cogent arguments would have to be advanced before it is to be abandoned.

We suggest, therefore, that the general practitioner paediatrician should not be established but that the consultant community paediatrician is essential to support the primary health care team.

D ROY

Department of Surgery,
Queen's University,
Belfast

REX FENDALL
F M SHATTOCK

Department of Tropical
Community Health,
Liverpool School of Tropical
Medicine,
Liverpool

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

SIR,—Resistance to the Court Report¹ is crystallising. It is time that the silent majority who do most of the work are heard.

The general practitioner members of this district's medical committee, representing 105 of their colleagues, welcome the proposal that child services should be based on primary care teams. They endorse the suggestion that more and better trained individual GPs should be involved in this work. They are totally opposed to the concept of the general practitioner paediatrician.

The report is ill balanced. Inspection of its membership reveals the flaw; these are big-city paediatricians talking big-city paediatrics. My colleagues can each find, on average, only five cases a year to refer to the paediatric outpatient department. Is this the picture painted? Statistics can prove anything, but interpolate Buckinghamshire in the infant mortality graph and we are among the best in Europe. This cuts no ice with us. We are not complacent, but equally we are not prepared to have our practices totally disrupted in pursuit of illusory benefits.

Your correspondence has already demonstrated the opposition to turning GPs into petty specialists. We would go further. We do not believe that 40% of GPs want to become part-time school medical officers. We do not believe that 60% of GPs are prepared to lose their young patients. We do not believe that many married women clinical medical officers (or their husbands) will accept the disruption of family life which goes with the GP's commitment to night, weekend, and holiday duties. Do they want Mum out working on Christmas Day?

Most of our larger practices are already part-way to Court, but by no means all are willing or able to go further. In the medium-sized the artificial barriers will disrupt the smooth day-to-day work-sharing which is so essential to harmonious working. The small practices, unable to accommodate a GPP, will inevitably tend to lose their young patients by drift to their competitors. We are not prepared to have our patients treated by competitors from other practices.

The report glosses over the fact that taking in an additional partner means a drop in income to the sitting tenants. For all their merits, redundant clinical medical officers in mid-career are not necessarily the first choice. The totally child-orientated health visitor is seen as a retrograde step. Children are individual members of a community. They cannot be isolated.

The nettle of finance is not grasped. Our 44 GPPs with appendages, even if only half came from new sources, would need an additional £365 000 a year. And what about the morass of committees? The mind boggles. We have equally pressing priorities stretching far beyond the likely provision of finance for the foreseeable future.

Finally, to quote what must be the crashing cliché of all time, "Tomorrow's services are for tomorrow's children." At this rate they will remain so.

There is much good in the report. It would be a tragedy to discard it altogether. The only practical solution, capable of immediate implementation, is to attach child health practitioners to primary health care teams on a part-time assistant basis, paid by the area health authority.

JOHN McLUSKIE
GP Member,
Wycombe District Management Team

Great Missenden,
Bucks

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

Amendment of Abortion Act

SIR,—Supporters of the Abortion Act (Amendment) Bill disguise their hostility to abortion as the cleaning up of so-called profit-making pregnancy advisory services. This intentional muddle must not obscure the fact that some kind of clinical pregnancy advisory service, advertising open access and preferably run by the NHS, is essential to supplement the normal route to NHS abortion through the general practitioner.

To my amazement the opponents of abortion seemed put out in the House of Commons debate on 25 February because the absolute number of abortions is falling, but even they must agree that abortions should be performed as early in pregnancy as possible. A pregnancy advice service increases the likelihood of early rather than late abortions for the following reasons:

Early diagnosis—Not all general practitioners do on-the-spot urine pregnancy tests in the surgery (though there is no reason why they should not). With a national rate of only five or six abortions per GP per year, expertise in confirming very early pregnancy by examination is not easy to acquire. Both result in delay.

Experience in obtaining NHS abortions—Considerable knowledge of the local consultants' individual views and booking systems and expert secretarial assistance are often needed to find an early NHS appointment. Many GPs refer patients to the charitable abortion agencies for this reason.

Public access—Some women, particularly young women, delay because they do not know where to go for help. Clinics may advertise. Some women know their family doctors are opposed to abortion, and need alternative help.

Local family planning clinics can meet all these criteria and are ideally placed to integrate pregnancy advice with their service, as many now do. Brook Advisory Centres, for example, have done so for the past five years. At the London Brook centres only one in 10 of our 15 000 clients a year is pregnant and seeking an abortion, or less than one per doctor session. The remainder come chiefly for contraception. The additional work is not difficult to absorb in the ordinary session. Women who come saying they want contraception and turn out to be pregnant can be helped on the spot. Women who come fearing they are pregnant and are relieved to find they are not can be promptly helped with contraception at a time when their motivation is high. Women referred by us for

abortion can be given long-term support and contraceptive aftercare, and most come back for this help. Wherever possible, of course, we work closely with the GP.

Why should not the family planning clinics leave this work to the charity abortion agencies, already doing it so well? The family planning clinics, like most of the Brook centres, are financed by the NHS and could provide a free service. The large number of family planning clinics makes the service accessible both for pregnancy advice and for long-term contraceptive aftercare. The efficiency of the charity pregnancy advisory services depends on speedy referral to charitable nursing homes which must charge a fee and which enable the NHS hospitals to get away with inadequate abortion facilities. The family planning clinics like Brook, which has no nursing homes, would be trying to obtain NHS appointments and using the charitable sector only where they failed. Adopting this policy in Brook we succeeded in obtaining NHS appointments for only half our clients in 1976 in London, demonstrating the true lack of NHS provision. And finally, the family planning clinics must help women who want abortions because the women are already there in the clinic, asking for help, and too often being turned away even before they see the doctor.

CAROLINE WOODROFFE
Chairman,
Brook Advisory Centres

London W1

Drug promotion

SIR,—The criticism by Dr L F Prescott of the advertising for Fortral (pentazocine) (26 February, p 574) is unjustified.

The full paragraph in the advertisement referred to states: "The alternative is Fortral injectable. With Fortral, the disadvantages are unlikely to be of the same degree as those of the opiates. And, of course, with Fortral, there are no MDA restrictions. Fortral means not only relief from severe pain for your patients, but also relief from the disadvantages usually associated with the opiates." As Dr Prescott notes, the disadvantages of the opiates which are referred to include nausea, vomiting, smooth muscle effects, and respiratory depression. As the advertisement states, these disadvantages are unlikely to be of the same degree as those of the opiates.

We do not claim that pentazocine is not a respiratory depressant. It should be noted, though, that investigations in the Department of Anaesthetics at the Royal Infirmary, Edinburgh, led the authors to state: "It would therefore appear that pentazocine is a much safer drug in respect to respiratory depression than pethidine particularly when repeated injections are to be given—for example, post-operatively or in obstetric practice."

In supporting his statement that "in larger doses it can cause apnoea" Dr Prescott refers to a publication of which he was a co-author.² The paper describes the use of naloxone in the treatment of drug overdosage and specifically refers to one case of reversal of "severe pentazocine intoxication." The fact that pentazocine is a central nervous system depressant which in overdosage may cause a fatal depression has never been concealed. Indeed, Winthrop Laboratories markets Narcan (naloxone) in the UK and one of the primary claims is that it "differs from earlier

antagonists in its ability to reverse the effects of pentazocine (Fortral)."³

Finally, I would point out that the data sheet for Fortral which is contained in the readily available *ABPI Data Sheet Compendium 1977* refers to respiratory depression both following normal dosage and following overdosage. The text referring to overdosage goes on to describe the appropriate treatment of such respiratory depression. This information would be supplied to any doctor who responds to the statement in the advertisement that "full prescribing information is available from Winthrop Laboratories."

J B SPOONER

Winthrop Laboratories,
Surbiton, Surrey

¹ Davie, I, *et al*, *British Journal of Anaesthesia*, 1970, **42**, 113.

² Evans, L E J, *et al*, *Lancet*, 1973, **1**, 452.

³ Advertisement, *British Journal of Anaesthesia*, 1977, **49**, xx.

Why I hate the BMJ

SIR,—Having fallen behind with my review of journals I now face a large pile of volumes to be read. I receive many other weekly, monthly, and quarterly publications so that even to scan the titles is a time-consuming task. However, none compares with the *BMJ* in its relentlessly abundant flow of clinically relevant articles. Compelled to read, I can seldom glance and file away. I offer my reluctant congratulations on this double-edged achievement.

JAMES R PHILP

Department of Medicine,
Bowman Gray School of Medicine,
Wake Forest University,
Winston-Salem,
North Carolina

The reprint game

SIR,—Having retired in 1961, having published many papers since then, and having usually had no departmental help in complying with reprint requests, I can add some comments on this chore to those of your correspondents. None of them has mentioned that, although photocopiers can reproduce text, their idea of a photograph is only a faint wraith. Authors of papers in which illustrations are important should therefore regard these requests with special tolerance. Among other deserving categories are those from friends and others who are known to be interested in the subject of the paper, those in the form of personal letters, those bearing detachable stickers with the return address or attractive postage stamps, and those occasioning mirth. These are rare, but I include two, from well known institutions in Washington and Chicago, evidently sent by secretaries who took the name of the little road in which I then lived for an abbreviation and addressed me at "2 Cross Pathology."

Categories of less deserving requests are, alas, far more numerous. Some are for publications of which one has no reprints, ranging from trivial letters in one of the weeklies to entire chapters in books. Some bear only illegible signatures (does one address the man as "Squiggle" or cut his signature off and glue it to the envelope?) or a name and address applied with a rubber stamp so parsimoniously inked as to give a barely legible impression. Unexplained requests for two or

more reprints I resent; I have been asked for as many as seven. When stocks are low one tends to favour MDs in preference to members of some paramedical departments who seem unlikely fully to understand one's subject (according to the letters after their names such correspondents in the United States are often either able seamen or bachelors of surgery). Lastly, a plea on behalf of those who have to address hundreds of envelopes themselves; *please* simplify your address. I have recently been faced with one of seven lines, the second and third being:

Department of Pharmaceutics—School of
Pharmacy, Pharmacokinetics,
Clinical Pharmacokinetics Laboratory.
Could tautology go further?

LAWRENCE P GARROD

Wokingham, Berks

SIR,—I have just received from Finland a printed postcard request for a reprint of my "article" "The reprint game" (22 January, p 231) and any other reprints of a similar nature.

JOHN W TODD

Frimley Park Hospital,
Frimley, Surrey

Atrial fibrillation in the elderly

SIR,—There still remains considerable confusion about the management of atrial fibrillation in the elderly and Dr E B Grogono (12 February, p 444) is quite right to question the role of digoxin in the treatment of this dysrhythmia.

Much of the confusion exists because of failure to understand the underlying pathology of atrial fibrillation and its natural history in the elderly. It has been known for a very long time that atrial fibrillation may be associated with both rheumatic heart disease and thyrotoxicosis—indeed, in the latter condition atrial fibrillation is almost invariably present in those over 70 years of age. But by far the commonest cause of atrial fibrillation in the elderly is degenerative change in the sinoatrial node, and in its natural history and management this condition is altogether different from atrial fibrillation occurring in younger people and associated with other conditions.

The onset of "degenerative" atrial fibrillation may be quite symptomless and in the early stages is frequently intermittent. About 5% of people over 70 in the community have atrial fibrillation when screened by 12-lead electrocardiograms (ECGs) and about 10% of these can clearly be shown to have intermittent atrial fibrillation.¹ It is likely that the true incidence of intermittent atrial fibrillation is very much higher than this in the elderly, and this could be shown by 24-h ECG monitoring tapes.

Many patients with atrial fibrillation have a slow ventricular rate, and this probably is the case in at least a third of all elderly fibrillators; these require no treatment. If the ventricular rate is rapid, then treatment is indicated. If cardiac failure is present diuretics together with small doses of digoxin should be given, and in many patients this drug can be tailed off after the heart rate has been controlled and any intercurrent illness treated.² If there is no evidence of heart failure digoxin is not essential and beta-blocking agents can be used, occasionally with a diuretic. Other anti-

arrhythmic agents may also be tried if beta-blocking drugs are unsuccessful, but I would certainly not advise the use of direct current shock for the treatment of paroxysmal atrial fibrillation as suggested by your expert (1 January, p 42). There is no reason to believe that atrial fibrillation in the elderly is harmful¹ or indeed permanently reversible, and all that require treatment are episodes of heart failure and tachycardia. The dangers of digoxin are so great in the elderly that its use must be very carefully reviewed.

ANTHONY MARTIN

Horsham Hospital,
Horsham, Sussex

¹ Martin, A, MD Thesis, University of London, 1974.

² Dall, J L C, *British Medical Journal*, 1970, **1**, 705.

Anergy in Crohn's disease

SIR,—We were gratified by the attention given in your leading article (29 January, p 253) to the general subject of anergy in Crohn's disease and to the work of our Mount Sinai group in particular. It seems to us, however, that several points in that article require comment and clarification.

Firstly, the "rediscovery" by Mitchell *et al* of Kveim reactivity in Crohn's disease has not been reproduced by most other laboratories¹⁻³ and is considered in many quarters to be an artefact of contaminated reagent.⁴

Secondly, the "thoughtful study from Stockholm" which reported normal lymphocyte transformation in Crohn's disease failed to construct dose-response curves with varying concentrations of phytohaemagglutinin (PHA), and hence cannot be considered entirely valid.⁵⁻⁷ This same problem was manifested in the "larger and well-controlled study of 38 patients from Vermont," although even in that study the impairment of lymphocyte transformation seen in three-day cultures from patients with Crohn's disease was statistically highly significant. Indeed, almost all of the "reports of normal PHA responsiveness [that] have outnumbered the earlier, abnormal ones" have suffered from similar technical or statistical difficulties, as noted by us and others.⁷⁻⁹ Likewise the failure of the Vermont group to demonstrate dinitrochlorobenzene (DNCB) anergy could be related to their failure to require induration as a necessary criterion for a positive skin test.¹⁰

Thirdly, the study you cite from Rhode Island appears to show "no reduction" in T-lymphocytes only if comparison between group means is allowed to obscure the observation, noted both by Thayer *et al* and by you, that nearly one-third of the Crohn's disease patients had subnormal T-cell levels. The existence of this large immunologically deficient subpopulation in Crohn's disease is, in fact, the very heart of the matter.⁸⁻⁹ Moreover, other laboratories have also confirmed this phenomenon of T-cell reduction in Crohn's disease.¹¹

Finally, and most important, we are puzzled by your reference to "small, unrepresentative, and poorly classified groups of patients." For our part, we have over the past four years reported studies of cellular immunity in 172 meticulously classified patients representing every variety of inflammatory bowel disease, as well as in 55 of their relatives. Our observations have consistently demonstrated impaired lymphocyte responsiveness,⁸ depressed proportions and absolute counts of T-lymphocytes,¹²⁻¹³