CORRESPONDENCE

General practice and tropical medicine			
C J Manning, BM.....	271	Diagnosis of allergy to insect stings	
Recent trends in opiate dependence		J W Speight, PHD.....	273
Elizabeth Tylden, MRCPsych.....	271	Unfit for holiday	
Rubella vaccination		A J E Pollock, MB.....	273
G Rocchi, MD, and others; T S Wilson, FFCM.....	272	Disposable syringes for insulin injection	
Management of maternal phenylketonuria		J M Oli, MRCP.....	273
D Kutter, MD, and J Thoma, MD.....	272	Raised HCG in hyperemesis gravidarum	
A "specialty" for second-class doctors?		C H Thornton, MRCOG, and others.....	274
A O Griffiths, MB; D P Brown, MB.....	272	Labetalol in severe tetanus	
Doubtful epilepsy in childhood		M A K Omar, MB, and others.....	274
M Saunders, FRCP.....	273	Why does the Committee on Safety of Medicines do what it does?	
Drug-induced oesophageal injury		A A Lewis, MRCS.....	274
Surgeon Lieutenant-Commander J G Williams, MRCP.....	273	Adolescent idiopathic scoliosis	
Photocoagulation and diabetic retinopathy		J V Fowles, FRCS(C).....	274
Eva M Kohner, FRCP, and P Leaver, FRCP..	273	The premature breech	
Seat-belt Bill before Parliament		J P Calvert, MRCOG.....	274
K C Easton, FRCP, and others; N M Davidson, DM.....	273	Eyes run on light	
		P A Gardiner, MD.....	275
		Rate of change of haemoglobin A₁ in diabetic patients	
		A P Brooks, MRCP, and others.....	275
		Handbook of Medical Ethics	
		Patricia A Bradley, MB.....	275
		Half-way houses	
		T H Howell, FRCPED.....	275
		Chlamydia	
		F J Wright, FRCP.....	276
		Abortion (Amendment) Bill	
		N A Chisholm, LRCP&SED; K P M Roche, MB, and J H Gould, FRCPSych; P R Norris, FRCOG.....	276
		Pay and contracts	
		J A Davis, FRCP.....	276
		New consultant contract	
		P M O'Connor, MD.....	276
		Community medicine—a change in direction	
		R A Haward, MFCM; J Gorman, MB.....	276
		Defence trusts	
		R M Bark, MB.....	277
		Reconciliation with HCSA	
		P J Hoyte, MRCS.....	277
		GMC elections	
		J K Johnson, FRCR.....	277
		Points Classic cardiology (T H Hughes-Davies); Sickle-cell disease and diabetes (J J Segall); Batemans not near Rottingdean (E C Till); To deflatulate or to flatovent (E J Trimmer) 277	

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

General practice and tropical medicine

SIR,—As one who has embarked from terminal three for work in rural Africa I was delighted to read the article by Dr Savage (14 July, p 111). I entirely agree with her remarks. Her account of medical work in Africa brings back many happy memories. I would like to add a few words to perhaps extend her ideas as applied to general practice.

With increasing immigration and increasing numbers of travellers returning from trips to developing countries GPs are going to encounter more patients with imported diseases. Statistics support this, and recent correspondence in the *BMJ* has pointed out the significant and in some cases preventable mortality from some of these exotic diseases like malaria.

Voluntary Service Overseas provides an excellent opportunity for young doctors to spend two years in a developing country working in general practice in the fullest sense of that term, as far as language differences will allow. This work is generally under the supervision of a doctor who has had considerable experience in tropical medicine. Supervision of such work cannot be as easily assessed as in this country, but the majority of such posts are of a high standard. Shortages of drugs and staff problems there will be, but despite all this it is a thoroughly worth while time that is of value in providing medical assistance to developing countries. In return the volunteer obtains more than adequate experience of

medical problems as encountered in this country plus a goodly taste, one hopes not literally, of tropical medicine and a clear insight into the importance of public health measures and preventive medicine.

Such work is of great value to any potential GP in this country, and perhaps the Royal College of General Practitioners and the Joint Higher Training Committee might care to reconsider whether two years' service with Voluntary Service Overseas could reasonably be accepted, in part at least, as training towards general practice.

Nuffield Health Centre,
Witney, Oxon OX8 7HQ

C J MANNING

Recent trends in opiate dependence

SIR,—I was surprised that neither your excellent leading article (7 April, p 911) nor Dr Max Glatz's letter (12 May, p 1279) received much attention. My personal experience over the last 15 years makes it apparent that we are once again dealing with a serious problem of drug dependence in younger people. From 1975 to 1977 most of the people I saw were in their middle 20s; recently the age has dropped, and now teenage referrals are extremely common.

Since speaking on drugs at the BMA conference in 1971, and publishing an article on cannabis,¹ I have received inquiries from

parents, social agencies, and doctors about youngsters with drug and alcohol problems, and I have treated some of them. I have also seen about 10 women a year with a drug problem at the Obstetric Hospital, University College. The number of inquiries has doubled in the last 18 months, and the average age of those I have seen has gone down from 25 to below 21. In 1978 and 1979 I have seen 41 drug users: 18 aged 16-20; 11 aged 21-25; 10 aged 26-30; and two over 30. Each individual had seven to 10 friends in the same age group also taking drugs.

The patients seen outside the NHS were told before seeing me that they would not be given a prescription for any opiate, barbiturate, amphetamine, or Valium. In spite of this they have turned up for appointments, and most of them kept in touch with me. Those who received prescriptions from other doctors were least reliable. They have an overriding need for support and psychotherapy and those on regular prescriptions from other sources have clung to a tiny dose of a drug so that at the same time they could keep in contact with the clinic or GP, even to this minimal extent.

The drugs used showed a considerable change from the early 70s when non-UCH patients usually came for cannabis-related problems. The main drugs taken in 1978 and 1979 were: eight took heroin; six took heroin phsyseptone; six took phsyseptone; seven took barbiturates with or without amphetamines; six took cannabis; and eight took many drugs. They had all at some time sniffed cocaine, regarding it as a great luxury. Most had sniffed heroin or taken linctus phsyseptone; all took sleeping pills. Half the heroin users sniffed it in preference to intravenous injection. All subjects drank alcohol or took Valium in large quantities when nothing else was

available. Two preferred Valium to any other drug.

More than half of them had been in trouble with the police—this often only came to light, however, when probation officers got in touch with me. Their offences were usually other than drug offences, though they had all been committed while under the influence of drugs or alcohol.

The high incidence of heroin use is due to the quantity of "Iranian" heroin on the black market. This is dissolved in lemon juice or citric acid for injection intravenously. The injections are reported to be less painful than diconal or physeptone.

One patient died; ten are known to be off drugs at the moment, and others have come off for varying periods. Those who resorted to alcohol sought an equally serious alternative escape from their very real problems and I do not regard them as being off drugs.

The work outside UCH has not been financed because there is no provision in the NHS for such activities. Probation officers, social workers, voluntary social agencies, and police have been extremely helpful. The work done in this field by GPs varies from excellent to highly irresponsible, as does the work of hospital casualty departments. City-centre casualty departments need to be in close contact with local experts in drug dependence. Prescribing GPs should be given special training in the problems of drug dependence and should be given adequate social work support. More co-operation between the official and voluntary agencies, some of whom do excellent work, is essential. An inquiry into these matters, including information from pharmacists' registers, would shed a great deal of light on how to deal with this condition with its high morbidity and mortality affecting people in every social class.

ELIZABETH TYLDEN

London SW8 1UQ

¹ Tylden, E, *Practitioner*, 1974, **212**, 810.

Rubella vaccination

SIR,—We read with great interest the data reported by Dr Constance A C Ross and Mr A McCartney (16 June, p 1636). Some data that we obtained in Rome support the observation that during the last few years there has been a progressive decrease in the proportion of women susceptible to rubella.

Routine antenatal tests for rubella immunity have been carried out in our laboratory since January 1972. Haemagglutination-inhibition (HI) tests were performed on heparin/manganous-chloride treated sera by standard micromethod employing 8 units of antigen, and pigeon red blood cells.¹ The results of HI antibody titrations are summarised in the table. The incidence of seronegative (<1:4) women showed a decline from 1976 to 1978, and was significantly lower in 1978 compared with previous years ($P < 0.001$). The incidence of high titre-positive sera ($\geq 1:64$) as well as the geometric mean titre (GMT) of HI antibody were significantly greater in 1973 and 1978 than in the remaining years. It seems of interest that a greater number of cases have been reported to the public health authorities to occur in Rome during 1973 and 1978 (see table).

Since rubella vaccination has been performed in Italy from 1974, the decrease in

Titres of rubella antibodies in asymptomatic women presenting to a Rome antenatal clinic

Year	No of women tested	Haemagglutination-inhibition titres			Clinical cases of rubella reported in Rome
		Sero-negative (<4) No (%)	High (≥ 64) No (%)	GMT	
1972	487	66 (13.6)	39 (8.0)	8.3	124
1973	705	99 (14.0)	134 (19.0)	16.4	1617
1974	496	73 (14.7)	40 (8.1)	10.6	237
1975	482	66 (13.7)	35 (7.3)	10.5	134
1976	576	80 (13.9)	59 (10.2)	11.7	299
1977	1067	123 (11.5)	124 (11.6)	13.4	727
1978	1807	134 (7.4)	302 (16.7)	18.7	1166

seronegative sera in the last years may have been due to immunisation. The increase of sera with antibody titres $\geq 1:64$ as well as the rise in GMTs which occurred in 1973 and 1978 probably reflect the booster action of re-infection on an already primed population during moderate rubella epidemics. We agree that it seems highly advisable nowadays for all women to be tested for rubella immunity before pregnancy.

G ROCCHI
A VOLPI
M ANDREONI

Clinica Medica III,
University of Rome,
00161 Rome, Italy

¹ Liebhauer, H, *Journal of Immunology*, 1970, **104**, 826.

SIR,—I refer to the letter by Dr Sam Rowlands (14 July, p 129). The impact of the schoolgirl vaccination programme on the incidence of congenital rubella will not become apparent until the mid-1980s. In the meantime an active screening programme for older women with vaccination of those found to be seronegative is recommended. Such a programme demands an immense amount of laboratory investigation and one wonders whether this work is nowadays really necessary. We are told that we cannot be sure that all vaccines are completely free from potential damage to the fetus. To balance against this we have the problem of conducting the campaign with adult women.

The blood must be taken, sent to the laboratory, tested, reported, the result sent to the practitioner concerned, and thereafter vaccination proceeded with. All these procedures ensure that the uptake in adult women will not be 100%; indeed, may well be something of the order of 25%. The difficulties to the practitioner and the patient are great.

T S WILSON

Cambuslang, Lanarkshire

Management of maternal phenylketonuria

SIR,—In their paper (26 May, p 1383) Dr G M Komrower and others stress the importance of dietary treatment of mothers with phenylketonuria (PKU) if possible even before conception occurs. Reviewing world literature we found that 62 parents (58 mothers and four fathers) with PKU have had homozygous PKU offspring in 14 cases, which contradicts the carrier frequency of one in 50 generally admitted, as in these 14 cases the homozygous parent must have encountered a heterozygous partner. For this reason we should like to add

the following to Dr Komrower's recommendation: partners of PKU parents should be examined for possible carrier state. If they turn out to be carriers reproduction should be prevented by all possible means. This also applies to PKU males. Out of four PKU fathers mentioned in literature, three had homozygous offspring.

DOLPHE KUTTER
JOHN THOMA

Luxembourg

A "specialty" for second-class doctors?

SIR,—I am sure that Dr M P Roseveare (30 June, p 1797) is not in a minority when he expresses anxiety over the direction taken by general practice and the increasing influence of a vociferous small group who wish to turn GPs into a collection of mini-consultants and to regulate them by creating, as with the present obstetric list, lists of primary care paediatricians, family planning practitioners, and who knows what next.

The whole point of the generalist is that he is concerned with the whole patient, and at times he must protect his patients from the dangers of being trapped in the wrong diagnostic category, and that he must not allow his broad view to be narrowed by the allure of special interests. I believe that there is in fact a vast majority, too busy doing the job to make much of a noise, that feels that general practice is a very real discipline in parallel with hospital practice and that the most important item of the practitioner's knowledge is his recognition of his limitations.

A OWEN GRIFFITHS

Upper Midhope,
Sheffield S30 5GX

SIR,—I would like to assure Dr M P Roseveare, in reply to his letter (30 June, p 1797) that he is not a lone voice crying in the wilderness. It has become increasingly apparent to me over the past few years that there are many doctors who are worried that general practice is being taken over by a highly motivated totalitarian minority. The majority wish to continue to practise to a reasonable standard in their own individual way.

I am one of the first to applaud the enthusiasm and hard work of the majority, both inside and outside the Royal College of General Practitioners, who have striven to raise the standards of training for and the execution of general practice with its special skills. I am afraid that they are now so involved in the perpetuation of their methods that, as Dr Roseveare says, they have lost sight of the content. I think that a large number of doctors, both trainers and trainees together with hospital consultants, have seen this danger, but tend to be silent about their views and cease to play an active part in vocational training. Those who do express their views are labelled, correctly, as non-conformists and due consideration is not given to those views because of the rigid attitude and uncompromising approach of those who organise vocational training.

These two processes have accounted for the withdrawal of a number of doctors interested in vocational training in the area around Stafford in the past three years. If this is repeated over the whole country, the high ideals of those who aimed to improve the status and performance of general practice