enlightened. Every new investigation carries an iatrogenic hazard, as illustrated in the early days of the E.C.G. when many were made cardiac neurotics because of findings now regarded as normal. This is a risk with endoscopy. Many patients suffer from nervous dyspepsia, headache, being the presence of food intolerance, aeropepsy, and obvious nervous symptoms elsewhere together with the absence of a positive pointing test and nocturnal pain. Then, I think, are best served by a barium meal x-ray examination, complete reassurance with discussion of any problems, and a follow-up visit in one month with a view to discharge. Removal of gall stones results in many continuing with their dyspepsia unless relieved by the placebo value of the operation. Referral for endoscopy puts a doubt in their minds. If, however, this is to be normal they must be told the result and again reassured. This is not easy in practice. Outpatients, though told before being driven home, may not remember because of amnesia from diazepam. They may fail to contact their general practitioners. We may fail to get the patient to send a copy of the letter to his doctor. Worst of all is the doubt cast by reporting mucosal abnormalities such as gastritis. Neither the general practitioner nor his colleagues in other specialties may know its significance. Gastritis is nearly always symptomless and common in normal people who never have dyspepsia, and patients with pernicious anaemia have gastric atrophy and do not know it. Endoscopy is now being done by junior staff whose clinical acumen may lag behind their technical competence, and they may be unaware of the work done by the second generation of endoscopists.

It is always exciting and more talking to “find something.” Redness of the gastric and duodenal mucosa may indicate circulatory and not inflammatory changes. Histological appearances must be recognized with scepticism as, for example, the mucosa of the duodenum may contain large numbers of round cells in health and assessment of these is difficult. Yet this was the main criterion for diagnosing duodenitis. I was very impressed when seeing Tom, the subject with the gastric fistula. His gastric mucosa would become oedematous and red when he was made angry by his investiga- tors, Wolf and Wolf.1 Some of our patients, in spite of diazepam, feel a tripe unhappy when the duodenoscope is in position. Perhaps the mucosal changes may then be due to an “angry stomach”—or duodenum.

Finally, the endoscopist is often called in merely as a technician and not asked to give a clinical opinion. The report of the endoscopy must then be clear and definite. This is no problem when an ulcer or carcinoma is found but it is easy to be non-committal when describing mucosal abnormalities. These, if thought incidental, must be reported as being so. Otherwise our nervous dyspepsia will spend their lives as gastric cripilles forsking the pleasure of the table, being convinced of the organic nature of their symptoms on the basis of the label of gastritis.—I am, etc.

CLIFFORD HAWKINS

Queen Elizabeth Hospital, Birmingham


Samples for Hepatitis B Antigen Testing

STIR—The risks of hepatitis to laboratory personnel handling infected blood and blood products are well recognized.1,2 Despite a local circular and the publication of the Public Health Laboratory Service monograph on laboratory hazards3 we were disappointed to find that of 101 specimens received in the past fortnight, no fewer than 37 were sent in unsuitable containers. As shown in the table, the containers used fall into two groups.

Group 1, hazardous containers:
- Glass flat-bottomed thin-walled tube with screw cap ... 17
- Plastic thin-walled tube with push-on cap ... 9

Group 2, unsatisfactory containers:
- Plastic universal containers with plastic ... 10
- Glass universal container with plastic cap ... 11

Containers in the first group carry the greater hazard and their use probably results from a failure of the ward staff to appreciate the dangers of blood specimens. Spillage of blood from a jaundiced patient on the ward could create considerable risk to the staff; they could helpfully refrain from putting laboratory staff at similar or greater risk by sending blood in containers with fragile walls and/or snap-on caps.

Containers in the second group are unsatisfactory in that the cap may become loose or the clot may fail to retract adequately (it has then to be separated by centrifugation, an additionally hazardous procedure). The use of these probably results from bulk purchasing by hospital supply officers. With the rising cost and scarcity of oil-based products, of which polystyrene is one, we are surprised at how many hospitals still use them. We urge a strong campaign on the part of ward staffs to ensure that undamaged, thick-walled, glass containers with metal screw caps and rubber liners (standard 1-oz universal and 1-oz biciput bottles or their metric equivalents) are available for sending potentially or actually infectious specimens to the laboratory. Support for such a campaign may be found on p. 11 of the P.H.L.S. monograph.—We are, etc.,

C. R. MADELEY G. E. D. URBHART S. MICHAEL W. R. GRIFF

West of Scotland Hepatitis Reference Laboratory, Regional Virus Laboratory, Ruchill Hospital, Glasgow


Sex Difference in Cardiac Actions in Prolactin

STIR—Earlier this year (6, p. 27) we demonstrated that prolactin in a concentra- tion of 50 mg/ml had chronotropic and inotropic actions and could produce dysrhythmias in perfused male rat hearts. This concentration of prolactin is in the range found in human plasma during exercise and surgery and after myocardial infarction.1,2

Primary Medical Care

STIR—"The fundamental differences between primary medical care and traditional general practice are its use of a team of health professionals rather than the solitary figure of the family doctor . . . ." This fatuous observation in the opening paragraph of your leading article (19 October, p. 126) will have given offence to many general practitioners. General practice is primary care and a good deal more besides.

Do you give the impression of the solitary family doctor bumbling along alone with your tongue in your cheek? It is known full well that a major part of so-called primary care is undertaken by general practitioners working together in groups from purpose- built premises with attached nurses and health visitors, aided by pathology and x-ray facilities and with consultant aid when necessary. These are very competent people with a depth of experience providing a very high standard of care in the fullest meaning of the word. They do not regard themselves as amateurs and their cost effectiveness is without parallel. Who then are these teams of health professionals?

I cannot believe that those of us engaged in general practice would accept either of the assumptions you quote from Professor A. D. Roy’s committee’s report1 that there is a continuous trend for general practitioners to form large groups and to work full-time. Health centres with the emphasis likely to move towards preventive programmes . . . . and all that. Our experience of the reorganization of the welfare services on a team basis has not impressed us with any improvement in efficiency.