constituted an error of judgment. If it is untrue, then the authors of the book should give high priority to putting the record straight.

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Large-bowel polyps and colonoscopy

SIR,—Your leading article "large bowel polyps and colonoscopy" (16 June, p 1587) emphasises the importance of screening in early detection and treatment of colonic cancer, yet comes to an odd conclusion.

Surely, before introducing a sigmoidofibroscope into outpatient clinics it would be simpler to ensure that every patient who attends outpatients with bowel symptoms has a guaiac test for occult blood in the stool obtained from a rectal examination. Then those who are positive can be investigated further—barium enema and endoscopy on a prepared bowel. For it is my experience that patients' symptoms are often ignored or misdiagnosed as piles until the chance for curative surgery is missed. Selective screening in the form of a guaiac test would help us to look at the right population with possible colonic cancer and, perhaps, to see the tumour earlier. A sigmoidofibroscope, however, for unprepared bowels, in an outpatient clinic, would be little more than toys for the boys.

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Diverticular disease in urban Kenyans

SIR,—Dr John F Calder (2 June, p 1465) has reported 15 urban Kenyan patients with diverticular disease in the Kenyatta National Hospital, Nairobi. This report should be compared with other reports on diverticular disease in urban Africans, such as that from Ghana Medical School, in which 14 cases of diverticular disease were observed in 360 barium enema examinations during 1974-6. Sixty per cent of these patients derived from Ghanians of higher social class.¹ Also from Johannesburg the first 16 Bantu patients suffering from diverticular disease were reported in 1977 by the physicians and radiologists in the 2000-bed University Baragwanath Hospital during 14 months of 1974-5.² Experience over many years led their Johannesburg group to entitle their article "Emergence of diverticular disease in the urban South African Black."

Development in Kenya has brought increasing affluence to urban Kenyans, with Westernisation of the diets, shown as increased consumption of sugar, while low-fibre sifted maize flour has increasingly replaced high-fibre maize meal, as mentioned by Dr Calder. Britain has been the first country to report dietary fibre intakes.³ In other countries these are not known but trends are certainly not only towards far lower intakes of cereals as Westernisation of diets occurs but in particular towards a reduction in cereal fibre. This is of importance as it contributes much more than does the fibre of fruits and vegetables to bulk and softness of stools.⁴

The World Health Organisation has reported in 85 countries dietary changes that accompany increasing affluence and Westernisation.⁵ Among the 750 million poor in-

habitants of developing countries 75% of the daily energy is derived from starch, whereas among the 500 million affluent inhabitants of the developed countries only 25% of daily energy is derived from starch. In the latter fibre-free fat has increased from under 10% to 40% and fibre-free sugar from under 5% to 20%. At the same time fibre-rich cereal meals, such as wholemeal bread and maize meal, have been replaced often by fibre-depleted refined white bread and refined, sifted, maize flour. For instance, wheat wholemeal bread contains dietary fibre 8.5 g/100 g, white bread 2.7 g/100 g.⁶ No data have been published yet concerning the dietary fibre content of maize meal and maize flour, but a comparable decrease of dietary fibre is anticipated. If in Western communities starch consumption decreases threefold and its associated fibre also decreases almost threefold, then wherever Western-type diets are consumed cereal dietary fibre intake certainly decreases considerably.

Workers in the urban areas of Africa have for many years been reporting increased incidence of appendicitis. Only recently, however, have reports of diverticular disease begun to appear. The former is among the first and the latter among the last of characteristically Western diseases to emerge following the impact of Western culture. Since Dr Calder states that these Africans are still on relatively high-fibre diets one cannot but wonder whether these figures are representative of urban Africans as a whole. A frequency of 7% of diverticular disease in an African group of average age 41 is comparable to Western figures; yet British vegetarians with their marginally higher fibre intake, compared with Africans, have a significantly lower frequency of diverticular disease than the community as a whole.⁷

Quantitative data are needed on all aspects of this problem, and also comprehensive dietary surveys.

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¹ Archampong, E Q, Christian, F, and Badoe, E A, *Annals of the Royal College of Surgeons of England*, 1978, **60**, 464.

² Segal, I, Solomon, A, and Hunt, J A, *Gastroenterology*, 1977, **72**, 215.

³ Southgate, D A T, Bingham, S, and Robertson, J, *Nature*, 1978, **274**, 51.

⁴ Cummings, J H, *Journal of the Royal Society of Medicine*, 1978, **71**, 81.

⁵ World Health Organisation, *Energy and Protein Requirements*, Technical Report Series, No 522, p 20. Geneva, WHO, 1973.

⁶ Paul, A A, and Southgate, D A T (editors), *McCance and Widdowson's The Composition of Foods*. London, HMSO, 1978.

⁷ Gear, J S S, *Journal of Plant Foods*, 1978, **3**, 57.

Maturity-onset diabetes

SIR,—I read with interest the article by Drs V Anne Ropner and J Anderson (7 April, p 938), as I am concerned at the possible diabetogenic effect of propranolol. One of our patients, who developed maturity onset diabetes, was taking 960 mg of propranolol daily for angina, and, on stopping this drug, his blood sugar returned to normal and he required no further hypoglycaemic agents.

The *BMJ* (20 January, p 159) had a report from Birmingham detailing the, what seems to me, significant rise in blood sugar concentration of some patients on 160 mg of

propranolol daily, and, although the makers of this drug deny that it can cause any significant hyperglycaemia, I shall be cautious in prescribing propranolol in future for patients with a history of diabetes or overt diabetes.

I thank Dr P de V Meiring, principal physician, for his encouragement and the Director of Hospital Services, Natal, for permission to report this case.

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Absorption of enteric-coated prednisolone

SIR,—We were interested to read the observations concerning the absorption of enteric-coated prednisolone tablets (9 June, p 1534). We have been unhappy about the reliability of their absorption for a considerable time and would like to refer to a case which nearly resulted in the loss of a renal transplant.

A 58-year-old man had a cadaveric renal transplant on 13 August 1975. He was started on enteric-coated prednisolone tablets and azathioprine. A few days later the patient showed evidence of a rejection and was given conventional treatment with pulse doses of methylprednisolone. However, 24 hours later he developed classical signs of an acute intestinal obstruction. A plain x-ray film of the abdomen showed aggregation of the enteric-coated tablets which had not been absorbed and were causing the obstruction. Intravenous fluid therapy and nasogastric suction were instituted and laparotomy was avoided. Parenteral prednisolone and azathioprine were commenced for the maintenance of immunosuppression. Approximately three days later the patient had relief of the intestinal obstruction and was able to take fluids orally. His medication was then changed to normal prednisolone and azathioprine.

This case illustrates that, although in some patients enteric-coated tablets are absorbed, in others they may be passed unabsorbed into the small intestine. In conditions in which the plasma levels of prednisolone need to be stable and predictable their use is unsatisfactory. We would agree that it is doubtful whether the coating of the prednisolone tablet prevents peptic ulceration and suggest that this effect may be due to non-absorption of the medication, with potentially dangerous effects.

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SIR,—In the paper by Dr R G Henderson and others (9 June, p 1534) the authors' use of enteric-coated prednisolone tablets to reduce peptic ulceration is referred to an observation reported 20 years ago.¹ I would like to make two comments.

Firstly, the observation applied only to a particular enteric coating that dissolved soon enough for the hormone to be absorbed before it was degraded. The BP enteric coating did not allow this, as others rediscovered to their cost years later.

My second comment is that I gave up such use of enteric-coated prednisolone tablets in favour of prednisolone phosphate tablets, taken dissolved in water, in 1963 and, following studies of the speed and completeness of their absorption, suggested their use for all children

and for adults with alimentary dysfunction.² (The highly soluble phosphate is absorbed rapidly over a wide area of mucosa and its clinical effect in rheumatoid arthritic patients is of similar duration to that following ordinary prednisolone.) The measurement of free corticosteroid hormones in urine, as a means of assessing their bioavailability, was recommended² and precise gas chromatographic techniques were subsequently described.³

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¹ West, H F, *British Medical Journal*, 1959, 2, 680.
² Bailey, E, Murphy, D, and West, H F, *Archives of Diseases in Childhood*, 1963, 38, 71.
³ Bailey, E, *Journal of Endocrinology*, 1964, 28, 131.

The surviving twin

SIR,—The question and answer (7 April, p 934) on psychological reactions in a surviving twin were of great interest to us, as we are concerned with a similar case at present.

This case, which is being described in more detail elsewhere, involved a surviving twin following a sudden infant death ("cot death"). The mother complained that the survivor was "possessed" by the spirit of the dead twin, and that this was causing his "naughty" behaviour. Psychiatric assessment disclosed that this was not a true delusional belief, but an explanation given by the mother in the face of difficult and unmanageable behaviour.

In fact, since the cot death two years ago, she had severely rejected the surviving twin. He was recently admitted to hospital when it was discovered that she was locking him up, and he was felt to be at risk. The problems of a very complicated domestic and social background could not be readily resolved and the child is now in foster care.

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Cervical cytology

SIR,—I was interested to read Dr R E G Sloan's letter (19 May, p 1356) concerning the reliability of technicians' reports on cervical smears. He complains that in one centre there were too many requests for repeat smears whereas in another comments were confined solely to the presence or absence of atypical cells.

In order to receive reliable reports it is essential that the specimens are collected correctly. A cervical scrape should include the squamocolumnar junction as this is an important site of origin of intraepithelial neoplasia. A satisfactory cervical scrape therefore must contain endocervical cells, usually in sheets. In only 5-10% of women, mainly those in the older age groups, the squamocolumnar junction is displaced and out of reach. While the absence of endocervical cells is of no particular importance in a "positive smear" a negative smear is unreliable unless endocervical cells are present and requests for repeat of such films are absolutely justified. I suggest that if Dr Sloan and his colleagues revise their smear-taking techniques the number of repeat smears will be drastically reduced.

With regard to his second complaint, I would like to point out that Dr Sloan confuses the task of the screener in population-screening centres with that of the cytopathologist, whose diagnostic scope extends far beyond the recognition of dysplasias and intra-epithelial carcinomas of the cervix. That the screeners are highly successful in their laborious efforts of reading large numbers of slides is evidenced by the declining incidence of invasive cancer of the cervix and its falling death rate. Incidental findings such as trichomonal, monilial, and herpetic infections are usually also reported but are not the main concern of the screener.

It is grossly unfair to submit buccal and nasal smears labelled as cervical scrapes to a screening centre and to expect the screener to recognise the ruse. The technician in the Gloucestershire laboratory would, in all probability, have rejected the smears and asked for a repeat—but then Dr Sloan complains about such a request. The Yorkshire laboratory stating that there were no malignant cells in the specimens submitted is probably right and Dr Sloan should feel reassured about the state of the epithelia in his buccal and nasal cavities.

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Blood transfusions and Jehovah's Witnesses

SIR,—Adult Jehovah's Witnesses, who refuse to receive blood and blood derivatives, may sign a form accepting full responsibility for their action. This release of medical and administrative staff from responsibility is acceptable so long as the patient is not subsequently rendered unconscious (and therefore unable to change his mind) by the administration of an anaesthetic for which he has given his signed consent. This consent should not be conditional on the non-administration of blood as it imposes an unacceptable burden on the anaesthetist, in whose care the patient has placed himself while unconscious.

I recently anaesthetised a Jehovah's Witness for an emergency caesarean section. During the procedure she developed diffuse intravascular coagulation and I had to abandon the unequal struggle with fluids and plasma expanders and resorted to fresh frozen plasma and 8 units of blood. The patient survived and she accepted, with regret, the need for the transfusion.

As often happens, a week later another Jehovah's Witness needed anaesthesia for examination for possible placenta praevia. When I gave an undertaking not to give blood except as a last resort, there was a hysterical response from both the patient and her husband with an absolute refusal of any blood under any circumstance. In the interest of the patient, I eventually made all the necessary promises and proceeded to anaesthetise her for examination and eventual caesarean section as I had done in the past—that is, agreeing not to give blood but prepared to do so if absolutely necessary.

Jehovah's Witnesses seem to be impervious to the problems they create for the nursing and medical staff (the anaesthetist in particular) by merely signing a quasilegal document. I therefore wonder whether I should carry on as in the past, and possibly be sued if I give blood when I consider it life saving, or whether I should also draw up and sign a quasilegal document agreeing to administer anaesthesia

without this absolute restriction. I would be grateful for a legal opinion and the view of any medical practitioners who are Jehovah's Witnesses.

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Medical reports and confidentiality

SIR,—I was interested to read the letter from Drs G B May and W P Garson (26 May, p 1427) and welcome the most enlightening reply from Dr David Gullick (16 June, p 1631). As a physician with an interest in life insurance medicine may I stress that the insurance company is only too anxious to give the patient the best possible deal—maximum cover for minimum outlay—and, further, that requests for medical attendants' reports are made as much for the benefit of the insured as the insurers. As Dr Gullick so rightly points out, this information is the property of the patient, who always gives permission for its disclosure.

On receipt of the request from the patient for insurance cover the underwriters' task is to assess any increased risk to life posed by past or present disease, and this may lead to an increased premium if the fit members of society are not to subsidise the unfit. Accurate assessment of risk may be difficult even when all the medical facts are known, but how much more difficult when they are not. In this latter situation the assessor may have to impose an extra for uncertainty, which might not exist were fuller information available. If there is any doubt about the histology of an excised lesion, the cause of an episode of jaundice, or whether the suicide attempt was genuine the premium may well be loaded; if on the other hand it is clear beyond doubt that the polyp removed was benign, that the jaundice was infective and not alcoholic hepatitis, or that the suicide attempt was just a simple call for help the premium may be normal or the loading minimal.

The medical examiner's report, although very helpful with regard to the current situation, cannot possibly give overall information to the same degree of accuracy as a medical attendant's report—particularly as the patient himself may be unaware of the exact nature of a previous illness. The insurance company is as concerned with the patient's welfare as is his doctor; and any general practitioner who refuses to disclose information requested by a Life Office for the purpose of insurance, far from helping his patient, may be doing him a positive disservice.

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Small hospitals and the nursing shortage

SIR,—I would like to draw attention to a parochial matter in north-west Surrey which could have serious implications nationally.

On Wednesday 30 May, the chairman of the medical staff of Walton-on-Thames Hospital received a telephone call from the district management team for north-west Surrey to say that from the following Sunday the women's ward of Walton Hospital would be closed for seven weeks. A similar call was received at the neighbouring Weybridge Hospital, with the added information that the casualty services at that hospital would be