improve the detection rate and possibly aid recovery as a result of early diagnosis and subsequent management.

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¹ Goldman, A, et al, *Journal of the Royal College of Physicians of London*, 1977, **11**, 291.

Rugby injuries involving the hand

SIR,—With reference to the letter (10 February, p 414) by Drs R W Nutton and M J Guy, it is not stated what kind of dislocations occurred. The common injury is the posterior one, which is usually no trouble; it is the anterior dislocation that is liable to cause rupture of the middle slip of the extensor tendon. This is not generally realised and is not in many of the textbooks. X-rays are not always taken after this injury, reduction being done on the spot; so it may not be known what type of dislocation occurred. So if after this injury a patient cannot fully extend the proximal interphalangeal joint, then he should be treated at once in a lively splint to prevent the Boutonniere deformity, which is a disabling and difficult condition to treat once it has developed.

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SIR,—With reference to the "Letter from Soweto" (17 March, p 739), allow me the following comments. First of all, I wish to state that I think this article is a reasonably fair account of the situation as it pertains at the present moment at Baragwanath, but certain statements do require revision in the light of recent events and perhaps others require some explanation.

I believe it is now a matter of record that salary discrimination among the medical profession in South Africa will soon be a thing of the past. I in fact expect that when this letter is published this will have already occurred to a large extent.

With regard to the hospital facilities, it is indeed true that there is an enormous demand for hospital beds for the black section of our community. In the light of what I have to say further on, the reason for this may become more apparent. Mr Sakalo is correct in stating that a new hospital has replaced the old Johannesburg General Hospital. What he has not mentioned, and perhaps did not know, is that a 2000-bed hospital is being built at the Medical University of South Africa, and that the University of the Witwatersrand medical faculty and also the University of Pretoria medical faculty in association with the Medical University of South Africa are involved in its implementation and its personnel development.

Finally, allow me to highlight several sentences in Mr Sakalo's final remarks. He states, "Many of the patients are treated for afflictions and diseases resulting from poverty and overcrowding." A little later he remarks "Malnutrition, in particular, is endemic among the black population and a study by the University of Pretoria has shown that 75 black children die of malnutrition every day." These two remarks should perhaps be seen in

the context of some other remarks he makes: "The maternity wards sprawl over 50 hectares of land and cope with a 2.7% birth rate, which is a rate higher than India's"; and a little further on he states, "Even in this modern day, in one of the most advanced black societies, witch doctors still retain a strong hold on the people."

While in no way trying to minimise our concern with the infant mortality rate and malnutrition (primarily a paediatric problem), the concerted effort by all the authorities to inculcate a concern for family planning programmes and for proper infant care and feeding has met with resistance from the major proportion of our black citizens who still cling to the old customs. I nevertheless believe that the programmes which have been instituted by our Department of Health and our faculties must ultimately bear fruit as the sophistication of our black peoples evolve.

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Schizophrenia or obsessive-compulsive neurosis?

SIR,—We were interested to read the case of Dettol addiction described by Dr J S Khan and others (24 March, p 791). The patient's psychiatric symptoms were a fear of acquiring syphilis, associated Dettol drinking to "purify" herself, and a morbid cleansing obsession, including use of Dettol-soaked pessaries. The patient was diagnosed as having a schizophrenic illness. Schizophrenia and obsessive-compulsive neurosis can be difficult to differentiate¹ and recent work² has suggested that resistance is not an essential feature of the latter, making the distinction even less clear. The limited description in the paper would certainly fit an obsessive-compulsive neurosis, which is usually amenable to behavioural treatment.³ If the patient died as a consequence of compulsive cleansing rituals—chronic ingestion of Dettol—this would be almost unique.

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¹ Stengel, E, *Journal of Mental Science*, 1944, **91**, 166.

² Stern, R S, and Cobb, J P, *British Journal of Psychiatry*, 1978, **132**, 233.

³ Marks, I M, Hodgson, R, and Rachman, S, *British Journal of Psychiatry*, 1975, **127**, 349.

Proteinuria at high altitude

SIR,—In your leading article (24 February, p 508) you discuss the physiological changes that occur on ascending to high altitude, with an emphasis on proteinuria. Some of the data reported are open to criticism.

Pines¹ reported studies on proteinuria in the early morning urine specimens of seven people climbing at heights of up to 5890 m. However, the urine protein was measured by an inaccurate method (Bili-Labstix), urine volumes were not taken into account, and there were insufficient data to allow any statistical correlation of proteinuria with altitude, exercise, or the development of acute mountain sickness. Rennie and Joseph² completed a more detailed study of proteinuria at altitude. They showed a good correlation of proteinuria and altitude, but again only early morning

urine samples were tested and an unsatisfactory correction for urine dilution had to be made.

During a recent expedition to the Himalayas³ 17 doctors and scientists collected 24-hour urine samples over a 14-day period during an ascent to 5500 m. In the group as a whole there was no correlation between proteinuria and altitude, although some individuals had an increase in proteinuria at altitude. Proteinuria was of no value in predicting and did not relate to the development of acute mountain sickness.

The effects of altitude on the body and the development of acute mountain sickness are difficult to study because of the large individual variation and problems associated with sample collection. However, progress will not be achieved by inadequate data collection and drawing unwarranted conclusions. For instance, there have been at least five controlled trials at altitude of the drug acetazolamide (which is widely considered to be of value in the prevention of acute mountain sickness); yet not one of these studies was well controlled under routine trekking conditions, and use of this drug cannot therefore at present be recommended.

At a recent symposium, shortly to be published,⁴ many clinical and biochemical aspects of altitude and acute mountain sickness were discussed. However, the mechanisms, early diagnosis, and prevention of the illness remain an open question.

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¹ Pines, A, *British Journal of Diseases of the Chest*, 1978, **72**, 196.

² Rennie, I D B, and Joseph, B, *Lancet*, 1970, **1**, 1247.

³ Birmingham Medical Research Expeditionary Society, October 1977.

⁴ *Postgraduate Medical Journal*, 1979, suppl, in press.

Nutritional intake, adiposity, and diabetes

SIR,—Professor Harry Keen and others (10 March, p 655) appeared surprised that, among their subjects, those with a high energy intake had less adiposity; they also had lower blood sugar concentrations and better glucose tolerance, and would be less likely to develop diabetes. High energy intakes had been associated with high intakes of total carbohydrate.

Professor J N Morris and his colleagues had also been surprised to record that among their subjects high energy intake had been associated with lower incidence of coronary heart disease; this had occurred in men eating more cereal dietary fibre, but not that derived from vegetables and fruit.¹ It would be helpful if Professor Keen gave us information concerning the dietary fibre in his diets: dietary fibre is an essential nutrient.

These findings do not surprise doctors who have worked in tropical Africa and observed a low incidence of obesity, diabetes mellitus, and coronary heart disease among those eating large amounts of lightly processed, high-fibre starch foods.² The dietary fibre hypothesis of diabetes mellitus has two aspects, even if only the first aspect is usually quoted. (1) Dietary-fibre-depleted energy foods tend to produce obesity and mature-onset diabetes in susceptible phenotypes. (2) Large amounts of high-fibre energy foods improve diabetes mellitus and obesity.