Membrane Disease. Unfortunately, you have seriously misrepresented our results. Our survival figures do not refer to "overall survival rate," they refer to the survival rate for infants who are severely affected by the illness, as defined in the article. Our overall survival rate is much higher. Furthermore, the numbers you quote are wrong. The survival rate for all seriously affected infants in 1976 was 69% and not 63%; and the survival rate for the ventilated ones in 1967-9 was 11% and in 1970-2 49%, not 15%; and 44%, as stated in your article.—We are, etc.,

E. O. R. REYNOLDS
A. TAGHIZADEH
Paediatric Department,
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Dr. Mikhail Shtern

SIR,—I wish to draw the attention of professional colleagues to the appalling case of Dr. Mikhail Shtern of Vinnitsa, Ukraine. The details are as follows.

Dr. Shtern is a leading endocrinologist in Vinnitsa. In November 1973 his son applied for a visa to go to Israel and subsequently Dr. Shtern was advised to forbid his son to emigrate. He refused and consequently lost his job. In May of this year his apartment was searched by the K.G.B. Dr. Shtern was arrested and imprisoned. Every attempt was made to find something to accuse him of. These attempts failed. Finally the authorities resorted to the mediaeval accusation that Dr. Shtern had poisoned some of his young patients. After much difficulty they have found "witnesses" to provide evidence and a trial was due to start on 2 December. This is reminiscent of the infamous "Doctors' Plot" of 1952 and cannot but cause grave apprehension. In addition, Dr. Shtern has been very ill in prison and has had recurrent haemoptyses.

I am sure we are all saddened at the treatment of a professional colleague in this way and I ask for support for him in his difficulties.—I am, etc.,

JOHN COHEN

London N.W.11

Value of Hospital Case Notes

SIR,—Dr. A. A. Lewis does himself and his colleagues in hospital considerable injustice in his letter (23 November, p. 468) on the matter of general practitioners' access to hospital case notes. I recognize and respect his feelings on this subject, but he must not allow the facts to be obscured. He knows very well, for he is on the district medical committee, that it is the district hospital medical committee and not the staff of St. Mary's Hospital alone that has incurred his anger. He knows very well that the hospital staff committee welcomed visits by G.P.s to their patients when in hospital and agreed to free access to the case notes with the permission of the consultant concerned. He ignores the very proper reservations of a few consultants in sensitive specialties and instead claims a divine right for the G.P. to read, without consultation, the records made by a specialist colleague. There are some patients, a thing, rightly or wrongly, wishes to keep from his G.P. but tells a specialist and I am sure there are many things the patient tells his family doctor but keeps from the hospital staff. We both have to respect these confidences and yet work together to help those who put their trust in us.

Dr. Lewis knows that no afford to G.P.s was intended—quite the reverse—and he should also know that working as a team committee involves accepting that confidences can differ.—I am, etc.,

A. J. HARROLD
Chairman,
Kensington and Chelsea and Westminster Area
North Western Local Medical Committee
St. Mary's Hospital, London W.2

Diagnostic Test for Multiple Sclerosis

SIR,—The absence of technical detail in the communication from Foster et al.1 denying the specificity of the linoleic acid depression (L.A.D.) test for the diagnosis of multiple sclerosis (M.S.) makes it difficult to analyse the possible sources of the discrepancy between their findings and those in the original positive report.2 However, one of us (B.K.S.) made the actual measurements in Foster et al.'s work and is aware of certain differences which obtained in the two series of studies.3 It now seems that a major factor was their use of tuberculin purified protein derivative (P.P.D.) instead of thyroid as test antigen. The former would have been quite in order had the test animals been free from "spontaneous" sensitization.

We have now repeated a double-blind trial using thyroid (P1 fraction) as well as P.P.D. (as used in the Foster experiments) since the latter has antigenic determinations in common with encephalitogenic factor (E.F.)4 and guinea-pigs become sensitized to both if Percentages Reduction in Response to Antigen Brought about by Linoleic Acid (L.A.) in M.E.M. test with Lymphocytes from Two M.S. Patients and a Normal Control using 'Spontaneously' Sensitized and Non-sensitized Guinea-pigs as Source of Indicator Macrophages.

<table>
<thead>
<tr>
<th>Antigen</th>
<th>Sensitized guinea-pig</th>
<th>Non-sensitized guinea-pig</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient 1</td>
<td>Patient 2</td>
</tr>
<tr>
<td>P.P.D.</td>
<td>42.6</td>
<td>52.4</td>
</tr>
<tr>
<td>T.S. (Ml)</td>
<td>91.4 (88.0)</td>
<td>91.0 (45.1)</td>
</tr>
</tbody>
</table>

* % reduction = %, slowing with antigen — %, slowing with L.A. + antigen x 100

Figures in parentheses are those obtained on aliquots by another observer using a different cytopherometer.

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*Our leading article recognized the high standards of the neonatal unit at University College Hospital, London, and we regret that these errors gave a false impression of the results treated there.—Ed., B.M.J.
exposed to antigens of bacal viruses such as influenza.\textsuperscript{2,4} Macrophages from animals so sensitized constitute a faulty indicator system for human lymphocyte-P.P.D. interaction. We have, however, found that even with guinea-pigs which have not been rigorously shielded from "spontaneous" sensitization and so show clear evidence of sensitivity to E.F. and P.P.D. it is still possible to obtain positive results in the L.A.D. test if the guinea-pigs are tested for human lymphocytes instead of P.P.D. Indeed, if the same M.S. lymphocytes are tested with both thyroid and P.P.D., then the latter leads to development of the disease is obtained with thyroid but not with P.P.D. Results with the latter seem to be randomly distributed depending upon a number of factors not as yet studied. Two examples from our protocols are set out in the table. It will be seen that when an animal which is not sensitized to E.F. and P.P.D. is used as the source of indicator macrophages the customary high result is found with both P.P.D. and thyroid, however, a presensitized guinea-pig is used for the macrophages then the high result is obtained only with the unrelated thyroid antigen.\textsuperscript{1} All these experiments were carried out with the original macrophage electrophoretic mobility (M.E.M.) test.\textsuperscript{2}

The importance of these results is that they (1) underline the need for the use of guinea-pigs free from "spontaneous" sensitization, (2) show that it is possible for those who do not have access to a protected source of animals to carry out M.S. testing with thyroid antigen, and (3) explain the difficulties experienced. Fosse, et al. in their work with P.P.D.—We are, etc.,

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Immunological Research Division, Departments of Physiological Chemistry and Neurology, University of Rostock; German Democratic Republic

3 Stenton, B. K., British Medical Journal, 1974, 1, 962.
8 Dønæg, J. V., and Turk, J. L., International Archives of Allergy, 1968, 64, 297.

All Change

SIR,—The light-heartedness implicit in the heading you award to Dr. H. R. Rollin's letter (9 November, p. 341) epitomizes an inadequate appreciation of the danger in a situation in which administration loses sight of its original purpose to improve the efficiency and efficacy of the artisans it administers and becomes an end in itself.

St. Mary's Hospital, Hampton, to which Dr. Rollin refers in his letter, has seen changes of catchment area within the past five years from Springfield Hospital to Horton Hospital and now again to Long Grove Hospital. These changes have taken place without any reference to local needs, requirements, or wishes, the only reason for them being a desire to tie in with boundaries of one kind or another. This has simply come when the people affected by these administrative manipulations will simply refuse to co-operate any longer. Let the authorities therefore take notice of this warning and ensure that in the future adequate consultation takes place at all levels.—I am, etc.,

HINWORTH, MIDDLEx

D. A. F. DOHERTY

Lincomycin and Clindamycin Colitis

SIR,—Your leading article entitled "Lincomycin and Clindamycin Colitis" (12 October, p. 65) discussed the incidence of pseudomembranous colitis occurring during the treatment of patients with the lincomycins. In our first report\textsuperscript{1} 10 years ago of studies with lincomycin hydrochloride diarrhoea occurred in two out of 24 patients receiving the antibiotic. In a larger series\textsuperscript{2} of 65 patients treated with lincomycin diarrhoea occurred in eight patients, but in only two was it severe enough to necessitate stopping treatment. Fifty-two of these patients had bone or joint infections. The mean duration of treatment in patients with acute osteomyelitis was 3-3 months and 5-4 months in those with chronic infections. More recently\textsuperscript{3} we reported the results of treatment with clindamycin of 50 patients, only one of whom developed diarrhoea. A total of 129 patients were included in these three studies (10 patients were included in two of the reports) and diarrhoea occurred in only 11 (8-5%). It stopped immediately when lincomycin or clindamycin was discontinued and in none was there evidence of pseudomembranous colitis.

To date we have treated a total of 50 patients suffering from osteoarticular infections with relatively prolonged courses of clindamycin, the duration of therapy ranging from 12 months with a mean of 4-4 months. All were carefully observed for adverse reactions during therapy and followed up after treatment. Three (6%) had transient diarrhoea which cleared when the antibiotic was temporarily discontinued for 48 hours, but none developed pseudomembranous colitis.

Since our initial studies with lincomycin in 1963 and with clindamycin in 1969 we have now treated several hundred patients with these two antibiotics in associations with diseases associated with therapy in only one. This was in a 64-year-old man who developed diarrhoea while taking clindamycin for an ear infection. We feel it is important that his wife developed diarrhoea before the onset of the patient's symptoms. The patient continued taking clindamycin after the onset of diarrhoea, and barium enema examination revealed ulceration of the ascending and proximal transverse colon. Treatment was started with salazopyrine, with satisfactory response and relief of diarrhoea.

Our experience with the lincomycins has convinced us that clindamycin has a greater potential in this respect. We have seen two cases of pseudomembranous colitis following treatment with clindamycin. One of these was in a patient suffering from bronchopneumonia and the other was in a patient with a long history of chronic bronchitis. Both patients had been treated with clindamycin with a view to curing chronic bronchitis. Each patient had been treated for 10 weeks. In both cases the pseudomembrane was confined to the transverse colon and the sigmoid and both responded to treatment with metronidazole. The clinical improvement produced by this antibiotic was so striking that we are now using it as a routine treatment for patients with pseudomembranous colitis. We should like to bring to the notice of the case of a woman who recently died here of this condition. The patient, aged 60, was admitted with gangrene of the toes and had to have her leg amputated. She died of bronchopneumonia some time after the amputation. The presence of pseudomembranous colitis was confirmed at post-mortem examination and it seems likely that this was the cause of death. We suggest that clindamycin is used as a prophylactic in patients with chronic bronchitis and that its use is extended to other patients who might benefit from it. We are, etc.,

SIR,—We were interested to read your leading article (12 October, p. 65) and the subsequent correspondence. We should like to bring to your notice the case of a woman who recently died here of this condition. The patient, aged 60, was admitted with gangrene of the toes and had to have her leg amputated. She died of bronchopneumonia some time after the amputation. The presence of pseudomembranous colitis was confirmed at post-mortem examination and it seems likely that this was the cause of death. We suggest that clindamycin is used as a prophylactic in patients with chronic bronchitis and that its use is extended to other patients who might benefit from it. We are, etc.,

A. M. GEDDES
East Birmingham Hospital, Birmingham

6 Pitman, F. E., Pitman, J. C., and Humphreys, C. D., Lancet, 1974, 1, 452.