sleeves and press the elbow on an ink pad while resting the head on the hand. This is a posture commonly adopted by people sitting in a chair or at a desk. When the elbows were examined it was seen that the skin over the olecranon was stained in all, and also the skin over the medial epicondyle in some. In none was the skin over the ulnar nerve marked. A telephonist with an ulnar palsy was asked to hold a telephone to his ear and mouth while resting his elbow on the ink pad. When he had taken up his position it was clear that he had strongly adducted and externally rotated his arm so that the medial epicondyle and the ulnar nerve were lifted clear of the pad.

I learned from Feindel and Stratford² that when the forearm is flexed the aponeurosis of the cubital tunnel compresses the nerve. I hoped by further observations to come to some conclusions about prognosis but failed since, on first principles, the prognosis would depend on the duration and degree of forearm flexion, and neither could be estimated with accuracy. Unfortunately the need for brevity prevents a description of the 15 patients. Each had individual points of interest.

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¹ Gowers, W R, *Diseases of the Nervous System*, vol 1, p 88. London, J and A Churchill, 1892.

² Feindel, W, and Stratford, J, *Canadian Journal of Surgery*, 1958, 1, 287.

Recommended terminology of urinary tract infection

SIR,—The report of the Medical Research Council Bacteriuria Committee (22 September, p 717) makes some useful recommendations towards clarifying the nomenclature of inflammatory disease of the urinary tract. The proposal that the terms urethral syndrome and chronic pyelonephritis should be no longer used is most welcome. The main problem that the committee had to face was the difficulty in reconciling clinical, bacteriological, pathological, and radiological findings; and it might have been better to have established clear terminologies in each independently, as was done with the radiological terms. Clinicians certainly need a clear and unambiguous nomenclature for the conditions they regularly encounter.

The suggestion that "cystitis" should be discarded and replaced by the "frequency and dysuria syndrome" would be more helpful if dysuria had been defined. Its definition (the *Shorter Oxford English Dictionary* and *Chambers Twentieth Century Dictionary*) is "difficult or painful micturition," which is too imprecise for scientific use—the more so as it would fail to distinguish between the various different pains associated with micturition. The report defines urinary tract infection and bacteriuria separately, but does not seem to me to make a clear distinction between them. Infection, strictly speaking, is a tissue phenomenon, whereas bacteriuria signifies the presence of bacteria in urine. The distinction is important, because it is quite possible to conceive of tissue infection without bacteriuria and vice versa. Urinary tract infection should therefore not be used as a synonym for significant bacteriuria, as appears to be implied under the heading "Criteria for cure."

The clinician would find difficulty with "chronic interstitial nephritis," which is to

replace "chronic pyelonephritis," because it is defined in pathological and aetiological terms only. He has usually no access to pathological findings in his renal cases and may not be able to decide what clinical entities come under this heading. The section on response to treatment is presented in purely bacteriological terms. One is bound to reflect that a woman who loses her bacteriuria but retains her symptoms is, from a clinical point of view, not cured at all. Significant bacteria should be considered as only part of the evidence when assessing a particular patient.

In a general practice here 10% of my work for the past 33 years has been concerned with inflammatory disease of the urinary tract. Only a minority of these patients have significant bacteriuria and the majority would therefore be included under "abacterial cystitis" or "chronic interstitial nephritis." No guidance is offered in respect of criteria for cure in these cases, which constitute the bulk of one's clinical material.

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SIR,—In the Medical Research Council report "Recommended Terminology of Urinary Tract Infection" (22 September, p 717) the term abacterial cystitis is suggested as indicating "a syndrome consisting of frequency and dysuria in the absence of bladder bacteriuria. The use of the term 'urethral syndrome' is not recommended because there is no evidence of urethral disease in most of the patients."

In actual fact there is no evidence of bladder disease in most of the patients. Why "cystitis"?

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University examinations and the medical student

SIR,—Dr D McCracken (22 September, p 730) provided a searching and sympathetic account of his long experience of examination anxiety. He did not differentiate between students taking different courses but one wonders whether medical students may not be subject to special stresses under the prevailing system. The scathing criticism of Thomas Huxley, in his rectorial address in Aberdeen in 1874, of a system that produces students "who work to pass, not know. They do pass, and they don't know" still applies. Besides needing to *know* what have been called "the stories of basic science," more importantly in the long run the student needs to *feel* (medicine as an art) and to *do* (medicine as a craft).

From raw material to finished product the output of the medical school is not being matched to its avowed purpose—to train doctors. The selection of those with the best marks from school is inappropriate. The preclinical-clinical layering of instruction, including various token concessions, fails to serve the best interests of any of the three aspects of medicine. The imposition on some of our brighter and best-motivated young adults of the sole obligation, throughout five of their best years, to pass examinations is a grave insult to their intelligence and antipathetic to the spirit of doctoring.

One may wonder that so few appear to crack under the strain, but many do later when the die is cast.

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Practical problems with the Clinitest

SIR,—Drs P A Aspinall and A R Hill reported (1 September, p 552) that both diabetic and normal subjects misread reducing sugar assays using Clinitest reagent tablets. It was stated that colours produced with "dextrose solutions" tended to be matched with colour blocks which were one or two higher than expected.

We understand from Dr Aspinall that the tests were performed using simple solutions of dextrose in tap water, that the same solution was used throughout the period of several weeks of testing, and that this solution was standardised by polarimetry. It is important to emphasise this use of a solution of dextrose in water because the Clinitest is specifically formulated for the assay of reducing sugars in urine, in the presence of other urine constituents, and at the specific gravities found in natural urines. In the absence of some of these other constituents different results will inevitably be obtained, and therefore the tests performed by Drs Aspinall and Hill are not relevant to the use of Clinitest in urine.

It has been confirmed in three laboratories that such tests carried out in water tend to be read one to two colour blocks higher than tests on the same concentration of glucose in urine. Moreover, the colours given by solutions of glucose in water are noticeably redder than the corresponding colours given by glucose in urine at the higher concentrations and must be expected to show some degree of metamerism throughout the range. It is not surprising therefore that subjects in the study of Drs Aspinall and Hill found difficulty in matching the colours yielded by solutions of glucose in water with colour blocks designed for use with urine. Nor is it surprising that these difficulties were accentuated in patients already suffering from a degree of impairment of colour vision. Patients suffering from certain defects of colour vision may experience difficulty in matching Clinitest colours even when the test is carried out correctly. Three of the papers cited by Drs Aspinall and Hill¹⁻³ report that such patients may be adequately controlled by blood tests using Dextrostix and one of the Ames meters or by using Diastix, which can be matched by comparison of hue.

It is clearly desirable that the ability of patients to carry out any self-testing procedure should be adequately checked at the time testing is initiated and at suitable intervals thereafter. This checking should include the ability to match colours correctly as well as the retention of adequate dexterity to carry out the test. The suggestion that diabetic patients should be regularly tested for impairment of colour vision is, we believe, a valuable one. However, it must be noted in interpreting the results that Thompson *et al*¹ reported that only moderate-to-severe deficiency led to difficulty in interpreting the Clinitest.

The Ames Division pioneered the development of convenient tests by which diabetic patients could control both their own urinary sugar levels and their blood glucose levels.

Since its introduction in 1943 over 6×10^9 Clinitest tablets have been distributed throughout the world. This demonstrates how universally acceptable this test has proved to be for diabetics—when used as directed.

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¹ Thompson, D G, *et al*, *British Medical Journal*, 1979, **1**, 859.

² Taylor, W O G, *Transactions of the Ophthalmological Society of the United Kingdom*, 1972, **92**, 95.

³ Thompson, D G, Howarth, F, and Levy, I S, *Lancet*, 1978, **1**, 44.

Choline chloride in the treatment of ataxia

SIR,—We note with interest that the initial encouraging report of the treatment of cerebellar ataxia¹ with choline chloride has been followed by reports which place the response to such therapy in better perspective (14 July, p 133; 8 September, p 613).

We have recently completed a double blind crossover trial (to be reported in full later) of oral choline chloride in the treatment of ataxia in three groups of patients: eight patients with typical Friedreich's ataxia, six with sporadic cerebellar degeneration, and six with atypical spinocerebellar degeneration with cerebellar ataxia and lower limb spasticity. The choline was administered for a period of six weeks before and after crossover and the response was assessed by numerical ataxia score. Patients were randomly allocated to three treatment groups—those receiving placebo, choline 12 g/day, and choline 6 g/day.

Preliminary results indicate a noticeable improvement in upper limb co-ordination in approximately 50% of patients in each diagnostic group receiving either 6 or 12 g/day of choline. Improvement in gait was noted in only two cases (one with cerebellar degeneration, one with "spastic" ataxia). Most of the patients who demonstrated an improved numerical ataxia score were noted to have some degree of useful functional improvement in upper limb co-ordination, but in the majority this was of a minor degree. Only one patient, who experienced recurrent vomiting, stopped the choline. Other side effects included depression (three patients) and nausea (three patients).

These preliminary results indicate that careful assessment will often reveal some improvement in limb co-ordination in ataxic patients on choline therapy but that this functional improvement is not of an order likely to improve disability significantly.

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¹ Legg, N, *British Medical Journal*, 1978, **2**, 1403.

Pindolol and pulmonary fibrosis

SIR,—Through the report from Western Australia (8 September, p 581) we became aware of a case of pulmonary fibrosis occurring in a patient who was under long-term treatment with pindolol. This is the only such reaction hitherto brought to our notice although pindolol has now been available for over 10 years. It is one of the most often prescribed β -adrenoceptor-blocking agents, with an esti-

mated total exposure of more than 2.5 million patient years worldwide.

On the basis of one observation it is, of course, not possible to be certain about the causation of the pathology in this case. From the published report, however, it appears that after seven years of treatment with pindolol the lung was the only organ involved in the fibrotic process. Such an observation, if correct, would distinguish this patient from previously reported cases of pulmonary fibrosis associated with β -adrenoceptor-blocking agents. In these, antinuclear antibodies were common and the pulmonary changes would have occurred only as a late feature, following symptoms attributable to fibrosis in other organs or to the oculomucocutaneous syndrome. The observation that the patient had no finger clubbing cannot on its own exclude "classical" cryptogenic fibrosing alveolitis. It might, however, suggest some rapidly evolving underlying pulmonary condition which led to a relatively short period of tissue hypoxia.

Although the available data do not allow one to exclude pindolol as the cause of the reported condition they certainly give no conclusive proof of such a relationship. Moreover, we cannot accept the authors' hypothesis that a nitrogen atom attached to an aromatic ring may be implicated in the fibrosing reactions induced by practolol, pindolol, or methysergide. Fibrosing changes in various tissues have been associated with β -adrenoceptor blocking agents not possessing a nitrogen in the aromatic ring. There are on the other hand a number of drugs commonly used in long-term therapy with a nitrogen atom on the ring which have never been suspected of eliciting fibrotic processes—for example, acetaminophen and indomethacin.

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Wanted: a new wound dressing

SIR,—I was rather surprised at one or two statements in your leading article "Wanted: a new wound dressing" (22 September, p 689). For the last 15 years or so of my working life—which finished in 1971—I treated all clean closed wounds by exposure to air without dressing of any kind, and certainly without any "ritualistic practice" of a plastic spray. I did not realise that I was in any way exceptional in this method; indeed I thought it was almost universal.

I did have some qualms in the early days about the effect on the patient of exposing my "affront to his body's integrity" directly to view, but never once found any mental reaction. Indeed, the sight of a sinuous lazy-daisy stitch meandering for 15 inches across the chest wall after a radical mastectomy more often than not produced interesting discussion between patient and surgeon on various methods of embroidery.

These wounds are sealed by nature within an hour or two of operation, and a loose theatre gown will take up any slight loss of blood arising in those few hours. Subsequently the patient can carry out her own toilet with soap and water and so save nursing time.

May I suggest, sir, that we already have a copious supply of a dressing whose use will

save our hard pressed Health Service a great deal of money. It is called fresh air.

ROBERT BEWICK

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Royal Medical Benevolent Fund Christmas Appeal 1979

SIR,—Annually, thanks to the generosity of the medical profession, the Royal Medical Benevolent Fund is able to give every one of its beneficiaries something extra for Christmas. Many of these are children to whom the fund's gift is essential to a happy day.

In 1978 the response to my appeal was most generous and the record total of £23 351 was subscribed. Each year, however, the need is greater as costs rise and our efforts must match it. The Royal Medical Benevolent Fund relies solely on doctors and their families for support and I am confident that they will respond as always. Contributions may be passed direct to the treasurer or medical representative of the local guilds of the Royal Medical Benevolent Fund or sent marked "Christmas appeal" to the director of the fund at 24 King's Road, Wimbledon, London SW19 8QN.

T HOLMES SELLORS

President,

Royal Medical Benevolent Fund

London SW19 8QN

Review of composition of the General Optical Council

SIR,—Your readers may be interested to know that the Privy Council is proposing to conduct a general review of the composition of the General Optical Council, using for the purpose the machinery provided by paragraph 13 of the Schedule to the Opticians Act 1958.

This provision enables the Privy Council, after the required consultations, to make by Order such alterations in the membership of the General Optical Council and the numbers and qualifications of its members as may be expedient in view of changes in circumstances since the council's establishment, or the last such Order, as the case may be.

I have already notified both the General Optical Council and a number of interested bodies of this proposal but think it appropriate to give it wider publicity through your columns and those of other relevant professional journals.

I would be grateful if any national organisations (including organisations representing the interests of Scotland, Wales, and Northern Ireland) wishing to make representations to the Privy Council on this subject could send them to me at this office (10 copies, please) not later than 30 November. If this deadline presents special difficulties, requests for a reasonable extension of time will, of course, be considered.

N E LEIGH

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Unblocking beds

SIR,—It is so clearly undesirable for elderly patients to be misplaced in acute hospital wards that if a mere change in clinical policy could solve this perennial problem no efficient department of geriatric medicine would have