas should have general-practitioner maternity units. Of course, such general-practitioner maternity units should always be well covered by the consultant (including flying squad) services of the nearest specialist department whenever complications unexpectedly arise. I cannot believe that any British doctor would wish to see normal, healthy mothers in labour being taken by road or rail for 20 miles to a specialist unit. It is the mother’s point of view alone, independent general-practitioner maternity units in many areas must inevitably be con-
considered both desirable and safe.

It must now be emerging in our minds what are to be the future duties of the general-practitioner obstetrician? Do we wish to encourage general practitioners to undertake full obstetric responsibility in the future, or are we to ask them simply to undertake the antenatal and postnatal care, and only occasionally be involved in the delivery? I believe that such a policy would be retrograde, and adhere to the belief that full responsibility by general-practitioner obstetricians should be maintained. Of course, one would qualify this belief by in-
sisting that the general-practitioner would be well supported in the community.

Surely the time has now arrived when a national committee with the interests of all the general-practitioner obstetricians well represented from the B.M.A. and the Royal College of General Practitioners might attempt to do justice not only to these questions, and thereby give a