but rather upon the situation which has evoked it.

Laconic though the council minutes often are, there is ample evidence in them that, especially between the Medical Acts of 1858 and 1886, direct professional representation has repeatedly been a burning issue outside the council. Though I hope the Bromnor Jones proposals on increased representation will soon become law, the really unfortunate feature of this and other issues is the, apparently, long leg between outside professional feeling and internal council response to it. I say "apparently" because, apart from being represented by its members, the council has kept its public light well turned down—until the spotlights were turned up a few months ago.

Whatever the outcome of the present unfortunate tension one simple step could be taken which might prevent recurrence of the undoubted damage done to all concerned. An annual report by the General Medical Council. sent to every registered doctor, would at least enable the council to claim that it tells those willing to read what it is about, and might even stir the silent majority to take more interest in a body to which film has not over a century the profession has been truly indebted. I do not care for the interminable use of words like "establishment," "autocracy," and "diehards"; I cannot believe that all those who seek by selection or election, on the G.M.C. are selfish power-lovers; and I deplore the unfounded, indeed now refuted, charges of extravagance and inefficient administration. Anyone who takes the trouble to read the history of the G.M.C. (did not Aristotle say, He who sees things from the beginning will have the finest view of them?) must become aware that, imperfect though this institution may have been and still is, there is much in its past and present to be thankful for.—I am, etc.,

I. M. RICHARDSON
Department of General Practice, University of Aberdeen, Aberdeen

SIR,—It is my opinion that the present dispute has been largely caused by lack of information. I must place most of the blame on the Association as the G.M.C. had no funds to spend on publicizing its activities.

The profession has, for long, been quite ignorant of developments in the work now required of the G.M.C. This was well brought out the other night during an interview on the television. The young hospital doctor insisted on a public inquiry before agreeing to the principle of retention fees. I am sure he did not know that following the Bromnor Jones report there were to be five lay representatives on the council appointed by the Crown. Neither did he know that Lord Cohen of Birkenhead had nothing against public inquiry. The other general practitioner being interviewed complained of the ineffectiveness of the G.M.C. over drug offences in London. He evidently was unaware that the G.M.C. has no power to move in that area. I do not have to wait for a conviction in the civil or criminal court to be reported to it by the clerk of the Court.

This examples convinces me that the B.M.A. has not given the lead to its members that it should have done. Surely members are entitled to know why the cost of running the G.M.C. has escalated to such an alarming extent. Why not tell members that the rent at Hallam Street has been raised enormously, that a computer has been bought, that the money paid in postal charges? This is only mentioning a few items and I know there are many others which would show adequately why the retention fee has had to be increased steeply.

I fail to see that erasures from the Register of non-payers should have any bearing on current negotiations on the size of the G.M.C. The size of the registration fee in the future will naturally depend on the outcome of these discussions. It is obvious that the G.M.C. has made this threat purely because it needs desperately the money from these unpaid fees.

Finally, many of us in the North will be resenting the remarks made in your leader (18 November, p. 577) about Lord Cohen of Birkenhead. One need only mention the confidence placed in this man from the provinces by his colleagues on the G.M.C. by repeatedly re-electing him as their president. His past experience in medical education would qualify him for this post. —I am, etc.,

A. H. HOLMES
St. Asaph.
Flints

**In the last year alone there have been published in the B.M.J. the full report of an independent investigation into the G.M.C.'s finances (Supplement, 1972, 3, 41), a statement on the G.M.C. in the B.M.A. Council's annual report (Supplement, 1972, 2, 77), reports of debates on the G.M.C.'s functions in the Council (Supplement, 1971, 4, 61; 1972, 1, 29, 61; 2, 73; 3, 14, 65; 4, 3, 29), and at the A.R.M. (Supplement, 1972, 3, 75, 88, 105), reports of the G.M.C.'s own proceedings including its president's addresses and a statement from its registrar (Supplement, 1971, 4, 70; 1972, 1, 70, 77; 2, 141; 3, 213). Of other mem-

Australia Antigen in Rheumatoid Arthritis

SIR,—Dr. C. J. Burrell and others (7 October, p. 23) were unable to demonstrate the presence of the Australia antigen in 29 patients with rheumatoid arthritis by counter-current immunoelectrophoresis, even after treatment of the serum with heat and mercaptoethanol.

We recently demonstrated Australia antigen, sub-group s, in a 39-year-old Algerian patient suffering from rheumatoid arthritis with a positive serodiagnosis, confirmed histologically, by electroimmunodiffusion without pretreatment. The antigen has persisted for six months in this patient. The role of the Australian antigen in provoking and maintaining rheumatoid arthritis is still uncertain.

NORA WILKINSON
Lancet

Head Injuries in Children

SIR,—I agree entirely with the statement in the paper by Dr. A. W. Craft and others (28 October, p. 200) that in the majority of cases recovery after head injury in childhood is rapid and complete.

This is supported by our investigations1 on 963 children with head injuries in the acute, early, and late stages. After clinical and electroencephalographic follow-up for 2-6 years, we concluded that the clinical course in children is usually benign; 60% of the children presented no problems at any time, although only serious cases were admitted to hospital and included in our series, and only 4% of the children died within the first few days after admission. Neuropsychological sequelae were found in 5% of the children in the later stages.

But the "majority" does not mean "all." For this reason we would emphasize that it is possible to assess the child's prognosis with certainty only after two years of continuous follow-up, that a normal electroencephalogram after two years means complete recovery, and that all children should receive phenobarbital for 1-3 years.—I am, etc.,

LILIANA DECUI
Bucharest, Romania

1 Horvath, L., and Deciu, L., Pediatr. (Bucharest), 1971, 26, 141.
debatable, but this case seems to show that rheumatoid arthritis and the Australia antigen can coexist. —We are, etc.,

S. DESCHÉ-LABARTHE
R. CAQUET
CL. LA ROCHE

Hôpital Cochin,
Paris

Sir,—Dr. C. J. Burrell and others (7 October, p. 23) stressed the occurrence in rheumatoid arthritis of false-positive results in tests for Australia or hepatitis-associated antigen (H.A.A.) using latex agglutination techniques. They suggested that the false-positive results were due to rheumatoid factor in the serum.

Our experience with the search for H.A.A. (using countercurrent immunoelectro-osmosphorosis) in the serum of 152 patients suffering from rheumatoid arthritis (84 of whom were positive for the rheumatoid factor) confirms the observation of Burrell et al. and we, too, have no evidence of a relation between rheumatoid arthritis and a significant incidence of H.A.A. detectable by countercurrent immunoelectro-osmosphorosis. The H.A.A. test was positive only in one rheumatoid-factor-negative patient with polyarthritis, who developed hepatitis two weeks after the serum was obtained.

Although we found in our series of 152 rheumatoid arthritis patients a significant incidence of positive tests for antinuclear factor (22.8% of those positive and 8.8% of those negative for rheumatoid factor), the absence of H.A.A. in rheumatoid arthritis is in contrast to the high incidence (by countercurrent immunoelectro-osmosphorosis) reported in systemic lupus erythematosus.1,2 We are, etc.,

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2 Alarc6n-Sev6n, D., Fishbein, E., and Diaz-Juanes, Clinical and Experimental Immunology, 1972, 10, 126.

Intestinal Parasites and Au Antigen Transmission

Sir,—Dr. M. Barbotin and Mr. J. L. Ondart (10 June, p. 653) suggested a possible association between hookworm and strongylid infestation and the presence of Australia antigen in the blood. We have examined stool and blood samples from 300 randomly selected patients aged 10 years or over attending the University College Hospital, Ibadan, for the presence of hookworm ova or strongylid larvae in the stool and for Au antigen in the blood (see Table). The overall incidence of Au antigenemia is 25%, and this is significantly lower than the incidence of 65% (P < 0.005) found among 8,000 blood donors in Ibadan.1 However, these donors were all young adult males, and when comparable age and sex groups in the present series are compared the antigenemia rate of 5% is found not to differ significantly from that found in the earlier blood donor series. Our sample of patients is therefore probably representative of the population at large.

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>Number of Patients</th>
<th>Hookworm Positive</th>
<th>Strongylid Positive</th>
<th>Au Antigen Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>0-10</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11-20</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21-30</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>31-40</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>41-50</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>51-60</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>61-70</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>71 and over</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No age recorded</td>
<td>37</td>
<td>18</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

Total 166 124 43 28 5 2

We found a substantially higher incidence of hookworm and strongylid infestation than was found in Senegal. Our rate of 24% for hookworm was similar to that reported by Cowper from Ibadan,2 though the incidence of strongylid infestation in the present series (10%) seems to be significantly higher (P < 0.01). Among the seven patients carrying our blood, three were excreting hookworm ova and one was excreting strongylid larvae, an incidence of 42.8% and 14.2% respectively. Chi-square analysis of the incidence of hookworm or strongylid infestation and Au antigenemia shows no evidence of a relationship between these two conditions (P > 0.3).

While there is little doubt that the incidence of Au antigenemia is higher in the tropics than in temperate areas, and transmission by insects has been shown to be possible,3 we feel that the present evidence is insufficient to implicate hookworm or strongylid as being concerned in the transmission of Au antigen, at least in the Ibadan environment.—We are, etc.,

E. A. LEWIS
D. MONTEFIORRE
J. A. SMITH
A. O. SOGREH

University College Hospital,
Ibadan, Nigeria


Trichuris Infestations and Difetarsone

Sir,—Mono infections with Trichuris trichiura were rare until anthelmintics selectively active against Ascaris lumbricoides, hookworms, and Strongylus stercoralis. Published evidence of the presence of Tr. trichiura. Difetarsone (14 October, p. 73) is specifically effective against Tr. trichiura, like piperazine against A. lumbricoides and benephenium against A. duodenale. Polyparasitism, with its multiple clinical manifestations, is increasingly encountered in temperate regions. Several broad-spectrum anthelmintics have been developed, but few completely remove both species.

Mebendazole (methyl 5-benzylbenzimidazole-2-yl) carbanate has been studied in children and adults with mono- and polyparasitism in Africa,4 Asia,5 Europe,6 and North America.7 The single 100-mg tablet radically cures infection with Enterobius vermicularis and A. lumbricoides. A standard 100-mg dose given twice daily for three consecutive days is virtually 100% effective against Necator americanus, A. duodenale, and T. trichiura, and shows high promise against Taenia solium and T. saginata. Activity against S. stercoralis, though significant, is less regular. Because of its potency and its broad spectrum of anthelminthic action, coupled with the low incidence of side effects and standard dosage, it is of possible therapeutic value in many parasites. —We are, etc.,

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D. THIENPONT

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3 Peltot, E., Brussels-Medical, 1972, 61, 605.
4 Klein, E., Deutsche medizinische Wochenschrift, 1972, 97, 1235.
5 Sargent, R. O., personal communication.
7 Chaia, M., Médecine et Chirurgie du Haut-Douar, 1972, 12, 9.

Myxomatoz and Retention of Urine

Sir,—Renal function is often moderately affected in hyperthyroidism,1 probably owing to interstitial infiltration, enlargement of the basal tubular membrane,2 and the low renal perfusion brought about by the illness.3 So far as we know there have been no reports of hyperthyroidism presenting as renal failure resulting from urinary obstruction due to vesicoureteric reflux with myxomatous hyptonia of the smooth muscle. We report here a case of this kind.

Six months before being admitted to hospital a 67-year-old woman developed chronic changes and urinary retention. Daily catheterization was required. Later constipation, a changed voice, mental confusion, and deafness also developed and became progressively worse. On admission the patient was typically myxomatous. The bladder could be palpated in the abdomen; the Achilles tendon reflex was slow, the E.G.C. presented low voltages, and the E.E.G. slow, diffuse, pre-dominantly frontal waves. Neurological examination was otherwise normal. Blood examination showed: haemoglobin 7.2 g/100 ml, leukocytes 9,200/mm³, protein-bound iodine 0.4 mg/100 ml,