histamines, which were significantly associated with motorcycle accidents (although not with road accidents of all types).

Dr Wheatley repeats his previous assertion¹ that general practitioners usually warn patients about possible effects of tranquillisers on driving skills, but he does not cite any evidence to support it. Unfortunately, the type of warning that he describes could not be relied on to prevent accidents, because it is postulated that tranquillisers "produce subtle effects undetected by the patient." In tests of low-speed vehicle handling, Betts and his colleagues² showed that drivers whose performance was affected by tranquillisers did not experience subjective effects.

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¹ Wheatley, D, *British Medical Journal*, 1977, 2, 126.

² Betts, T A, Clayton, A B, and Mackay, G M, *British Medical Journal*, 1972, 4, 580.

Use of car headlamps

SIR,—Dr D F Martin (21 April, p 1086) seems to think that my unwillingness to dazzle other road users (not just car drivers) typifies a selfish attitude, yet I think exactly the reverse is the case (31 March, p 891). As long as such diametrically opposed views can be honestly held and justified there is no hope that laws, regulations, or even codes, will be adhered to.

Just because a car may be seen more easily by having extra lights, and headlamps are extra to sidelamps, this does not unfortunately mean that accidents will be reduced. The other person, blinded by dazzle, may run into a ditch, a pedestrian, or even the first person's car. One cannot expect the other person to take safe avoiding action if one has made him temporarily unable to see to do so. There are snags even when dipped headlights are properly aligned (this is by no means 100%)—they still dazzle coming over the brow of a hill and by reflection from wet or snowy roads.

Apart from these points, which apply to everyone, I listed in my letter some common ophthalmic conditions where patients are more susceptible to dazzle and complain to me about car headlamps. These are things which medical people should consider to a greater degree, and not advocate anything which will only increase the already alarming dazzle.

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Obstetrics in general practice

SIR,—I would like to congratulate Dr W J Reilly on his Personal View (21 April, p 1077). The doctor, who is an old friend of mine, loves to be controversial and he has therefore succeeded in making me put pen to paper. I am not prepared to debate the question of general practitioner obstetricians, but I am prepared to debate the preparation made by the patient, midwife, and doctor for the home confinement in the early 1960s.

Many of our young general practitioners and your consultant obstetricians will have gained a false impression if they regard Dr Reilly as typical of the era. I worked with six first-class district (that is, community) midwives, who

before they would permit a home confinement made sure that everything was to their satisfaction. This included the preparation of the confinement bedroom down to the smallest detail. The bed had to be raised to the required height, the lighting improved, and help made available.

When I or one of my partners received a request for help from the midwife I loaded my car with my portable anaesthetic machine, several spare cylinders, a portable transfusion stand, a transfusion-giving set, artificial plasma, a cutting-down set in case the veins in the arms had collapsed, my obstetric bag containing all my instruments (which had already been sterilised); gowns, gloves, etc, were in a sterile drum. I also included a portable light in my equipment but usually the midwife had arranged this. I asked my second on call, who was a skilled general practitioner anaesthetist, to meet me at the patient's home. In other words, I brought everything that a flying squad would bring except blood. I already had a container labelled in order to take blood for cross matching. I always received excellent support from the ambulance service in transporting the patient and ferrying blood.

Very often the midwife had alerted a colleague and I had the help of two midwives. I agree with Dr Reilly that we did not have a flying squad, but our three consultant obstetricians in Shrewsbury stated that it was impossible for them to give this cover for various reasons. However, they did urgent domiciliary visits as soon as they were available, supported by a member of their midwifery staff.

I appreciate that Dr Reilly was describing personal experiences in home confinements in the early 1960s and these may have been applicable to some of his general practitioner obstetric colleagues, but I hope his readers will understand that there were many of us who were attempting to do something better.

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Yaws or syphilis?

SIR,—In your leading article (7 April, p 912) entitled "Yaws or syphilis?" you state that "The most common mode of presentation is a latent infection brought to light by routine serological tests for syphilis." I wonder whether the word "latent" is the right description of these cases as it suggests that there is still dormant active disease present. These serological tests show that the patient has had a treponemal disease in the past, but they do not suggest activity.

When immigrant West Indians began to attend the clinics in the mid-1950s, many were found to have weakly positive serological tests for syphilis or yaws and were treated as for syphilis. During the next 20 years many of them were retreated and retreated, some for multiple pregnancies and some for attacks of gonorrhoea, receiving up to 60-70 million units of penicillin—despite which their serological test results remained the same. If there had been any activity present which caused the serological changes perhaps it is reasonable to suggest that treatment would have caused some reversal. Also, none of these patients with weakly positive serological reactions, whether treated or not, have ever developed any signs of a relapse of yaws or have produced children infected with yaws or any sign which might indicate active disease.

Perhaps a better description of these cases would be "past yaws" or "past treponemal disease."

However, as your leader writer says, these cases should be treated in case syphilis has been missed. In the treatment of syphilis to ensure the highest possible penicillin blood level, many years ago we raised the dosage of procaine penicillin from 600 000 to 1.2 million units daily for 10 days as this was the largest volume of the drug generally acceptable to the patient for daily injection. The results have been so good that it now seems doubtful to me that serological follow up in treated early syphilis is of value. Certainly such delicate tests as the *Treponema pallidum* immobilisation and haemagglutination tests and the fluorescent treponemal antibody test are more trouble than they are worth in treated early syphilis; their persisting positive results, which mean only that the patient has had a treponemal disease, often mislead the inexperienced physician and cause unnecessary anxiety to the patient.

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SIR,—It was very interesting to read your leading article "Yaws or syphilis?" (7 April, p 912). This dealt mainly with the clinical features. I would like to add that the pathological diagnosis of yaws is equally difficult, having worked myself in pathology. Moreover, other pathological states can be misdiagnosed as yaws, and plasmacytoma is an example.^{1 2} The following case illustrates this.

A 30-year-old Jamaican presented with complaints of left nasal obstruction and swelling of the left cheek. Six months earlier he had had two upper teeth extracted in view of complaints of toothache, and on two occasions the specimens of the swelling were reported histologically as yaws; but serological tests were negative. There was an initial response to penicillin and later to tetracycline, but this tumour continued to grow. It was decided on clinical grounds to start radiotherapy and further pathological opinions suggested a plasmacytoma later. A maxillectomy was performed and the histology was confirmed as that of a plasmacytoma. Thus tumours can be misdiagnosed as yaws.

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¹ Pahor, A L, *Journal of Laryngology and Otology*, 1977, 91, 241.

² Pahor, A L, *Journal of Laryngology and Otology*, 1978, 92, 223.

Male sexual dysfunction during treatment with cimetidine

SIR,—We have read with interest the recent report by Dr N R Peden and his associates (10 March, p 659) on male sexual dysfunction in three patients with duodenal ulcer during treatment with the histamine H₂ receptor antagonist cimetidine. Hormonal imbalance as a possible cause of loss of libido and impotence has been suggested but such a relationship has not been proved. An alternative or additional mechanism for the sexual dysfunction reported after cimetidine therapy may involve an antagonism of the effects of endogenous histamine on the smooth muscle of the penis.

Stimulation of sacral parasympathetic nerve