A Common Goal?

Like the hero—or villain—in the old-fashioned silent movie serials the General Medical Council crisis regularly teeters at the edge of the cliff but never quite falls off. So it was in the latest episode when the B.M.A. Council met specially last week (Supplement, p. 29) to discuss the report of the Joint B.M.A./G.M.C. Working Party on the G.M.C.'s functions (Supplement, p. 33). Two facets of the G.M.C., its constitution1 and its finance,2 have already been studied and the results broadly accepted by the profession. The latest study, a working party set up in July and chaired by Sir Ronald Tunbridge, has been seeing whether the differences between the G.M.C. and the B.M.A. about the former's functions are narrow enough to be resolved within the profession.

According to the report differences exist but the working party saw them as "capable of resolution by further detailed discussions." Its members had faced a tight timetable as the Representative Body in approving the study in July had set a deadline of six months for an agreed report.3 Sir Ronald Tunbridge explained to the Council that while the discussions ranged over many subjects (listed in appendix C of the report) he and his colleagues had dealt in principle with certain broad areas. These were registration; the pre-registration year; registration of overseas doctors; specialist registration; the cost of registration; undergraduate medical education; professional discipline; and communication with the profession. Though described by one Council member as "talk about talks," the report has served a useful function in clearing the decks for more detailed discussions. By a large majority the Council decided that progress so far justified a move forward to such discussions. This decision was helped, no doubt, by the news from Mr. Walpole Lewin that he expected no erasures from the Register until December—several weeks later than the Council had thought likely at its last meeting.4

This extra breathing space should help, though the B.M.A. Council will make a final decision on whether it thinks the R.B.'s conditions have been met on 22 November, when it will have the reaction of the full G.M.C. (meeting on 9 November) to the joint report. If the G.M.C. reacts unfavourably or is thought to be procrastinating then the B.M.A. is likely to endorse the call for a public inquiry made in October by some members of Council. Other medical bodies have already publicly called for such an inquiry but Sir Keith Joseph, dealing recently with a Parliamentary question asking whether he would hold a Government inquiry into the G.M.C., showed that he was awaiting the outcome of the joint discussions before deciding "what further action, if any, is required concerning doctors threatened with removal . . ."

Mixed Connective Tissue Disease

Some patients with a rheumatic type of disease show such a diversity of symptoms and signs as to defy precise rheumatological diagnosis.1-3 Commonest among these mixed syndromes are ones with features of rheumatoid arthritis associated with those of systemic lupus erythematosus and syndromes with systemic sclerosis complicated by features of either dermatomyositis or systemic lupus. Despite initial diagnostic difficulties the patient's subsequent history usually permits a satisfactory resolution of the diagnostic problem. But some of the mixed syndromes do seem to persist indefinitely, and now a combined study from the U.S.A. has defined the features of what appears to be a distinct disease which the authors designate "mixed connective tissue disease."4

Over the past eight years G. C. Sharp and colleagues have studied 25 patients in this category. The clinical features indicated mixed connective-tissue lesions. Thus
Renal Radiology

Recent advances in the treatment of renal disease have been accompanied by equally impressive progress in the histopathology, immunology, bacteriology, and physiology of the kidney. Radiology has not lagged behind. Originally the intravenous pyelogram, as its name implies, was used mainly to examine the kidney’s drainage system, but now as much attention is paid to the nephrogram, and it would be more correct to refer to it as an intravenous urogram. Furthermore, radiology no longer provides only a static picture of renal structure; it has become an important tool in the dynamic study of functional disturbance in disease. The current edition of the British Medical Bulletin, which is devoted to renal radiology, provides a timely review of the clinical status and potential for research in the field.

Undoubtedly the most important practical innovation has been the recognition that the use of high dosage of the contrast media enables a useful urogram to be obtained in patients with severe renal failure. Since obstruction of the urinary tract can often be excluded by this means, the need for the more difficult and hazardous retrograde pyelography has been lessened. The excretory urogram is of value even in the differential diagnosis of oliguric acute renal failure. For example, acute tubular necrosis characteristically produces an immediate, dense, and persistent nephrogram with little or no pyelogram, an appearance which has been observed in only one other condition—acute suppurative pyelonephritis. In addition this observation has helped our understanding of the pathogenesis of acute tubular necrosis, since it supports the theory of continuing glomerular filtration with almost complete reabsorption of tubular fluid. I. K. Fry and W. R. Cattell have been pioneers in the dynamic interpretation of the excretory urogram, and in the British Medical Bulletin they analyse in detail the nephrographic pattern in various disorders. The safety of the contrast media is fundamental to their use in high dosage, and from a comprehensive account of their toxicity by R. G. Grainger it is reassuring to learn that with simple precautions, especially against dehydration, the present-day agents are remarkably safe.

Arteriography is a well-established technique for the investigation of the major renal vessels and of renal tumours and cysts, but little attention has been paid to the smaller vessels. Macro-angiography, however, enables vessels as small as the interlobular arteries to be visualized, and M. E. Sidaway describes characteristic patterns in diseases such as hypertension, chronic pyelonephritis, and polycystic nodosa. J. P. Lavender and T. Sherwood give other examples of the use of radiology in pathophysiological research with their studies of the renal microcirculation in experimental haemorrhagic hypertension in the dog. Bone disease in uraemia, formerly little more than a pathological curiosity, has increased in importance with the advent of long-term haemodialysis, for it has crippled many otherwise rehabilitated patients. Separation of the various radiological patterns is necessary for the rational choice of treatment, and those are detailed, together with a correlation with bone histology, by F. H. Doyle and his colleagues.

Other articles deal with the techniques of videocystography, topographical scintigraphy, and ultrasonic and isotopic diagnostic methods. Any clinician or radiologist with a special interest in renal diseases will find this issue of the Bulletin a useful progress report in a rapidly advancing field.

1 British Medical Bulletin, 1972, 28, No.3.

Pertussis in Adults

If a doctor has spent a large part of his life working in the whooping-cough wards of an infectious diseases hospital, he will probably have seen a few cases of whooping-cough in adults. No doctor will have seen many, for whooping-cough is a disease of early childhood. But no age group is immune. Second attacks may occur, though very rarely. And immunization does not confer life-long immunity.

An attack in the adult may be typical or atypical. In the