the real obstacles to a renal transplantation programme, which should be rapidly expanding and for which there is such need. Such expansion will not occur until there is an improvement in the nursing establishment and conditions and a staff who can care for the average acute medical or surgical ward, particularly in hospitals where the actual renal transplantation is not done.—I am, etc.,

JOHN GARFIELD

Wessex Neurological Centre, Southampton General Hospital

V.D. Statistics

SIR,—When will producers of television programmes on Venereal Disease (B.B.C.2, 17 November), some of the participants, and unfortunately the authors of otherwise admirable papers (Dr. R. A. S. Wigfield, 6 November, p. 342) learn that statistics produced by venereal disease clinics can be most misleading? In 1968, when the figures were widely quoted represent infections or conditions and not individual patients.

In the last few years the number of conditions recorded on the annual returns requested from the clinics by the Department of Health has increased considerably. Obviously if we increase the number of diseases recorded the figures must rise, and multiple infections, especially in women, that is, gonorrhoea and trichomoniasis, or gonorrhoea and moniliasis, or all three, or even more all added to a grand total must inevitably give a distorted view of the overall picture. A quarter of the registrations does not mean a quarter of a million people. Surely the first thing we must do when dealing with such a highly emotive subject is to define our objectives. Do we want to disseminate knowledge or fear? The increase in gonococcal infections alone is bad enough without overstating the case even by inference, and it is difficult to see that examination serves any useful purpose.—I am, etc.,

LESLIE WATT

Manchester Royal Infirmary, Manchester

Provision for the Mentally Handicapped

SIR,—Campaign for the Mentally Handicapped is disturbed by some of the conclusions that Dr. D. C. Jones (13 November, p. 429) has drawn from his visit to services for the mentally handicapped in Denmark and Sweden. He says their hospitals are overstaffed because parents, who are not anxious to accept their adult children home—even though social services in Sweden are extremely well organized—and concludes from this that "the majority of parents and relatives of patients still favour hospital care."

As an argument for retaining the present British hospital service for the mentally handicapped this is both disingenuous, and unfair to the Scandinavian parents who are not only given the only coherent principles of care for the handicapped we have to work from but are translating those principles into practice at a rate which puts us to shame. The Scandinavian principle of "normalization" demand that mentally handicapped people should be offered as nearly as possible the experiences and opportunities that the rest of us enjoy. This has led to a range of residential care in which the central homes Dr. Jones visited form only a minor part. The main emphasis is on ensuring that local facilities in the mentally handicapped person's own locality, drawing on normal community provision for their services, and offering—as do the central homes—residential facilities for the mentally handicapped person during training rather than anything we would understand by "hospital care." An important secondary principle is that the adult mentally handicapped person should have the right to leave his family home and establish his own social context, just as we "normals" do.

Dr. Jones points out that the Scandianavians have not yet always provided the locally based residential facilities to make their principles practice. But he cannot in justice conclude from this that parents and relations prefer hospitals. The only point that can fairly be made here is that they opt for residential provision for their adult children as is their right, and his—and that hospitals may be the only places which yet provide this. We know of no research in any country which shows that parents, given a free choice between small local homes which offer their child a continuing link with his community and a necessarily more distant hospital composed of a large number of mentally handicapped people, would opt for the latter.

It is important to establish this point. The Government's plans, in Better Services for the Mentally Handicapped envisage a parallel development of locally based residential services by both hospital and local authorities. Campaign for the Mentally Handicapped believes that this dispersal of mentally handicapped people into the localities they belong to is the right pattern for the future. We are all aware that if the Scandinavian local residential services can be said to be inadequate, ours do not yet exist. If workers in the present hospital service seek to defend the existing pattern of residential care by drawing false conclusions from Scandinavian practice, the task ahead of us in establishing new service is going to be made harder than it need be.—I am, etc.,

ANN SHEARER

Campaign for the Mentally Handicapped, 96 Portland Place, London WIN 4EX


Pregnancy Testing

SIR,—In your leading article on pregnancy testing (20 November, p. 444) you state, in reference to the home pregnancy test (Precidio) my company has just introduced, that a woman's belief in her own pregnancy implies that she should have medical advice whether the result is positive or negative. In case your comment evolves from a belief that we are of a different opinion, I wish to draw to your attention the fact that we emphasize twice in the instruction leaflet not only that the woman's doctor should be consulted as soon as possible in the event of a positive result but also in the case of a negative result, of which we say: "If (a repeat test) shows negative again, it is most unlikely that your missing period has anything to do with pregnancy. There may be other causes, however, and you are strongly advised to see your doctor for further investigation."—I am, etc.,

A. B. GILES

Marketing Manager, Chefaro Proprieties Ltd.

Morden, Surrey

Prolonged Fever in Bacterial Meningitis

SIR,—Early this year I wrote to you about this subject (15 May, p. 403). In that letter I stated that four sulphonamide-resistant strains of Neisseria meningitidis RAS 10 recently described1 were non-groupable but a strain which cross-reacted with many antisera. This strain, in fact, did not react with any of our range of anti-sera, which were prepared from the RAS 135 strain isolated in 1963 from a 13-year-old boy. Further examination of the strain isolated in this laboratory and also by Dr. Harry Feldman of Syracuse, has shown them to belong to serogroup B.—I am, etc.,

R. J. FALLON

Department of Pathology, Ruchill Hospital, Glasgow


Carol's Disease

SIR,—The cases of focal congenital dilatations of the intrahepatic bile ducts described by J. Caroli et al. differ from that described in the interesting report by Dr. M. J. Kelly (13 November, p. 407). Caroli's patients showed relatively normal extrahepatic bile ducts, quite different from choledochal cyst. The segmental intrahepatic duct dilatations were either superficial or deep within the liver parenchyma. Some contained areas of calcification. Jaundice in this disease may be due to ascending cholangitis or passage of a calculus into the common hepatic or common bile duct. Any patient with ascending cholangitis may develop intrahepatic abscesses which communicate with the bile ducts. In view of the long history of cholangitis in Dr. Kelly's patient it is possible that the intrahepatic ducts dilated demonstrated are related to abscess formation rather than true congenital dilatations. Associated findings usually present in Caroli's disease, not mentioned by Dr. Kelly, include hepatic fibrosis (usually present, according to Caroli) with portal hypertension, renal tubular dilatations resembling medullary sponge kidney, and undermineralization of the skeleton as in any patient with chronic liver disease. As Dr. Kelly mentioned, a choledochal cyst may involve one or more of the main hepatic ducts or the common bile duct. However, Caroli's disease and choledochal cyst are two different diseases with different radiological appearances. Caroli's disease may be
mimicked by multiple abscesses communicating with the intrahepatic ducts.—I am, etc.

Jervis Street Hospital, Dublin 1


Operations for Obesity

Sir,—Your leading article entitled ‘Operations for Obesity’ (30 October, p. 247) gave a comprehensive review of the value and hazards of small-bowel shunt surgery in the management of gross refractory obesity. May I comment on this form of treatment from my own limited experience of four patients upon whom I have performed jejuno-ileostomy within the past two years? Three women and one man have undergone end-to-side jejuno-ileostomy of the ‘1+4-4’ dimension for refractory obesity amounting to 95-133% above ideal body weight. The follow-up period has been 4-18 months. The figure shows that satisfactory reduction in weight occurred in each, some stabilization developing in the one patient followed for 18 months. One patient has had one bulky stool each day, but the remainder have three to five loose unformed stools daily. This frequency has not been too much of a disadvantage and has varied with dietary intake. No abnormalities of bowel picture, haematological indices, or serum vitamin B12 levels have occurred. Only in the patient followed for 20 months has there been evidence of weight loss with jejunal fluid loss. The figure shows that there have been no episodes of serum, haematothis, dehydration, incisional hernia, or postoperative respiratory difficulties. The operation is hardly disastrous, though good retraction is necessary. Though jejuno-ileostomy is still regarded as an experimental procedure, I believe that the ‘1+4-4’ operation* has now been performed with satisfaction by a sufficient number of surgeons as to justify a place in the management of gross intractable obesity. Not only is it effective and relatively uncomplicated, but it also has the advantage of being reversible. The main proviso to its use in selected patients is that they should be followed closely for several years to determine early any of the potential nutritional and metabolic abnormalities which may arise.—I am, etc.

Michael Baddeley

General Hospital, Birmingham


Diagnosis of Established Deep Vein Thrombosis

Sir,—I was most interested to read the account of Mr. N. L. Browne and his colleagues (6 November, p. 325) on the use of the 125I-fibrinogen test in the diagnosis of established deep vein thrombosis. This method has superseded the 123I-fibrinogen test and was developed in this department.3 Subsequently the accuracy of the method was shown by ascending functional phlebography4 and later confirmed by numerous workers.5 The original method used a scaler, but was superseded by a much simpler technique using a scaler.6 The results using a scale and a raterometer were compared.8 Well over 1,000 patients have now been investigated by us using the 125I-fibrinogen test. It was pointed out when the raterometer was introduced that the most accurate method in diagnosing a thrombus was a 20% difference in radioactivity. Subsequent experience has confirmed this. I am happy to see that Negus and his colleagues agree that 20% is a more accurate measurement than 15%.7

There is no doubt that the 125I-fibrinogen test is the most useful method at present available for examining large numbers of patients and detecting early, forming thrombi. It is particularly useful in postoperative patients. Nevertheless we have made it clear8 that there are defects. In the more proximal groin and pelvis, there is not sufficient difference in the radioactivity over the veins and adjoining tissues to be confident about diagnosis of thrombosis. In addition, there are difficulties with established thrombosis where the process is static or resolving.

We have now completed an investigation into 82 patients with clinical signs suggesting established deep vein thrombosis. The results of this study are being published in detail elsewhere.11 In each of the patients both the 125I-fibrinogen test and phlebography were used. In 15% there was a false positive finding in the radioactive test. The phlebograms established that there were, in fact, no thrombi there. Subsequently it was found that these patients suffered from such conditions as rupture of muscle fibres in the calf, haemothoma within the calf, infection in the region, or other conditions. On the other hand, approximately 25% of old thrombi, proved phlebographically, were negative with the radioactive test. This is curious, and here we agree with Mr. Browne and his colleagues, that apparently static or dissolving thrombi can in a considerable proportion of cases become radioactive. Our practice, therefore, with so many false positives and negatives in suspected cases of established deep vein thrombosis is to use venography. Our experience indicates that this is the more accurate and practical way of assessing the condition at this stage and deciding on the management of established deep vein thrombosis.—I am, etc.

J. G. Murray

Department of Surgery, King's College Hospital Medical School, London S.E.5


11 Kakkar, V. V., *Archives of Surgery*, 1971, in press.