sunset resting or sleeping, so that energy expenditure is a lot less than normal.

Fortunately pregnant diabetics are usually quite willing not to fast, so their control is not affected during Ramadan. Many patients ask to be allowed to stop their insulin, and where this is not allowed it is difficult to be sure whether the patient is obeying instructions or not.

I think that it may in theory be dangerous to fast during Ramadan but in practice the patients seldom seem to get into any trouble.

J C DAVIDSON

Rumailah Hospital,
Doha, Qatar

Mycoplasma pneumoniae infection and neurological complications

SIR,—The case reports of Drs J Aidan Twomey and M L E Espir (6 October, p 832), and Dr A B Jones (3 November, p 1144) prompt me to bring to your attention a survey carried out in this laboratory to investigate the association between *Mycoplasma pneumoniae* infection and neurological disease.

We tested sera from 800 patients, presenting with a wide variety of neurological syndromes, for complement-fixing antibodies to *M. pneumoniae*. Three patients had rising titres and a further 14 had high (≥ 256) static titres suggesting a current or recent infection with the organism. Of these 17 patients (2.1% of the total), 13 were 14 years or younger, and the remaining four were 17, 23, 42, and 49 years old. Six of these patients had meningism; in one case echovirus type 6 was isolated from the faeces and in another there was a measles complement-fixing antibody titre of 256. Four of the 17 patients had aseptic meningitis (one with echovirus type 4 isolated from the faeces) and two others possible aseptic meningitis. The table relates the cases by year of illness to the total cases of *M. pneumoniae* serologically diagnosed in this laboratory.

The percentage of *M. pneumoniae* infections associated with neurological disease is small (6.7% of the total) and is a constant fraction of the total for each year except in 1973, when we diagnosed only 22 cases. Because only 2.1% of the 800 "neurological" patients showed evidence of infection, it appears unlikely that *M. pneumoniae* contributes significantly to the causation of serious neurological disease; in three of our patients there was also evidence of current or recent infection with potentially neurotropic viruses.

An aetiological association with minor neurological illness remains to be proved. Seven of our 17 patients had meningism, for which the causes in children are numerous, and it is not necessary for the organism to infect the central nervous system directly to cause it. In the 10 cases of actual or possible aseptic meningitis causation cannot be proved,

but attempts to isolate the organism from CSF would help to resolve the difficulties of interpreting these serological findings. In any case it appears that if *M. pneumoniae* does affect the CNS it does so infrequently and in our experience is associated only with mild disease.

G E D URQUHART

Regional Virus Laboratory,
Ruchill Hospital,
Glasgow G20 9NB

SIR,—We wish to add a further case report of neurological complications of mycoplasma infection to those already reported in your columns (6 October, p 832; 3 November, p 1144).

The patient was aged 16 when she presented in February 1977. In December 1976 she had developed a sore throat with swollen lymph nodes in the neck. She was treated with a short course of ampicillin, with complete resolution of her symptoms. In mid-January her symptoms recurred and again resolved with a short course of ampicillin. Her illness responded within 72 hours. In early February she complained of headache and neck stiffness and over a few hours developed nausea and photophobia and became irritable. At this time she was given a course of septrin. Two days later she complained of a "funny sensation" in her right arm and leg and had a grand mal seizure with a focal right-sided onset. Because of this she was admitted to a peripheral hospital, where she was found to be irritable with neck stiffness and a positive Kernig's sign. The cerebrospinal fluid examined at that time was reported as normal. During the following 48 hours she had further grand mal seizures and became comatose. She was subsequently transferred to the neurology unit. At that time (18 days from the onset of her illness) she was comatose, responding non-purposely to painful stimuli. Horizontal nystagmus was present on central gaze with intermittent opsoclonus. The brainstem reflexes were preserved. She was hypersalivating and showed forced trismus. Tone was symmetrically decreased and the plantar responses were extensor.

Treatment was started with epanutin 300 mg daily and prednisone 120 mg daily. The only abnormal finding at that time was the presence of symmetrical delta activity on the electroencephalogram. A lumbar puncture on day 20 of her illness showed 12 lymphocytes with normal sugar and protein concentrations. Over the next 21 days she slowly recovered. She had no recollection whatsoever of her illness. A repeat lumbar puncture on day 37 showed protein of 0.64 g/l, 1 lymphocyte, and normal sugar. The EEG returned to normal apart from the presence of moderate bilateral theta and delta components, most marked posteriorly. Titres of complement-fixing antibodies to *Mycoplasma pneumoniae* were (for blood): day 20—1/20; day 37—1/160; December 1977—1/160; June 1978—1/160; December 1978—1/80; (for CSF): day 37—1/20; December 1977—1/20.

Over the two and a half years since she was discharged from hospital, the patient has continued to have grand mal seizures. These were frequent in the first 18 months, but in the past year reasonable control has been obtained with a combination of valproate and carbamazepine. Recent computed

tomography scans have been normal. Within a month of her discharge from hospital, however, it was apparent that she had sustained major intellectual impairment. Ten months after her illness her verbal IQ (89) was still only within the dull normal range, even though she had passed five O levels, including English literature and language. Wide variations in subtest results were seen, low scores being noted on general knowledge, attention span, and mental arithmetic. The subtest scores for reasoning and vocabulary were within the normal range. The performance IQ (99) was found to be average, though this was considered low given that she had been receiving a sixth-form education. Again variations in subtest scores were noted, relatively poor results being found in relation to speed of visual perceptual-motor functioning and visual associative reasoning. Although the patient did not display short-term memory deficits she experienced great difficulty when attempting to learn new material. Her incidental retention of material from short-term memory was similarly extremely poor. The Halstead-Reitan neuropsychological test battery provided evidence of widespread cortical dysfunction, with moderate abnormalities noted bilaterally in the posterior cortical areas. No dysphasic symptoms were encountered. Repeat neuropsychological investigations 24 months after her illness showed no significant or consistent improvements.

In this patient the persistent intellectual difficulties and postencephalitic epilepsy contrast with the favourable outcome of neurological damage resulting from mycoplasmic infection previously reported in the *BMJ* and elsewhere.^{1,2}

W J K CUMMING

Department of Neurology,
Manchester Royal Infirmary,
Manchester M13 9WL

C E SKILBECK

Avon Neurological/Stroke Rehabilitation Unit,
Frenchay Hospital,
Bristol BS16 1LE

¹ Taylor, M J, et al, *Journal of the American Medical Association*, 1967, **199**, 149.

² Jachuck, S J, et al, *Postgraduate Medical Journal*, 1975, **51**, 475.

Stress and premature labour

SIR,—I would like through your columns to answer the questions raised by Drs Judith Lumley and Robin Bell (10 November, p 1222) about our paper (18 August, p 411).

We are well aware of the difficulties involved in gestational assessment and we drew evidence from a variety of sources, considering the uterine size on booking, subsequent biparietal diameter on ultrasound scans, bone age, and assessment after delivery before allocating the baby to a particular study group. We demonstrated a continuous trend through three study groups (not merely a difference between two groups), linking prematurity with higher levels of maternal stress. It is unlikely that an error in assessment of a week either way would interfere with this trend.

About 25 women at term were excluded as their labour was induced. In the preterm groups we excluded four women who were sporting Shirodkar sutures, three with multiple pregnancies, and three Asian ladies from Manchester who spoke no English. No other woman in the preterm group had an obvious "obstetric" cause for premature labour and there seems to be little scope here for a control group as suggested by Drs Lumley and Bell. Besides, we were relating levels of stress to duration of pregnancy and a control group of mothers with "obstetric" causes for preterm labour would be quite inappropriate to this question.

***M. pneumoniae* infection and neurological disease 1970-4**

Year	No of "neurological" cases tested	No (%) positive	Total No of <i>M. pneumoniae</i> cases diagnosed	% positive neurological cases out of total diagnosed
1970 (Oct-Dec)	32	2 (6.3)	33	6
1971	216	7 (3.2)	98	7
1972	216	3 (1.4)	40	7.5
1973	214	0	22	0
1974	122	5 (4.1)	62	8
Total	800	17 (2.1)	255	6.7

"Positive" and "diagnosed" = fourfold or greater antibody rise or high titres (≥ 256).

If Drs Lumley and Bell had read our paper carefully they would have seen that we were careful to state that consecutive women in "each gestational group" were interviewed. Prior to the study we defined how many women in each group were needed to make statistical comparison possible. Once this target was reached that group was "closed." An implication of a 37% prematurity rate was not meant.

I must emphasise again that it was those women going to term who had the better recall for subjective rather than objective life events. This is indeed opposite to what one might predict. The most common major life events recalled by the women in the preterm groups were "income decreased substantially—25%," "immediate family member seriously ill," and "prolonged ill health in a close relative." It may be that these particular life events and the others more commonly observed have a predictive quality and a prospective study is required to confirm or refute this.

I agree with Drs Lumley and Bell that the provision of financial and emotional support is difficult but with the widespread breakdown of the extended family it is necessary that someone tries.

RICHARD W NEWTON

Booth Hall Children's Hospital,
Manchester M9 2AA

Medical reports not to the lawyers' liking

SIR,—Understanding relationships between lawyers and doctors are essential to the health of society, especially where parents and children are concerned. If Judge Curtis-Raleigh had given any other judgment than that reported (24 November, p 1376) the doctor in the courts, obliging the lawyer by omitting important sentences, would have moved one further step away from his position as an expert assisting the court to the best of his ability. My own practice when asked to prepare a report is to make it plain to the solicitor, particularly in a case involving custody or access, that what I have to say after studying all the data may not be to his liking. If he finds this acceptable we proceed. Although my fees are paid through him I am not his bought man.

ALFRED WHITE FRANKLIN

London W1N 2DE

The care of children in hospital

SIR,—I have read with interest the letter from Dr John Wilson (10 November, p 1227) regarding the training of paediatric nurses.

Dr Wilson correctly states that there is no pecuniary reward for those who undertake training for the Registered Sick Children's Nurse qualification. Nor is there a career structure in paediatrics beyond the level of senior nursing officer. It is therefore unfortunate but inevitable that many children's nurses will be lost to this particular field in order to advance their careers. With regard to nurse training, however, I would question the authority on which Dr Wilson makes his comments. I am certain that he would not welcome similar comments from a nurse about medical training. Furthermore, he is not trained as a nurse tutor. But since he has expressed his opinions they deserve a reply.

It is true that there is a strong body of opinion that the three-year training for the children's register should be reintroduced. This would possibly be one solution to the shortage of paediatric nurses, but I would venture to state that this is a rather narrow view to adopt. The care of sick children and their families is emotionally demanding, far more so than that of adults. It is necessary therefore that the nurses engaged in such work should themselves be sufficiently mature to meet these demands. The average student of 18 years has not gained emotional maturity, but during the course of a three-year general training she will acquire this. In the paediatric setting, however, she frequently fails to mature as quickly as others of her own age; and I can assure Dr Wilson from personal experience that the students in his own hospital cannot be compared with their peers in general training schools.

The advocacy of a general basic training, to be followed by one in a specialised field, is not merely to ensure bureaucratic tidiness: it is an attempt to produce nurses who have gained wider experience and are able therefore to give a better standard of care to their patients.

PAMELA M JEFFERIES

London SE1

A do-it-yourself medical centre

SIR,—When doctors who run privately owned surgery premises cannot see their problem how will we ever persuade the DHSS to improve the system?

Drs A N Ganner and A C K Lockie (17 November, p 1269) describe their building a health centre under the cost-rent scheme as "financially rewarding." And I would agree that those using the cost-rent scheme usually do not make a loss, though they themselves admit that "partners 3 and 4 have a short-term cash flow problem" and that "it will probably cost partners 4 and 5 about £600-£700 a year during the first three years" after tax relief—that would be over a £1000 a year before tax relief. But they do not mention the problems in store for their new partner when partner 1 retires, even though the figures are available in their article.

Suppose they suddenly need to replace partner 1. On the assumption that their centre has risen in value to £85 000 (and £17 000 per doctor is a common practice share now), even at 16% the General Practice Finance Corporation interest payable by a new partner would be £2720. But the cost rent payable to the new partner will still be £1860 and the alternative notional rent would certainly not be more. The new partner has a shortfall of £860, plus the same £1000 which partners 4 and 5 already have, so will be going into practice with a deduction from his income of almost £2000 a year—more if interest rates have risen—just when he will be facing mortgage and car purchase problems.

Younger doctors will not willingly opt for privately owned premises in face of this level of commitment. Yet it is important for the independence of the profession that many doctors are in their own buildings and that the premises are satisfactory. I know doctors in several practices who will not improve premises under the cost-rent scheme because they appreciate better than Drs Ganner and Lockie the financial problems they will be storing up for future new partners.

The GMSC is about to negotiate for reimbursement to be based on a percentage of capital value instead of current market rent. It is essential that this negotiation is successful, even if only for those newly entering practice or changing practices within the first few years. Doctors who live in Cloud-cuckoo-land should be wary of talking about "nest eggs." It would be sad if complacent reports such as this one were to make it harder for the GMSC accurately to describe the plight of young GPs when negotiating with the DHSS.

MARTIN LAWRENCE

Chipping Norton, Oxon OX7 5AA

Medically qualified preclinical academics

SIR,—Once again preclinical teachers are being urged to do clinical sessions to show they are "proper doctors" (Dr E N Glick (24 November, p 1370)). I never cease to be amazed at the attitude of those of our clinical colleagues who assume that the only proper doctors are clinicians, conveniently forgetting that most of the major advances in medicine have been due to laboratory research workers, including many non-medically qualified staff.

As a medically qualified anatomist I can assure Dr Glick that my time is already fully occupied in teaching and research. With the heavy teaching load in most preclinical departments few members of staff can afford to give up any of the already limited time available for research, and to do so would in the long term be detrimental to the academic standards of preclinical departments.

While there may be a plethora of clinical sessions available in London this is not the case in other regions. For example, I have found that my clinical colleagues in Dundee are opposed to sessional work for preclinical teachers on the grounds that there is already a shortage of such posts for married women on the retainer scheme. One possible solution might be for preclinical teachers to do two subconsultant sessions a week while our teaching is taken care of by our consultant colleagues doing two anatomy demonstrator sessions a week, although I fear that this would lead to inadequately treated patients and inadequately taught students.

R R STURROCK

University Department of Anatomy,
Dundee DD1 4HN

Revised consultant contract

SIR,—May I, as a whole-time consultant, comment on Professor Douglas Roy's letter (24 November, p 1371). He states that—"They [our negotiators] seem to have failed to realise that the full-time salary is the touchstone whereby all other salaries will be judged."

Our negotiators have displayed many shortcomings but failure to recognise the depressing effect of a persistently unsatisfactory level of wholtime remuneration on all other salary grades is not one of them; the spin-off has, in fact, been in the reverse direction to that envisaged by Professor Roy. For the whole-time consultant, the decision to support the latest contract amendments cannot be based on the prospect of substantial private practice, although the freedom from total bondage is welcome. The decision must be based, rather, on the improved negotiating stance which derives from this freedom.