authors' conclusions include increased faecal loss of active metabolites, increased intestinal breakdown by side-chain cleavage,⁴ defective synthesis of binding proteins, and target-organ resistance. The last might result from impaired nutrition and/or atrophy such as is presumably associated with resistance to parenteral treatment in coeliac osteomalacia.⁵ Alterations in side-chain cleavage by liver or intestine⁴ might also produce target-organ resistance from accumulation of interfering vitamin D metabolites, and other circulating compounds (bilirubin, ammonia, etc) might also interfere with vitamin D activity.

If further studies do confirm the suggestion that patients with biliary cirrhosis may show true resistance to parenteral vitamin D then it is important that all the questions should be asked and critically evaluated, since consequent research may prove any one (or more) of them to be correct.

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¹ Krawitt, E L, *et al*, *Lancet*, 1977, 2, 1246.

² Stamp, T C B, Haddad, J G, and Twigg, C A, *Lancet*, 1977, 1, 1341.

³ Whyte, M, Stamp, T C B, and Haddad, J G, in *Endocrinology 1977*, ed I MacIntyre *et al*. In press.

⁴ Kumar, R, and DeLuca, H F, *Biochemical and Biophysical Research Communications*, 1977, 76(2), 253.

⁵ Nassim, J R, *et al*, *Quarterly Journal of Medicine*, 1959, 28, 141.

Household products and poisoning

SIR,—I was interested to see the paper by Dr Roy Goulding and others (4 February, p 286). I was not surprised by his findings, as the range of items included in the research are responsible for only about 16.5% of the poisonings from household products. If the research had been widened to include turpentine and white spirit, paraffin, disinfectant, surgical spirit, perfume, and alcohol he would have covered a further 35% of the problem.

Dr Goulding's conclusions are misleading in that he implies that the dangers of household products are being exaggerated. He does not say who he feels is exaggerating the problem. We would like to see more done to prevent poisonings from both medicines and household products.

While ingestion of these substances may well require no treatment, Dr Goulding makes no allowance for the distress to the child and his family that such an incident can cause. Prevention is still better even if no cure is needed.

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Glucagon levels and vagotomy

SIR,—Dr L V Campbell and others (10 December, p 1527) suggest that the glucagon peak expected during hypoglycaemia is absent in some diabetics because of vagal neuropathy. Russell *et al*¹ demonstrated that under similar conditions the glucagon rise was significantly less after truncal vagotomy than after selective vagotomy. These results implied that provided the coeliac and hepatic branches of the vagus remained functional a normal glucagon response to hypoglycaemia should be expected. It would seem therefore that glucagon assay during hypoglycaemia is

potentially an index of the selectivity achieved during vagotomy. This may prove useful in assessing and comparing operative techniques.

Dr Campbell and his colleagues suggest that increased glucagon release is essential for recovery from hypoglycaemia. Russell *et al* found no difference in the rise in plasma concentration of enteroglucagon (which stimulates insulin release but does not have the hepatic glycogenolytic/gluconeogenic capacity of pancreatic glucagon) after a glucose load between patients who had undergone truncal and those who had had selective vagotomy. Unfortunately they did not state if any patients suffered from "late dumping" or developed it after the glucose load.

Thus, postvagotomy and postprandially, enteroglucagon could stimulate insulin release and the low pancreatic glucagon level would be unable to offset the impending hypoglycaemia. Could this situation contribute to the pathogenesis of late (hypoglycaemic) dumping? Would it be of therapeutic value to attempt to raise postprandial glucagon levels in these patients?

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¹ Russell, R C G, Thomson, J P S, and Bloom, S R, *British Journal of Surgery*, 1974, 61, 821.

The new Sinbad syndrome

SIR,—I have read with interest and amusement the recent column "The new Sinbad syndrome" by our recent distinguished past president, Dr Peter Banks (18 February, p 423).

Dr Banks states that my observations regarding the growing "antigovernment paranoia" exhibited in his writing was "not becoming" to him. He also suggests that this change in the tone of his writings (a more basic, naked distrust of governments) does not indicate a progressively worsening paranoid state but rather a recognition of reality.

Verily, Peter, I did not suggest that your written observations on Canadian government, on how we are grossly overgoverned, our out-of-control Civil Service, the detrimental effect of these facts on life in general and medicine in particular, etc, were unbecoming or incorrect. I simply pointed out that if you continue to write of their existence in a systematic, albeit on occasion slightly exaggerated, fashion they are so extensive and grotesque that the resultant chronicle may jeopardise your credibility with UK readers.

The transmission of a message across the oceans is a very fragile operation more frequently requiring, and benefiting from, the approach and techniques of the neurosurgeon rather than those of the orthoped.

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Canadian Medical Association

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General practice expenses

SIR,—Our partnership has just received our audited accounts for 1976-7.

For the past two years our accountants have calculated the percentage of our costs against our income and the frightening situation now shows that this figure has risen to 45%, an increase of 10% over the past year. This figure does not take into account each partner's

personal expenses for his car and maintenance for emergency facilities in his own home.

We wonder how many of our fellow general practitioners have found it impossible to increase their banker's orders over the past three years? This is the sorry tale we have to tell, and the sad part about it is that it is not due to a static income—in fact our work load has increased, our numbers have increased, and extra work done has claimed extra fees. We have tried to look at the problem objectively, and in our particular case we feel that the three problems outlined below perhaps are responsible for this rather sad situation.

(a) Our local pathological laboratory is 26 miles away from here and all telephone calls made before 2 pm are at the high tariff rate. In 1975 our telephone costs were running at £1200, in 1976 they had risen to £1750, and now in 1977 the figure is £1960.

(b) Our heating expenses have risen by over 100% to £650 per annum during these past three years.

(c) Our maintenance costs—painting, replacement of carpets, etc—have risen from an average of £250 to £550 per annum.

This practice is an urban and rural one; 32% of its patients, approximately 1500, are over 65. Each partner interests himself in local organisations, among which are listed St John's, the Round Table, and the Lifeboat Institution, and each participates in the local welfare of this area. This year has seen a drop in our net income of £1000 for each of us; this now means that two of us have to have extended overdrafts because the cost of living and maintaining a family has risen by some 30% and yet our income in real terms has fallen by this amount.

We do not want to lower our standards of medical care and attention; we can only hope that the Review Body and the general public will realise just how serious our plight now is. Unless the Government can find ways and means of reimbursing us adequately then we must ask the question, "Where is it all going to end?"

A WEST COUNTRY GENERAL PRACTITIONER

Community Medicine Consultative Committee

SIR,—A very confused debate took place at the meeting of the Central Committee for Community Medicine held on 10 February.

It concerned the formal constitution and inauguration of the all-important Community Medicine Consultative Committee between the BMA, the Faculty of Community Medicine, and the Department of Health and Social Security. I regret to have to inform colleagues in community medicine that a formal constitution has not been agreed even after four years have elapsed since reorganisation, and it may not be clear from the report of the CCCM proceedings quite why this is so important.

I therefore urge all community physicians to question their regional representatives on this matter and to mandate them very clearly for the next full meeting of the CCCM on 12 May this year, when this subject will no doubt be discussed further. An early decision must be made.

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