Tropical Splenomegaly Syndrome

Str,—We would like to bring to your notice a serious anomaly which in our experience occurs quite frequently in the granting of full registration by the General Medical Council.

Present requirements for full registration are no fewer than six months in both medicine and surgery at a provisional registration level. However, it follows that once one has attained and satisfied these requirements full registration should be automatic with the General Medical Council, and the dates of full registration should obviously follow on immediately those of provisional registration. The authority to approve preregistration appointments is delegated by the General Medical Council to the university medical school in the particular hospital region. In our experience there is an unreasonable delay in granting full registration. Where the individual doctor is to be employed in a post requiring full registration—for example, vocational training schemes in general practice—both he and the training practice are in breach of N.H.S. contract if the full registration certificate has not been issued by the date of commencement.

The General Medical Council issues the full registration certificate on receipt of the signatures of the two consultants nominally responsible for the provisionally registered doctor. Should it not be possible to declare a doctor fully registered when in possession of a copy of these documents signed by the two consultants and endorsed by the university? We believe the fault to lie at the central office of the General Medical Council, where they appear to date the full registration form not from the date they receive our applications but from an arbitrary date known only to their administrative staff.

In view of the gravity of this anomaly we ask your support in bringing to the notice of the General Medical Council our dissent and alarm at this practice, in the hope that the General Medical Council accepts our criticism and modifies the procedure for full registration.—We are, etc.,

G.M.C. Delay in Full Registration

A. S. GREEN, Chairman,
Vocational Training Group, North-East of England.

Morpeth, Northumberland.

G.M.C. Delay in Full Registration

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Arthur W. Prince, Honorary Secretary.

A. S. Green, Chairman,
Vocational Training Group, North-East of England.

Morpeth, Northumberland.

Tropical Splenomegaly Syndrome

Str,—Dr. M. N. Lowenthal and Professor M. S. R. Hutn (1 August, p. 262) have reported the tropical splenomegaly syndrome in a Caucasian woman who had lived for 29 years in malarious areas of Africa. She had “always” taken antimalarial suppressive drugs and had never experienced an overt attack of malaria. However, a raised malarial antibody titre suggested that her syndrome had been caused by an unusual response to malaria.

Asymptomatic malaria is not unusual among indigenous adults of malarious areas, because they have acquired a degree of partial immunity to being exposed to the disease from early childhood. On the other hand, non-indigenous residents are usually expected to develop an acute episode of fever after being infected with malaria. This may not eventuate if suppressive drugs are used at irregular intervals or in inadequate doses. Incomplete suppression of parasites enables such persons to develop partial immunity to their infections and, consequently, they may maintain an essentially asymptomatic parasitaemia even after withdrawal of drug prophylaxis.

An essentially asymptomatic course of malaria in persons returning from the tropics may be more common than is generally realized.1,2 Such persons may transmit the disease by donating blood to other individuals.3 In addition, asymptomatic carriers may reintroduce malaria into areas or countries where eradication of malaria has resulted in “anophelism without malaria.” In attempting to prevent the potential transmission of falciparum malaria by persons leaving a malarious area it may be more appropriate for such individuals to receive a short course of chemotherapy than to continue with chemoprophylaxis (which may be haphazard) for a month after departure. Drugs used in the treatment of potential carriers should include an effective sporontocide—for example, primaquine—especially if there is a possibility of infection with drug-resistant strains of P. falciparum.5 The case described by the authors shows that, in non-indigenous residents from malarious areas, the possibility of an essentially asymptomatic course of malaria should always be borne in mind.—I am, etc.,

K. H. Rieckmann.

Army Medical Research Project, Department of Medicine, University of Chicago, U.S.A.

References


