and then to school medical officers without the prior knowledge and consent of the referring general practitioner. I further understand that this practice is not peculiar to my district.

This raises considerable ethical problems, as I am sure that in certain circumstances the information may be considered to be of a highly confidential nature. There is no guarantee of security of records kept by school medical officers and I am sure that the parents are not aware of the dissemination of information about their children. An important point is the fact that it is no longer obligatory for children to be examined by school medical officers so that information about these children is being distributed to people with whom they may never have any professional relationship.

We are living at a time in which there is increasing concern about personal liberties and privacy and I would like to have the response of other practitioners about what I feel is a rather sinister procedure.

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Aortography in infantile coarctation

SIR,—I wish to confirm Dr B R Denham's finding on the usefulness of the balloon angiocatheter in producing retrograde flow of contrast in children with congenital heart disease (13 May, p 1282). The use of balloon-directed angiography in patients with congenital heart disease was reported from this unit to a recent meeting of the British Cardiac Society.

The technique is applicable not only when the descending aorta can be entered through a ductus as in severe coarctation or atresia of the arch, but also in cyanotic heart disease. If the catheter is passed through the aortic valve and the balloon inflated in the descending aorta, it will cause obstruction to forward flow, and balloon-directed flow of contrast will fill any major aortopulmonary anastomoses which are present. The technique has now been used in over 20 patients ranging in weight from 2 to 20 kg. No adverse effects have occurred.

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Isolation of campylobacter

SIR,—The discussion in your pages of campylobacter enteritis has been most interesting. We have been comparing the methods of Butzler *et al*¹ and Skirrow² for the culture of *Campylobacter jejuni* and have found no notable differences in selectivity and sensitivity between the media.

Overgrowth with yeast was a problem, but addition of amphotericin B (2 mg/l) has resolved this. We now use Skirrow's medium plus amphotericin B. Filtration, while it eliminates other bacteria, also decreases the recovery of campylobacter. We do not use filtration except when culturing the faeces of animals. This has been necessary owing to growth of spreading proteus despite the presence of antibiotics in the medium.

Alkaline peptone water, as suggested by Tanner,³ has proved to be useful to recover *C. jejuni* from faecal suspensions inoculated

with these organisms when incubated at 42°C for 6-8 h. Incubation for longer than 8 h results in overgrowth of other intestinal flora. However, when this medium was used for patients' stool specimens isolation of *C. jejuni* was not as good as with the other media described.

As a holding medium, especially useful for transporting swabs, we use thioglycollate broth containing 0.16% agar and the same antibiotics as in Skirrow's medium plus amphotericin B. After inoculation this medium is refrigerated overnight and then plated.

We have also found that *C. jejuni* stains poorly with safranin as the counterstain in the Gram method. The substitution of 0.06% carbol fuchsin for safranin has overcome this difficulty.

Using these methods we have recently isolated *C. jejuni* from five patients with diarrhoea. Further discussion will be forthcoming.

W L WANG

MARTIN BLASER

JAMES CRAVENS

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¹ Butzler, J P, *et al*, *Pediatrics*, 1973, **82**, 493.

² Skirrow, M B, *British Medical Journal*, 1977, **2**, 9.

³ Tanner, E L, and Bullin, C H, *British Medical Journal*, 1977, **2**, 579.

George III's offspring

SIR,—My attention has been drawn to Dr Shirley Fisher's assertion (3 June, p 1479) that George III had descendants by an illegitimate line. This suggestion would have been more possible if made about almost any other member of the Hanoverian royal family, including brothers of George III, but it is totally at variance with all the very considerable evidence available to historians about the king's character and personality. He was a man of strong moral principles and sincere religious convictions. Again, under the conventions of the time there would have been no reason for secrecy about the existence of a royal bastard, had one been born, but in 30 years of studying this period I have never come across a fragment of social gossip hinting at the presence of one in the circumstances posited by Dr Fisher. Letters offering patronage and support are no evidence of such a liaison. Indeed, they suggest the opposite; for had there been a liaison ample provision would have been made at the time and occasions for promises later would have been unlikely.

The temptation to make pretensions to royal descent is not uncommon. These pretensions may sometimes begin with a deliberate fabrication, or perhaps more often with a wild guess based on inadequate evidence which hardens a generation later into firm belief. Except in those cases which have been publicly known and acknowledged from the beginning, such claims are in my judgment likely to prove empty if exposed to the rigours of historical investigation. If Dr Fisher will refer to Patricia Storrar's book, *George Rex: Death of a Legend* (Johannesburg, 1974), in which I had some share, she will see how this was demonstrated in the most famous case of an attempt to foist an illegitimate brood upon George III. Some of the crucial evidence in that case was also discussed by me in *Notes and Queries* for January 1975.

Of course—reflecting on the controversy in your pages some 10 years ago—if porphyria is endemic in the family to which Dr Fisher refers, then I would concede a strong presumption for a Hanoverian descent, though not from George III.

IAN R CHRISTIE

Croxley Green,
Herts

The consultation and the therapeutic illusion

SIR,—Dr K B Thomas is to be congratulated on his brief but important and profound paper (20 May, p 1327). He finds that in general practice undiagnosed patients who receive no treatment do as well as those who are given a symptomatic diagnosis and medication.

This principle can, and arguably should, be extended to no treatment for self-curing conditions. To take but one example from orthopaedic practice, if the patient with a frozen shoulder is told the good news that it is not arthritis or cancer, that no other joint than the shoulder is ever affected, and that the pain will inevitably go and the movement be restored completely or almost completely he usually receives with equanimity the bad news that recovery will take a long time and that no treatment hastens it.

E SHEPARD

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Cough mixtures

SIR,—Dr D Adler (3 June, p 1489) has clearly never suffered from a nocturnal cough and perhaps never had children who did. Neither investigations nor antibiotics will give immediate alleviation of what can be a distressing and disturbing symptom in the common cold, bronchitis, bronchial carcinoma, etc. But the despised symptomatic remedies he mentions (Actifed compound linctus, Benylin) do provide exactly this relief and allow a therapeutically beneficial night's rest in such conditions. They were never intended to do more than this. We should remember that good doctors treat symptoms at the same time as effecting cures and consider the patient's comfort as well as his diagnosis.

BARBARA COMAISH

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Housing and violence to children

SIR,—The report issued by the Department of Health and Social Security entitled "Violence to Children,"¹ which was recently presented to Parliament, merits discussion. I would like to comment upon one of the issues raised in this document—namely, housing (paras 29-32).

The first part of the recommendation on housing stresses that young people have to be housed in the area in which they have grown up so that they can have the support of their extended families. This is in keeping with current research, since most of the studies show that violent parents are socially isolated^{2,3} and detached from their roots,⁴ and have very little contact with their extended families.⁵ But the report then proceeds to suggest that better housing conditions and

rehousing can prevent violence to children, an assumption which is not supported by current studies.

Although housing problems can contribute to family stress,⁶ many people in deprived sections of the community do not batter their children,⁷ and in most samples of violent parents all social classes are represented.⁸ Studies of the social characteristics of battering parents show that they are no worse off than parents in the same social class who never batter their children.³ There is nothing to support the view that parents become violent if they have a housing problem, and it seems more likely that they batter their children and have housing problems for the same reasons: their emotional and personality problems. Constitutional personality factors have proved to be more fundamental than financial factors in the causation of baby battering.^{9, 10}

Some studies even claim that rehousing, although it provides temporary relief from external pressures, may actually precipitate battering incidents.^{11, 12} In one study¹³ nearly two-thirds of the parents had received financial assistance during or before the year of the battering incident. Although every effort has to be made to improve the housing conditions of the population at large, we must resist the attraction of the utopian view that violence will disappear once we have solved the housing problems of violent families. Since everybody is now talking about lack of cash, I wonder whether the money which the report suggests spending on the rehousing of violent families would not be better spent on providing more nursery placements for children from these families.

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¹ Department of Health and Social Security, *Violence to Children: a Response to the First Report from the Select Committee on Violence in the Family (Session 1976-77)*. London, HMSO, 1978.

² Davoren, E, in *Battered Child*, ed R E Helfer and C H Kempe. Chicago, University of Chicago Press, 1968.

³ Nurse, S M, *Smith College Studies in Social Work*, 1966, 35, 11.

⁴ Schaffer, H R, and Schaffer, E B, *Occasional Papers on Social Administration*, No 25, London, Bell and Sons Ltd, 1968.

⁵ Smith, S M, et al, *British Journal of Psychiatry*, 1974, 125, 568.

⁶ West, D J, and Farrington, D P, *Who Becomes Delinquent?* London, Heinemann, 1973.

⁷ Paulson, M J, and Blake, P R, *Child Welfare*, 1969, 48, 86.

⁸ Kempe, C H, *Hospital Practice*, 1969, 4, 44.

⁹ Scott, P D, *Medicine, Science and the Law*, 1969, 13, 197.

¹⁰ Smith, S M, et al, *British Medical Journal*, 1973, 4, 388.

¹¹ Gibbens, T C N, et al, *Cruel Parents*. London, Institute for the Study and Treatment of Delinquency, 1956.

¹² Skinner, A E, and Castle, R L, *Seventy-eight Battered Children: a Retrospective Study*. London, NSPCC, 1969.

¹³ Gil, D G, *Violence Against Children: Physical Child Abuse in the United States*. Cambridge, Mass, Harvard University Press, 1970.

Disposable clothing for operating theatre staff

SIR,—To lessen the amount of skin shed by male personnel in operating theatres have Dr N J Mitchell and his colleagues (18 March p 696) considered the use of clothing made with a microporous membrane of polytetrafluoroethylene (PTFE) (developed, I understand, for haemodialysis machines) bonded to fabric? Such a material is now being used by the back-packing fraternity because it is permeable to water (perspiration) vapour but

not to liquid water and so is useful and comfortable in heavy rain. It should be sterilisable.

Dr Mitchell and his colleagues do not quote the water vapour transmission of their Fabric 440; a commercial version of PTFE as above (Gore-tex) is claimed to have a transmission of about 4800 g/m²/24 h, much the same as Ventile.

My hiking friends assure me that this fabric is indeed comfortable in rain when they are climbing hard, so it may well be useful in the theatre. I have no commercial interests in the material and indeed do not own any, as I don't hike enough (alas!).

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Sweet cigarettes

SIR,—Sweet cigarettes are offered for sale at prices which young children can afford. They are given to youngsters by parents and other adults, thus giving an indication of adult approval, yet they are imitations of the real thing, similar to the packet of 10 with sometimes a cigarette card too—all that is lacking is the Government Health Warning.

In view of the very early age at which smoking is being presented as an attractive habit it is surprising that there appears to be so little comment from those interested in the smoking and health campaign. Since a letter appeared in the *Medical Officer* in 1963¹ I have been unable to trace any other references to the topic. An indication of the views of one group of health professionals, however, has been given by the analysis of a questionnaire recently sent to dentists in this health district; 128 questionnaires were despatched with prepaid envelopes for reply, 67 dentists replied as follows:

Sweets resembling cigarettes are easily available for children.

Do you consider this—

(a) of no consequence?	14	21%
(b) should be discouraged	39	58%
(c) calls for a national ban?	11	16%
Don't know	3	4%
		74%

Although dentists as distinct from general medical practitioners and chest physicians are not continually reminded of the health hazards of smoking cigarettes, 74% of this group support some discouraging action.

DENIS D HILTON

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¹ Hilton, M E, *Medical Officer*, 1963, 109, 111.

Maintenance treatment of duodenal ulcer with cimetidine

SIR,—We read with interest in your leading article on cimetidine (3 June, p 1435) the implied suggestion that the nocturnal dose of choice for maintenance treatment in duodenal ulceration might be 800 mg rather than the 400 mg recommended in the data sheet.

In a study of overnight gastric secretion Blackwood and Northfield¹ showed that 400 mg of cimetidine taken orally at 11 pm produced greater than 90% inhibition of acid secretion during the period 1 am to 7 am. Following a dose of 800 mg there was no alteration in the degree of suppression of either total acid output, acid concentration, or volume of gastric juice. Similarly, a study by Longstreth

and his colleagues² reported over 90% suppression of overnight acid secretion with 400 mg of cimetidine.

Studies employing endoscopic assessment of maintenance of healing of duodenal ulcers by 400 mg of cimetidine at bedtime have shown relapse rates of 19% over 12 months in a large non-selected ulcer population³ and 27% over six months in patients with severe ulcer disease.⁴ In the only study reported in which an 800-mg nocturnal dose was employed⁵ the relapse rate in a six-month period was 24%.

We would submit that there is no evidence on either pharmacological or therapeutic grounds for use of a larger dose of cimetidine at night than 400 mg to prevent relapse of duodenal ulceration.

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¹ Blackwood, W S, and Northfield, T C, in *Proceedings of the 2nd International Symposium on Histamine H₂-receptor Antagonists*, ed W L Burland and M Alison Simkins. Amsterdam, Excerpta Medica, 1977.

² Longstreth, G F, Go, V L W, and Malegela, *New England Journal of Medicine*, 1976, 294, 801.

³ Bodemar, G, and Walan, A, *Lancet*, 1978, 1, 403.

⁴ Gray, G R, et al, *Gastroenterology*, 1978, 74, 397.

⁵ Blackwood, W S, Maudgal, D P, and Northfield, T C, *Lancet*, 1978, 1, 626.

Ballot of consultants and registrars

SIR,—On 6 June I complained to the controller of ballot services of the Electoral Reform Society that of 18 consultants and 11 senior registrars in histopathology, microbiology (including PHLS), and haematology at the University Hospital of Wales, Cardiff, and its associated hospital, the Cardiff Royal Infirmary, only seven consultants and one senior registrar had been circulated with ballot papers.

The controller replied on 10 June admitting that the first distribution of ballot papers "left something to be desired" and expressed a hope that a late despatch of ballot papers, each containing an enclosure notifying the decision to extend the closing date from the publicised 9 June to 13 June, would correct the matter. This extension of the ballot served to net only two additional persons in the population I describe. The controller acknowledged that minor deficiencies will occur in any ballot, but he expressed confidence in the overall coverage of the electorate, basing this on a quoted number of 17 000 papers despatched. However, he made the point that his organisation played no part in the issue of ballot papers, or, presumably, in determining the electoral list.

I am sorry I cannot share his confidence. The electoral list has not been published and as far as I know no open attempt has been made to construct one. Consequently nobody is in the position of being able to judge whether those unfortunately omitted in the ballot circulation are drawn from certain sections of those eligible to vote. Confidence can possibly be restored if you will publish this letter to prompt others to compare their experience with mine; but, more importantly, the analysis of the ballot must give the breakdown for each of the specialties, including the honorary consultant component, as allowed for in the data entered on the ballot papers.

Only from knowledge of the size of the response from these various subgroups may the even-handed construction of the electoral