Pathological Consequences," the other "Prostaglandins—an Experiment." The first was from authors in the Departments of Geodesy and Geophysics and of Applied Mathematics and Theoretical Physics at Cambridge, describing the misuse by reprint-requesters of key words such as those in the title of their letter; the second was from me. In each case, the authors gave their previous experience as victims in the reprint game and made it quite clear that one object of their letter was to fool some of the culprits. In my case at least the results were as expected. Although the letter specifically asked the reader not to send for a reprint, more than 100 cards arrived as always, mostly from the USA.

I submit that the only reprint request cards that should not be immediately thrown away are those from people you know to be interested or who may have difficulty in seeing the original and those bearing interesting postage stamps.

V R PICKLES

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Cardiff

SIR,—Unlike the baffled Dr J W Todd (22 January, p 231) and the exasperated Dr E Elkan (5 February, p 382) I enjoy receiving reprint request cards. They lift morale, even though one knows that the quality of the article and the number of requests are inversely related. Some, albeit a diminishing number, carry attractive stamps and how else would I have heard from "Aesculapius"? No address, but that is the joy of these cards because a reply is not expected. To do so would only baffle the recipient and exasperate his secretary: the one confused by an obscure printed message from a stranger and the other irritated because her filing system contains no copy of the request she made.

No, they are simply messages of good will and hence mainly of North American origin. They must not be confused with the reasoned letter that merits a courteous response.

R FINLAYSON

Cuffley, Herts

Misuse of statistical methods

SIR,—Since it appears possible to confuse the random variable measured by Miss Sheila M Gore and others (8 January, p 85) in table I with the category of error discussed by them in the text perhaps they are guilty of a "category I error." The possibility of confusion arises from a confusing description of the variable whose histogram is given in the table.

I A KINSELLA

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Blood pressure measurements in SI units

SIR,—Further to the letter from Professor David Kerr (15 January, p 167) the attention of the medical staff of the North Tyneside Area Health Authority was drawn to the annotation by Dr. W Lees in *Health Trends*¹ indicating a potential change in blood pressure measurement to SI units, and it was unanimously agreed that this change should be resisted.

We trust that all other Cogwheel organisations of similar view will indicate this to the DHSS, since, as indicated by Professor Kerr, it is not the custom of the DHSS to invite the views of practising doctors before instituting changes of this nature.

I O B SPENCER
Chairman,
Medical Staff Committee

Preston Hospital,
North Shields,
Tyne and Wear

¹ Lees, W, *Health Trends*, 1976, 8, 105.

***As Dr Lees points out in his annotation, the DHSS is bound by the decisions of the European Commission. In view of widespread objections from the medical profession the Commission has already postponed the date designated for replacement of the millimetre of mercury by the kilopascal for the measurement of blood pressure from December 1977 to 31 December 1979. In the meantime the Commission is to consult the World Health Organisation, in the light of whose advice a final decision will presumably be made.—ED, *BMJ*.

Future of child health services

SIR,—I feel I must write to support Dr J B Wilson (5 February, p 375) in his concern over the future of the child health services.

While there must be few who have read the Court Report¹ completely, the conclusions are well known. I am particularly worried about the proposal for the creation of a general practitioner paediatrician (GPP).

My main anxieties are, who will be the ordinary GP of the future? What will be his role? Will we be able to get on to the "paediatric list" in the same sort of way as the "obstetric list"? Surely the creation of a GPP will fragment general practice and create a specialty in primary care with exclusion of the one person who really knows what is going on—namely, the GP.

General practice has been built up on total care of the patient as a person, as a member of a family, living in a community. Such knowledge becomes an essential part of management of patients. How often are recurrent abdominal pains in children related to parental anxieties over such things as imminent redundancy or illness within the family? How can a specialist GPP ever come to realise these problems without knowing how to look after people and not conditions?

No, sir, we must resist the creation of a new grade in general practice. We must resist the fragmentation of general practice into numerous specialties "which the other chap must deal with." By all means let us improve out knowledge in these fields, but please let us look after *all* the family.

J C OAKLEY

Gravesend, Kent

¹ Committee on Child Health Services, *Fit for the Future*. London, HMSO, 1976.

SIR,—Whether or not "failed specialists" make poor general practitioners (Dr K J Bolden, 29 January, p 92)—and what dispassionate and objective evidence is there that this is so?—is irrelevant to the arguments advanced in the Court Report¹ for the GP paediatrician. On the other hand morbidity and mortality data suggest that hospital medicine has achieved

its maximum impact on, for example, infant mortality. Logically, if an investment is to be made in primary medical care as a way to improve such indicators and increase the general standards of child care, then general practice must provide evidence that it will be able to meet the challenge. Before condemning Court perhaps our academic departments of general practice should be asked to suggest suitable alternatives. If anything, the report may underestimate the amount of formal paediatric training required for general practice, as indeed do some vocational training programmes.

Eight years as a GP (paediatrician) in Livingston New Town have not, in my experience (and that of my colleagues with other specialty interests), been blighted by interpersonal difficulties about patient management, nor have they been characterised by depersonalised patient care; very much to the contrary, a truly continuous and longitudinal approach to care has and is being constantly developed. No one can dispute that this is essential for the care of children. Dr Bolden should not be too hasty to condemn the report. General practice can hardly afford not to accept the challenge it offers.

W J BASSETT

Livingston, W Lothian

¹ Committee on Child Health Services, *Fit for the Future*. London, HMSO, 1976.

Henoch-Schonlein purpura due to food sensitivity

SIR,—In your recent leading article on Henoch-Schönlein purpura (22 January, p 190) you omitted to mention the relationship of this clinical condition to food and drug hypersensitivity. This relationship has been well documented in the literature¹⁻³ and reinforced in my mind by the occurrence of this condition as a manifestation of apparent fish hypersensitivity in a recent inpatient at this hospital.

A 66-year-old white man presented with a macular purpuric rash over the lower limbs, lower abdomen, and arms associated with subcutaneous oedema, effusions into both knee joints, and recurrent abdominal pain with the passage of several black, tarry motions, the last one being two days before admission. His only other clinical problem was acute-on-chronic bronchitis, for which he was taking Amesex (containing aminophylline, ephedrine, and amylobarbitone) and Benlyn (containing diphenhydramine, ammonium chloride, sodium citrate, chloroform, and menthol). He was a non-smoker and a non-drinker. During his stay in hospital he had no evidence of either macroscopic or microscopic haematuria and his basic biochemical and haematological parameters were normal, apart from a leucocytosis and raised erythrocyte sedimentation rate probably due to his acute-on-chronic bronchitis. Platelet counts, Hess test, and coagulation profiles were all within normal limits. The antistreptolysin O titre was normal and showed no significant change on two subsequent analyses. Sputum cultures grew commensals only.

Nothing was clearly implicated as a precipitating factor in the initial episode, although obviously the respiratory infection must be considered. The patient himself felt that it might have been either a meal of plaice or a chicken and mushroom pie consumed several days before the onset of the rash. There was no history of a sore throat. There was no doubt, however, that on two consecutive Friday evenings during his stay, after the consumption on each occasion of a fish meal, fresh "showers" of purpura appeared over

the legs and abdomen. No further outbreaks occurred after the exclusion of fish from the diet. Of questionable significance is the finding of moderate skin-test reactions to fish, shellfish, cheese, milk, grasses, house dust, and dust-mite despite the absence of a history of any atopic reactions in the past at all.

B W S ROBINSON

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- ¹ Jensen, B, *Acta Medica Scandinavica*, 1955, **152**, 61.
² Alexander, H L, and Evermann, E H, *Archives of Dermatology and Syphilology*, 1927, **16**, 322.
³ Ackroyd, J F, *American Journal of Medicine*, 1953, **14**, 605.

Mucocutaneous lymph node syndrome

SIR,—Your leading article (12 February, p 407) on mucocutaneous lymph node syndrome (MLNS) came out a week after we had diagnosed our first case at this hospital. The purpose of this letter is merely to report that it is undoubtedly occurring in England.

The patient was an 18-month-old West Indian boy and the findings were so striking that we do not think we could have missed it before. In fact the description in your leading article of a typical case is such that we could use the wording to describe our patient. He became acutely ill with fever, dry lips, red mouth, and a strawberry tongue. Some three days later he developed a rash over his hands and feet in a glove-and-stocking distribution. The skin became indurated and oedematous (though only for a short period was there pitting). The skin of his fingers and toes then desquamated, like the cast of a snake's skin rather than in small flakes. He had cervical adenitis which did not suppurate and investigations showed polymorphonuclear leucocytosis and raised ESR, but all other tests for specific infection, including viral, were negative. The illness has lasted some three weeks and he is steadily recovering now.

If, as you say, this is a new disease we clinicians should be aware of it. If the features are as striking as our case it is unlikely that we shall miss them.

J W SCOPES
J A HULSE

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St Thomas's Hospital,
London SE1

Pancreatic diagnosis

SIR,—We were sad to read how unlucky Dr P B Cotton and Dr R B Stern (15 January, p 166) have been in their experience of pancreatic radioisotope scans. With such results one would indeed conclude that scanning has no value. However, reviewing the literature recently,¹ we found no other results as poor and, in our hands, scanning has consistently shown a low false-negative rate. Spencer *et al*² have reported similar experience in a district general hospital service.

Grey-scale ultrasound offers greater potential in distinguishing between carcinoma and chronic pancreatitis. However, identification of the normal pancreas can be difficult and a significant incidence of false-negative results has been reported—at least 10% in carcinoma of the pancreas³ and somewhat greater in chronic pancreatitis.⁴ Thus in the absence of further evaluation ultrasound alone cannot be relied upon in excluding pancreatic disease.

We value radioisotope scanning in avoiding dependence on clinical judgment and endoscopic pancreatography (ERCP) alone. As a screening test we feel it can avoid subjecting to ERCP a considerable proportion of patients with a normal pancreas. Ultrasonography can similarly play a vital role in avoiding the hazards of ERCP in a patient with a pseudocyst.

Although Drs Cotton and Stern say that recurrent pain and hyperamylasaemia characterise chronic pancreatitis with a normal pancreatogram, we did not detect a raised serum amylase in our two patients with this combination (27 November, p 1307).

We are by no means satisfied with our diagnostic abilities in pancreatic disease. Our recommendations are based on an attempt to minimise patient discomfort and to achieve the best overall yield from currently available tests.

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E ELIAS
J E AGNEW

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- ¹ Agnew, J E, Maze, M, and Mitchell, C J, *British Journal of Radiology*, 1976, **49**, 979.
² Spencer, A M, *et al*, *British Medical Journal*, 1974, **4**, 153.
³ Hancke, S, *Journal of Clinical Ultrasound*, 1976, **4**, 223.
⁴ Doust, B D, and Pearce, J D, *Radiology*, 1976, **120**, 653.

Cardiomyopathy after gonadotrophin treatment

SIR,—We have recently observed two brothers who developed a cardiomyopathy which in both was fatal after a relatively short time. Both had received injections of human chorionic gonadotrophin for undescended testes earlier in their lives and we wonder whether there is a causal connection between these two events.

In 1964 the younger brother was found to have an undescended right testis at the age of 7½ years. He was treated with injections of chorionic gonadotrophin 1000 IU intramuscularly weekly for 12 weeks. This failed to bring the testis down and he therefore underwent orchidopexy at the age of 9. At this time (1967) his older brother, who was then 12, was found to have undescended testes too, and he received the same course of hormone treatment.

At the age of 19 the older brother developed heart failure with paroxysmal tachycardia and numerous haemoptyses, and in spite of intensive treatment died of intractable heart failure in 1974. At post-mortem the heart was found to be grossly enlarged. Both ventricles were markedly dilated and hypertrophied and the myocardium appeared fibrotic to the naked eye. There was no valvular abnormality or endocardial fibrosis and the coronary vessels were normal. Histological examination showed only areas of fibrosis scattered throughout the myocardium with the muscle fibres themselves apparently normal. Examination of some skeletal striated muscles showed no abnormality. There were no other useful findings.

At the age of 18 the younger brother developed gross heart failure with generalised heart enlargement, and in spite of treatment he steadily deteriorated. He had recurrent attacks of supra-ventricular tachycardia which were first controlled with beta-blocking agents. However, in spite of intensive medication his condition steadily deteriorated and the arrhythmias became uncontrollable. He died in May 1976 and the post-mortem findings were essentially identical with those of his brother.

None of the four sibs (3 boys and 1 girl) show any evidence of cardiomyopathy so far; none of them has received hormone injections. The parents are healthy and there is no family history of cardiomyopathy or any other

cardiac disorder. We have reported the two case histories to the Committee on Safety of Medicines and would be interested to know of any others which may resemble them.

We are grateful to Dr Dennis Deuchar, physician in charge of the cardiac department at Guy's Hospital, for his advice on reporting these two cases and for supplying us with the post-mortem findings.

T W I LOVEL
G D PORTER

Andover, Hants

Rubella reinfection?

SIR,—Dr J A M Snijder and others (1 January, p 23) report two cases of suspected congenital rubella in which the diagnosis was established by demonstration of rubella IgM antibodies in cord blood. In their comments the authors state that "Case 2 was probably a case of reinfection." In this connection they refer to a report by us. We should like to stress that, as reported later,^{1,2} our case was not one of reinfection. The low haemagglutination inhibition (HI) activity in the first serum specimen from our patient was first thought to be due to antibody, since the activity was recovered in the IgG-containing fractions after sucrose gradient centrifugation. Later, when we performed flotation centrifugation, the HI was shown to be due to a lipoprotein, being accordingly a non-specific inhibitor.³ The possible occurrence of residual inhibitors by conventional procedures was further studied by one of us.⁴ It was shown that the heparin manganese chloride procedure did not remove very low density lipoprotein and high density lipoprotein, which are rubella haemagglutination inhibitors.³ Kaolin removed inhibitors more efficiently but failed occasionally, as in our reported case.

It would be of interest to know if Dr Snijder and his colleagues have considered the possibility of a false-positive reaction.

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Bergen, Norway

- ¹ Haukenes, G, *Acta Pathologica et Microbiologica Scandinavica, Sect B*, 1973, **81**, 719.
² Haukenes, G, Haram, K, and Solberg, C O, *New England Journal of Medicine*, 1973, **289**, 429.
³ Blom, H, and Haukenes, G, *Medical Microbiology and Immunology*, 1974, **159**, 271.
⁴ Haukenes, G, and Blom, H, *Medical Microbiology and Immunology*, 1975, **161**, 99.

Geriatricians v psychogeriatricians

SIR,—When and how is the conflict between psychogeriatricians and geriatricians going to be settled?

There comes a time when the elderly demented patient requires long-term care. The often infirm relatives are unable to cope despite district nursing, bath attendants, day hospital care, sheet cleaning services, home helps, and meals on wheels; but the general practitioner is told that long-term care is not indicated or even unavailable.

Psychogeriatric wards are unwilling to accept a patient with any medical condition greater than an ingrowing toenail, but geriatric wards are reluctant to accept any patient who exhibits even a little confusion. As a result the