The problems of diurnal variability and laboratory variation in the measurement of plasma urate are real ones, as Mr Dunlop and Mr Davison clearly state. The former problem is not so important if blood is taken at a consistent time of day (in the morning in our study); and the latter problem can be reduced if repeated readings are demanded before a rise is accepted as real (three consecutive measurements in our study). By adopting these precautions we were able to identify a group with platelet count changes suggesting early consumption and consistent with the hypothesis that this is characteristic of the early onset of pre-eclampsia.

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Rubella vaccination

SIR,—May I raise again the question of our policy on rubella vaccination?

The Department of Health and Social Security issued a circular letter CMO 76-4 in February 1976 reaffirming the policy of directing the immunisation programme at girls between their 11th and 14th birthdays and susceptible groups of women of child-bearing age. It was admitted that this policy had not resulted in any decrease in the incidence of congenital rubella. Recent serological surveys had shown that about 10% of young women were susceptible compared with about 20% before the vaccination programme began in September 1970; the acceptance rate of rubella immunisation was between 70 and 75% and no further significant reduction in the proportion of susceptible mothers was expected until the 1980s.

It is known that the protection afforded by rubella vaccination lasts for at least eight years and probably for very much longer. In view of this, should we not reconsider changing our policy and aim at the elimination of outbreaks of rubella by the routine vaccination of all children, boys as well as girls? Obviously the girls would still receive individual protection, and the growing practice of screening pregnant women for rubella antibodies and offering immunisation after delivery to those found to be susceptible could continue with advantage.

The Joint Committee on Vaccination and Immunisation should be asked to look at this again.

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Coronary heart disease and male sex hormones

SIR,—Several authors (25 February, p 472; 1 April, p 851) have recently presented indirect evidence suggesting that male sex hormones contribute to men's higher risk of coronary heart disease. However, several older investigations provide evidence against this hypothesis. Castration of teenage boys and young men apparently does not cause a significant difference in death rates from

cardiovascular disease.¹ Castration at older ages is not associated with any change in coronary atherosclerosis.² A comparison between young men who had recovered from a myocardial infarction and age-matched controls showed no significant differences in serum concentrations of testosterone or dihydrotestosterone.³ No consistent differences in the masculinity of body characteristics have been found in comparisons between young men who have coronary heart disease and controls^{3,4}; there were no significant differences in balding or in overall body hair, and observed differences in body form could for the most part be attributed to the greater obesity of the subjects with coronary heart disease. These observations suggest that male sex hormones are not a major cause of men's higher rates of coronary heart disease.

Other evidence indicates that major causes of men's elevated coronary heart disease mortality are men's higher rates of cigarette smoking and of the hard-driving coronary-prone behaviour pattern.^{5,6}

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¹ Hamilton, J B, and Mestler, G E, *Journal of Gerontology*, 1969, **24**, 395.

² London, W T, et al, *Annals of Internal Medicine*, 1961, **55**, 63.

³ Phillips, G B, *Lancet*, 1976, **2**, 14.

⁴ Gertler, M M, and White, P D, *Coronary Heart Disease in Young Adults*. Cambridge, Harvard University Press, 1954.

⁵ Waldron, I, *Social Science and Medicine*, 1976, **10**, 349.

⁶ Waldron, I, *New England Journal of Medicine*, 1978, **298**, 57.

Cetiprin (emepronium bromide) in patients with prostatism

SIR,—In the advertisement for Cetiprin (emepronium bromide) on the inside back cover of the *BMJ* dated 15 April the manufacturers, KabiVitrum, state under "contraindications and precautions": "Whilst emepronium bromide is indicated in the early stages of prostatic enlargement with urinary frequency, it is contra-indicated in later stages with flaccid bladder and large amounts of residual urine." In *MIMS* the contra-indications listed are advanced prostatic hypertrophy, with special precautions in patients with glaucoma and gastric retention.

I wonder if many urologists would recommend suppressing bladder activity in patients with prostatism. There is an obvious danger that the reduced bladder awareness and activity achieved by this form of treatment may well lead to increased residual urine. My own view is that emepronium should be prescribed only for patients who are not in danger of developing residual urine. I would hope that a warning to this effect may be included in subsequent advertisements.

ERIC GLEN

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*.*Mr Glen sent a copy of his letter to the manufacturers of Cetiprin, whose reply is printed below.—Ed, *BMJ*.

SIR,—Mr Glen rightly questions the use of emepronium bromide in patients with prostatic hypertrophy who are likely thereby to develop undesirable levels of residual urine. While we accept Mr Glen's comments as being con-

structive, it would, I feel, be wrong to regard prostatism, even in its earliest stages, as an absolute contraindication to emepronium therapy.

It is well known that even a small obstruction to the vesical outlet can increase bladder irritability, resulting in impaired control, frequency, and uninhibited bladder contractions. The balance between the degree of obstruction to the bladder outlet and the efficiency of the neuromuscular mechanism is important. Although large quantities of residual urine may be found in association with inefficient voiding contractions, it is possible that emepronium bromide can, by blocking involuntary uninhibited contractions and restoring normal detrusor-sphincter balance, improve bladder function and thereby reduce the amount of residual urine. I will be happy to refer Mr Glen to several urologists who hold this point of view.

ALLAN D LAUDER
Medical Director
KabiVitrum Ltd

London W5

Stricture of oesophagus associated with ankylosing spondylitis

SIR,—The letter from Mr A M Hay (4 May, p 1138) concerning a stricture of the oesophagus associated with ankylosing spondylitis is interesting but does not mention the association between spondylitis and Crohn's disease. The latter may present as dysphagia and strictures can develop.^{1,2} This may well have a bearing on this case.

A P WEETMAN

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¹ Gelfand, M D, and Krone, C L, *Gastroenterology*, 1968, **55**, 510.

² Dyer, N H, et al, *Gut*, 1969, **10**, 549.

Is pancreatic isotope scanning worth while?

SIR,—It was interesting to have comments from Dr H J Testa and his colleagues (18 March, p 720) on our paper (4 February, p 282) concerning isotope scanning of the pancreas since Manchester must be one of very few centres with an interest in pancreatic diseases still apparently relying on the technique; indeed, can they tell us of any other in Britain or overseas?

Their own data on 200 patients confirms everyone's experience that abnormal scans are meaningless; of 107 patients with abdominal scans, 49 proved to have no pancreatic disease. Thus only 93 (the normal scans) of all their 200 studies could be of any clinical value, even if they were all correct. The Manchester false-negative rate was certainly lower than ours, but even they were only able to detect 64% of patients with a normal pancreas, which seems rather poor for a screening test. Scans of all types are in demand if they are clinically useful; indeed many are requested even when they are not. Isotope scanning has been available for many years. From our own experience and the reported survey of nuclear medicine departments it is quite clear that pragmatic clinicians have now discarded the technique; it is just not worth asking for.

There is now no shortage of alternative diagnostic techniques for the pancreas. Most are complex and expensive, but grey-scale