treatment for most conditions, which would presumably in the course of time become standard practice throughout the National Health Service. I detect here a faint whiff of state control, probably with severe penalties for deviant behaviour. Even if this were possible in our own country he surely cannot believe that we could get agreement with the other countries in the European Economic Community in a measurable period of time.

The fact is that over very large areas of medicine our knowledge of disease processes and the effects of treatment is very incomplete, sometimes negligible. While this problem exists individual beliefs based on experience or prejudice will continue to hold sway. Dr O'Donnell's objectives of the acceptance of agreed and effective methods of assessment, investigation, and treatment are admirable but Utopian and require not a reorganisation of medical education but a huge accession of new knowledge on the processes of pathology and the effects of treatment.

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Home blood glucose monitoring for insulin dependent diabetics

SIR,—Dr R Worth and others (30 October, p 1233) concluded that intensive attention improves diabetic control while provision of facilities (glucose meters and sticks) for self monitoring of blood glucose does not. Certainly within the design constraints of their detailed study this conclusion appears to be justified. None the less, their findings should be viewed with caution. It is self evident that urine glucose estimations in the patient with a normal renal threshold give no information about blood sugar concentrations of 10 mmol/l (180 mg/100 ml) or less; the only way to obtain such information is by direct measurement.

Since they present evidence that the blood glucose readings their patients obtained were reliable but that their control remained bad we conclude that the patients were not able to use the information obtained in order to improve their control. It is interesting that during the preliminary intensive education programme the treatment was changed from one that provided on average two thirds of the insulin as soluble and one third as medium acting to one where more than half was medium acting. We believe that they should not have stopped at that since in our experience many long standing type 1 diabetics can be stabilised with excellent control on isophane twice daily with little or no soluble insulin. We suggest that one factor may be that their patients are still on too much short acting insulin to allow them safely to keep blood sugar concentrations in the normal range without having frequent hypoglycaemic attacks.

A second criticism of this study is that throughout the patients were seen for 30 minutes every two weeks by a doctor. The Utopian supervision did lead to improved (although still poor) control, which was not enhanced by self monitoring of blood glucose. What is needed, however, is more information on the value of self monitoring by the patient, with proper back up facilities, in the real world (where if they are lucky they may see the clinic doctor for as much as 30 minutes a year).

Finally, before we conclude that visual results are as good as those read by machine it is

important to point out that even if true this hardly matters. At their present price in this country (twice as high as in Australia, we understand) the major cost implication of home blood glucose monitoring lies in the reagent sticks (about £200 a year as used in this study) and not in the machine to read them (about £70). In case, as we suspect, home blood glucose monitoring can be shown to work on a large scale, the Department of Health and Social Security will be well advised to take steps now to break the stranglehold that the manufacturers of blood glucose reagent sticks apparently have on the United Kingdom.

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Family medicine—Thamesmead

SIR,—Professor Higgins's excellent two part review of Thamesmead (27 November, p 1564, and 4 December, p 1631) stirred many memories. He generously attributed the initiative of the project, "then without precedent and since without imitation," to Sir John Butterfield and me.

Thamesmead was a product of its time arising out of a happy combination of people and circumstances. The wide scope of the idea and its basic simplicity caught the imagination of all concerned, but this was not enough. It required also the generosity and farsightedness of my chief at the Wellcome Foundation, Dr David Long, who released me to do this work at Guy's Hospital, as well as crucial support from Gordon McLachlan of the Nuffield Hospital Trust, whose guidance and encouragement led to a grant from the Nuffield Foundation, without which we could not have proceeded. Also Michael Curwen's steadfast, clear thinking assistance in those early days kept the project afloat and prevented it from becoming entangled in bureaucracy and dragged under. But perhaps the successful launching of the project depended most on an individual not directly mentioned by Professor Higgins. When I outlined the plan to Sir George Godber, then Chief Medical Officer, he immediately gave his unstinted support. This greatly helped both at Guy's Hospital and at all the levels of the National Health Service concerned. His was the spark we needed to ignite the project.

Now located some thousands of miles away and nearly 20 years later, I continue to enjoy the efforts of family medicine at bridging the gap between the community and academia. I am happy to report that Sir George periodically visits us here, and we continue to benefit from his wise and humane counsel. "Plus ça change . . ."

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Histopathology services for developing countries

SIR,—Professor M S R Hutt and Professor H Spencer (6 November, p 1327) have correctly pinpointed the real need of developing countries—that is, mobilisation of technical

resources. A similar experiment in providing histopathology services in India has also been very successful.

The Wanless Hospital at Miraj, which is affiliated to a government medical college, embarked on postal histopathology services in 1964 with a view to offering specialised services on demand and with the object of helping the medical profession to improve the quality of its practice. Various hospitals, clinics, and consultants were informed about the facility of postal histopathology services. Detailed instructions for the fixing and dispatch of specimens were incorporated into a suitable requisition form. (The postal delay before receiving the specimen is helpful in fixing the specimen.) Important or unforeseen observations were reported telegraphically; other reports were sent by ordinary post.

The results of this experiment have been very encouraging. The use of these services escalated from 1800 requisitions in 1964 to more than 4000 in 1976. More than 180 medical centres, including mission hospitals, district hospitals, cottage hospitals, and private practitioners, in 14 different states of India have made use of these services, which shows nationwide acceptance of the facility and also credibility of the reports and reporting system. The promptness of service, the round the year facility, the quality of reports, and the low cost have been the attractions of this service, which is still available.

India, like other developing countries, has most of its skilled medical manpower concentrated in urban areas, and remote areas in the interior and rural areas are deprived of adequate medical and laboratory facilities. Postal services are potentially helpful in solving the problem, at least in histopathology. The role of medical colleges and affiliated hospitals in initiating such services needs to be reiterated.

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Rising female predominance in incidence of gastric ulcer

SIR,—Dr S P Lee (25 September, p 853) reported a significant reversal in the male to female ratio in cases of gastric ulcer (0.7:1). The tendency was especially strong in type 1 gastric ulcers, which were five times more common in women.

We have looked at case histories recorded in our gastroenterological unit from 1974 to 1981, where 3803 patients underwent upper gastrointestinal endoscopy. Peptic ulcers were found in 1211 (32%) of the patients: 866 duodenal ulcers and 345 benign gastric ulcers, with a ratio of 2.5:

Malignant gastric ulcers and postgastrectomy ulcers were excluded, and we considered pyloric ulcers as duodenal ulcers. The overall male to female ratio was 2.5:1. For gastric ulcers the male to female ratio was 1.6:1. On examining annual distribution, however, we found a continuous reduction in the percentage of men with gastric ulcers, although this was not statistically significant ($r=0.5$, Kendall test). Unlike Dr Lee, we found that ulcers in the gastric body and fundus (type 1) were much more common (64%) than ulcers in the antrum (type 3) (31%) or those associated with duodenal (type 2) ulcers (5%). The male to female ratio was at 1.7:1 for type 1 ulcers; 2.6:1 for type 2 ulcers; and 1.7:1 for type 3 ulcers. The average age of patients with type 3 gastric ulcers (58 ± 12 years) was significantly higher than that of patients with type 1 and type 2 ulcers (respectively 53 ± 14 and 51 ± 13 years).

The number of gastric ulcers in patients with rheumatic diseases who were taking steroid or non-steroidal anti-inflammatory drugs was not significantly different in men and women, and in any case it was too small for any variation in the male to female ratio to be determined. For duodenal ulcers the male to female ratio was 3:1. In this case too, although less obviously, there was a slight tendency towards a reduction in the percentage of men ($r=0.28$).

In conclusion, the data from our case histories do not confirm Dr Lee's observations, and they confirm a higher male prevalence in the incidence of gastric and duodenal ulcers. We emphasise the tendency towards a reduction in this prevalence, however, although it was not significant, since it accords with the findings of Crown *et al*¹ before the introduction of H₂ blockers, and with Elashoff's and Grossman's subsequent findings.² Even if our study and that of Dr Lee are not large enough to justify significant epidemiological conclusions, we can hypothesise that widely differing geographical distributions and environmental and socioeconomic conditions in the two populations may explain the difference in the two studies.

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¹ Crown RC, Langman MJS, Lambert PM. Hospital admissions for peptic ulcer during 1959-72. *Br Med J* 1976;i:35-7.

² Elashoff J, Grossman MJ. Trends in hospital admissions and death rates for peptic ulcer in United States from 1970 to 1978. *Gastroenterology* 1980; 78:280-5.

A health hazard

SIR,—Sir Richard Bayliss, in aiming his cautionary tale primarily at Christian Science, is altogether too simplistic. The healing ministry of this church shares at least one characteristic with medical treatment—both must inevitably be judged by results. But, as Sir Richard I am sure will agree, no general conclusion as to any treatment, medical or otherwise, can properly be drawn from isolated cases where healing has not taken place unless the view takes in the broad picture. While as a general rule successes in Christian Science healing would not in the nature of things come to the notice of doctors, the record that constitutes that picture exists and is readily available.

It may or may not be that the case to which the story refers is an actual experience—though the feel of the piece and certain details do not ring true to the Christian Scientist—but he would certainly join with your readers in considering it tragic indeed. Yet the repeated vacillation the story indicates between turning to God in total reliance, which is of the essence of healing as Christian Scientists understand it, and orthodox medical treatment is believed by them to be detrimental to the effectiveness of both systems and inevitably tends to a falling between two stools.

Two other points need to be made. Christian Scientists are free agents in their decision to turn to their faith for healing and are under no coercion from their church. Secondly, what Christian Science has achieved time and again in serious, even terminal, conditions, and often with medical recognition, merits a more conscientious assessment than Sir Richard's too confident dismissiveness.

Christian Scientists know full well that

they have a long way to go in realising the full potential of Christian healing as they see it, and I am sure that doctors would take a similar view in surveying both the achievements and the possibilities of their own profession.

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Factors protective against retinopathy in insulin dependent diabetics

SIR,—In their paper on factors that protect insulin dependent diabetics from retinopathy Dr Timothy Dornan and others (16 October, p 1073) drew attention to the fact that men constituted 72% of those with proliferative retinopathy. They suggested that this apparent susceptibility to retinopathy in men may be a reflection of poor attendance at hospital clinics and that more complete identification of patients who do not attend clinics is required.

We have just completed such a study (15 January, p 189) and found that about 71% of patients who were lost to follow up at our diabetic clinic were men, a percentage almost identical to that found by Dr Dornan to have proliferative retinopathy. Against this, however, there is some evidence that more men attend diabetic clinics than women. A recent survey of our own clinic showed that men comprised 54%. This would nevertheless suggest a male preponderance in the development of proliferative retinopathy. Other risk factors in addition to poor attendance, such as smoking, should obviously be taken into consideration.

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Can infection be abolished?

SIR,—Sir James Howie (4 December, p 1593) raises several pertinent issues regarding the future of the specialty of communicable diseases. Probably more than any other branch of medicine the management of infection—thinking of infection in its widest sense—requires an integrated approach whereby those concerned should have particular knowledge not only of the clinical but also of the epidemiological and laboratory aspects of the subject. Often the same organisms are active inside as well as outside hospital, and the opportunity to take an overall view and to implement comprehensive control measures can be crucial. The imposition of man made administrative barriers on problems of infection merely compounds the natural difficulties which are encountered despite the fact that one tenet of the National Health Service reorganisation was the unification of the previously disparate elements of health care. In addition the problem may be further compounded in that many communicable diseases—for example, the zoonoses—do not respect interprofessional or international boundaries.

Consideration of the cost of infection to the community—for example, from outbreaks of food poisoning or influenza—leaves little doubt

about the benefit which could accrue from pooling the skills of those who have had intensive training in all aspects of investigation, management, and control of infection. Sir James is right to advocate a change *now* in our attitude to the organisation of infection control so that better results may be forthcoming from the deployment of available resources both now and in the future.

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Maternal deaths in England and Wales, 1976-8

SIR,—Professor J K Russell (8 January, p 82) suggests that it is time to look afresh at the form and purpose of the triennial reports on maternal deaths. He gives examples of categories in which the number of deaths is now so small that variation from one three year period to another has little or no significance.

One broad category, that of avoidable factors, was not mentioned. The report points out that the identification of such a factor does not mean that death could have been prevented or that the factor was the direct cause of the mother's death, but "it does imply that there was some departure from the generally accepted standards of satisfactory care . . . which may have contributed to the fatal outcome." Factors, judged by contemporary standards to be avoidable, were identified in 43% of deaths in 1952-4 but 58% in 1976-8. The proportion increased about 15 years ago and remains high.

In the latest three years studied in a quarter of the avoidable factors identified the responsible person was the patient, but in two thirds it was a doctor. Most commonly this doctor was a member of the consultant obstetric team, and the abbreviated case reports presented show that often the consultant was not personally involved. Surely we cannot be satisfied when the proportion of deaths in which an avoidable factor can be identified is now higher than it was 30 years ago?

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A regimen for low dose aspirin?

SIR,—Dr S D Hanley and others (6 November, p 1299) suggest a dose of 40 mg aspirin every 48 hours to inhibit platelet aggregation with minimal depression of vascular prostacyclin production.

Studies with a dose of 150 mg aspirin¹ indicated that in some subjects the aspirin effect could be lost if the dosage interval was as long as 48 hours. At lower doses this "loss" is more likely to occur. Furthermore, we found (Chetty N, Bradlow BA, unpublished observation) that a dose of 20 mg aspirin daily inhibited platelet function adequately for two weeks but after four weeks the effect was significantly less than the effect of 150 mg daily. A lessening of the aspirin effect was evident by the end of the experiment.

The effect of treatment for many weeks or months at such low doses on endothelial prostacyclin is unknown. Thus on the one hand