treatment with prazosin, or prazosin plus a beta-blocker. Pape *et al*¹ report similar findings in 14 patients, of whom 13 had negative ANF tests before and after prazosin and one a positive pretreatment test, which became negative after 18 weeks on prazosin.

Marshall points out that his ANF findings are unlike those of systemic lupus erythematosus and that no patient had symptoms of an autoimmune illness. This is in agreement with my experience in 85 patients now treated with prazosin for periods up to five years (total patient years 255). There have never been signs or symptoms indicating an autoimmune reaction, nor have any significant laboratory abnormalities been found.

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¹ Pape, J, *et al*, *Therapiewoche*, 1977, 27, 6062.

SIR,—From the observation of a positive antinuclear factor test (ANF) in 12 of 47 hypertensive patients on prazosin and the swift conversion from a negative to a positive ANF in three of 10 patients after start of treatment with this drug, Dr A J Marshall and others suggested an association between ANF and prazosin (20 January, p 165).

ANF was associated with the hydralazine and prazosin syndromes and caution should always be paid to any new drug in order to avoid equivalent syndromes. However, before an association between ANF and a certain drug can be considered to be proved, one or more of the following criteria must be fulfilled: (a) The ANF test should be negative before treatment. (b) Titres and frequency should be above what is seen in healthy subjects. (c) ANF subclasses should always be investigated—for example, IgA, IgM, and IgG. (d) Age, sex, and severity of the hypertension should be taken into account—for example, WHO stages. (e) ANF should disappear after cessation of the drug in question and recur after rechallenge with the drug.

These requirements are based on the following observations. Compared with normotensive healthy subjects, titres and frequency of ANF have been found significantly higher in both treated and untreated patients with essential hypertension,^{1,2} and associated with blood pressure and fundus grade in untreated patients.¹ ANF of IgA and IgM class in titres of 1/16 are age and sex dependent, in contrast to IgG-ANF.³⁻⁵ IgG-ANF is more often associated with pathological conditions than are IgA-IgM-ANF.^{3,4} IgG-ANF in titres of 1/20 or more were not found in 78 healthy normotensive subjects without familial predisposition to hypertension or clinical signs of atherosclerosis.¹ In keeping with the findings of Marshall *et al*, only three of 12 ANF-positive patients had a titre above 1/20, and ANF persisted for more than four months after cessation of prazosin. Moreover, no information was given on blood pressure levels, age, sex, or ANA subclasses.

The persistence of a positive ANF test in 10 of the 12 patients suggests that ANF is associated with something other than prazosin. Hypertension is a well-known risk factor for cardiovascular diseases, and it must be stressed

that autoantibodies, including ANF, have been found to be associated with cardiovascular mortality and morbidity, and suggested to be markers of vascular lesions.⁶ That prazosin was added to the combination of diuretic and beta-blockers in some of the patients in the study of Marshall *et al* suggests that these patients had a more severe hypertension than had those in the groups they were compared with. The authors should check this, as well as the age and sex distribution in the three groups and the ANF subclasses.

In conclusion, an association between ANF and prazosin cannot be excluded, but it is far from proved from the study of Marshall *et al*.

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¹ Kristensen, B Ø, and Andersen, P L, *Acta Medica Scandinavica*, 1978, 203, 55.

² Wilson, J D, *et al*, *Lancet*, 1978, 2, 996.

³ Wiik, A, *Acta Pathologica Scandinavica* (C), 1976, 84, 215.

⁴ Svec, K H, and Veit, B C, *Arthritis and Rheumatism*, 1967, 10, 509.

⁵ Andersen, P L, *Clinical Experimental Immunology*, 1977, 27, 74.

⁶ Mathews, J D, *et al*, *Lancet*, 1973, 2, 754.

Communication

SIR,—The editor of a specialist journal asked me recently to read a paper that had been sent to him for publication. Its title was "Criteriae for systemic therapy of non-Hodgkins' lymphoma and non-Hodgkins' lymphomata." The authors used these terms to indicate respectively Hodgkin's disease and lymphomas other than Hodgkin's disease. They shortened them in the text to "N.N.H.L." and "N.H.L." The editor's letter to me ended: "Hopefully you will provide me a meaningful opinion of the publication suitability of the article which in the light of the space shortfall situation we are reluctant to accept lengthwise at this moment in time. Best regards, yours faithfully, dictated but not signed by Editor."

As the content of the paper is outwith my competence, it has been returned to the editor for referral to someone qualified to assess it.

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Kidney transplants, doctors, and the media

SIR,—The recent review by Dr Tony Smith (20 January, p 182), "Kidney Transplants, doctors, and the media," outlined kidney transplantation programmes in Australia, which in some respects are more favourable than in this country.

However, there is little evidence that the Australian public are more "pro-doctor" than their British counterparts, with surveys in this country still ranking medicine high among the occupations most respected. Nor is it true that the public's attitude has been responsible for the dearth of donors in the United Kingdom. A much greater problem has been the reluctance of our own medical colleagues to refer patients who could be suitable donors. The reasons for this are, of course, many but often stem from an understandable wish to protect the relatives from further distress at what is inevitably a difficult time. While this is understandable, experience

over many years has shown that few relatives are seriously distressed by a sympathetic interview by an experienced member of a transplant team, requesting permission to remove organs. However, transplantation in this country and permission from relatives will not be forthcoming if the press continue to ignore the specific requests of donor's relatives for anonymity.

Recent experience in Cambridge suggests that relatives' wishes can still be flaunted to the obvious distress of the donor family. It is imperative that both the family and doctors concerned in approaching relatives for permission should be confident that the family will not be subjected to inquiry and interview by the media. It is difficult to imagine what public interest is served by the publishing of details of donors under these circumstances.

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ESR in gonococcal arthritis

SIR,—I read with interest Dr Dermot Murray's article on ESR in gonococcal arthritis (6 January, p 22). He stated that the ESR is "invariably raised" in such patients. This is not always the case, as we currently have a patient under our care with an ESR of only 2 mm in the first hour.

A man, aged 41, had had a persistent urethral discharge since May 1978. He was admitted on 27 January with headache, pain in shoulder and wrist, and "septic spots." He was febrile, and the right shoulder and right wrist were hot and tender. Necrotic vascular lesions were found on his skin over his right ankle and left knee. The diagnosis of gonococcal arthritis was proved by isolating *Neisseria gonorrhoeae* from a urethral swab. The total white count was $5.7 \times 10^9/l$ and the ESR 2 mm in the first hour. As the patient was allergic to penicillin, he was given intramuscular spectinomycin and oral oxytetracycline, with rapid improvement.

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SIR,—Correspondence arising from my case report (6 January, p 22) stimulates me to comment further.

As Dr Martin Siefert (27 January, p 265) states, patients with benign gonococcaemia usually do not present at venereology departments. Only six out of the 24 reviewed by Barlow did so.¹ In a series of 23 patients reported by Barr and Danielsson² cases were referred from the orthopaedic department (1), surgical outpatients (2), the department of gynaecology (2), medical outpatients (1), and the department of dermatology (3).

Taken together the published reports show this complication of gonorrhoea to follow in about 2% of cases. If this figure is applied to cases of gonorrhoea at present reported from the English clinics at least 1300 cases may be occurring annually. Barlow could trace only 24 cases reported from the British Isles since the second world war. The implication could be that cases are being adequately managed without being reported or, more worryingly, that cases are not being recognised. It was the latter possibility that prompted me to report