are all amenable to appropriate treatment, and in every case the diagnosis can be made rapidly and reliably by endoscopic examination.

Endoscopy is mentioned in the article, but almost casually, and the reader is left with the impression that physiological investigations, particularly the flow volume curve, are of much greater importance. The article would, in my view, have served a more useful purpose if it had included a short account of the indications for endoscopic examination in the type of case in which localised obstructive lesions of the trachea and main bronchi are apt to be mistaken for asthma. Stridor is, of course, a characteristic feature in such cases (it was present in all but one of Harrison's 16 patients), but physicians are often slow to distinguish it from wheeze and perhaps need reminding that it is accentuated by coughing. This is indeed always the case with inspiratory stridor, which is by far the most common type. It will seldom be missed if the patient takes a few deep inspirations with the mouth open, and is then asked to cough. Laryngoscopy and bronchoscopy should be carried out immediately on every patient with stridor. Although advanced diffuse airways obstruction occasionally produces apparently typical stridor, the number of such patients who may be unnecessarily subjected to endoscopic examination will be extremely small. Finally, it must be emphasised that tracheal stricture is a not uncommon complication of tracheostomy, particularly in patients who require artificial ventilation via a cuffed tube for several weeks, and this possibility should always be considered when dyspnoea and "wheeze" develop for the first time within six months of removal of the tracheostomy tube.

There are still a few situations in medical practice where a direct diagnostic approach has much to commend it, and this, pace the respiratory physiologists, is surely one of them.

IAN W B GRANT

Respiratory Diseases Unit,
Northern General Hospital,
Edinburgh

¹ Harrison, B D W, *Quarterly Journal of Medicine*, 1976, 45, 625.

Tourist hepatitis

SIR,—With reference to your leading article (22 January, p 189), as one with some responsibility for the health of a large number of people travelling to and living in overseas territories I have found it difficult to formulate a rational policy for prophylaxis of hepatitis. Official guidance is scanty. During 1976 the Department of Health and Social Security advocated gammaglobulin injections for those travelling to Ecuador and Iran. Now the advice offered is more general. Taiwan, Indonesia, and "South America" (Dr F Morgan, 5 March, p 646) are territories with an allegedly high level of prevalence. It would seem that a great part of the assessment of risk is anecdotal (vide Dr Morgan's letter) and furthermore no attempt is made to relate risk to mode of living. The executive living in a hotel is less vulnerable than his technical colleague investigating the efficacy of a pesticide in an underdeveloped rural area. Elementary precautions, like eating only cooked food while it remains hot and avoiding all dubious sources of water, may help prevent infection with hepatitis A virus. Hepatitis B appears to be capable of transmission by biting

insects and sexual contact, factors more difficult to control.

What are the risks of repeated injections of human immunoglobulin? American practice is to give injections at six-monthly intervals, although the passive immunity gained after each injection is probably only of a high order for three months. Has any attempt been made to investigate the large numbers of individuals injected repeatedly over many years in pursuance of this policy?

F W BEST

Imperial Chemical Industries Ltd,
London SW1

***Official guidance is scanty simply because hard data are just not available. On theoretical grounds, however, it is certainly likely that technical personnel employed in field work in underdeveloped areas are in greater need of protection than executives who do not stray far from their modern hotels. The precautions which can be taken are alluded to in Dr Best's letter.

With regard to the risks of repeated injections of human immunoglobulin, this seems to be small, although reactions have been described. The report of the MRC Working Party on Hypogammaglobulinaemia¹ describes one death in a 27-year-old man with hypogammaglobulinaemia who had been receiving weekly injections of immunoglobulin for four years and some occasional generalised but non-fatal reactions in other patients treated in a similar way. It is unlikely, however, that repeated injections to prevent viral hepatitis (which would have to be given every four months to provide complete protection) would give rise to anything more serious than local pain.—Ed, *BMJ*.

¹ Medical Research Council, *Hypogammaglobulinaemia in the United Kingdom*. Special Report Series No 310. London, HMSO, 1971.

Orthopaedic services in Lincoln

SIR,—A recent six-week locumship spent in Lincoln as consultant orthopaedic surgeon—a capacity in which I served Derby for 25 years—filled me with the gravest concern for both the folk of Lincoln and its surroundings, for which the Trent Regional Health Authority is responsible, and for my two colleagues who are flogging themselves to death in the effort to meet the clinical demands.

That there should be a 4-5-year waiting list for such a cost-effective and pain-relieving operation as the installation of an artificial hip is atrocious; that it requires to be done in an unprotected theatre shared with other cases of an infected nature is wrong—both for this and many other orthopaedic cases involving large implants.

A shortage of "second-stage" or convalescent beds is clogging the top-grade surgical wards and a waiting period of some 8-10 weeks for outpatient consultation fills in a sorry picture which might well sustain litigation by the folk of Lincoln against the regional health authority, who are clearly not doing their duty. However, the action would simply call forth the defence of lack of funds and be as destructively wasteful for the country as the "strikes" have been. Nevertheless, this state of affairs does draw painful attention to the even more fearful shortage of funds suffered by our armed services.

The solution for Lincoln, and for the many similarly deprived areas throughout the NHS,

is simple. Charge a "hotel-fee" daily for all in hospital and increase the number of highly remunerative private beds, these funds to be used locally where they are earned to finance more consultant staff and more convalescent beds. Also encourage local voluntary subscription, which would quickly provide a sterile-air operating tent in the existing theatre.

Meanwhile invite those so long and patiently waiting sufferers to come elsewhere.

R LUNT

Boylestone,
Derbyshire

***Mr Lunt sent a copy of this letter to Professor J A Scott, regional medical officer to the Trent RHA, whose reply is printed below.—Ed, *BMJ*.

SIR,—So long as the Trent RHA is under-resourced it will have to select particular services for improvement and inevitably some parts of the population it serves will have to wait for the developments which no one doubts are necessary. A great deal of capital development has already been undertaken in Lincolnshire, and while most of this has been at Boston, Lincoln itself has benefited through the construction of new geriatric and younger disabled units at St George's Hospital and a new general operating theatre at the County Hospital. New geriatric wards have also been built at Gainsborough and an upgraded accident department is under construction at the Lincoln County Hospital.

It is very easy to criticise the inadequacies of the National Health Service, but fundamentally they are not of its making.

J A SCOTT

Trent Regional Health Authority,
Sheffield

Responsibility and management in pathology laboratories

SIR,—It has been brought to the attention of the Wolverhampton Consultants' Committee that evidence has been submitted to the Royal Commission on the National Health Service by the Institute of Medical Laboratory Sciences in which the opinion was expressed that the managerial head of the medical laboratory service in each health district should be a medical laboratory scientist (technician) accountable to the district management team for all medical laboratory investigations performed in the district. This opinion was unacceptable to the committee, which considered that the only appropriate person to be the head of a laboratory is a consultant pathologist.

This matter has recently been ventilated in your journal and I am instructed by the committee to say that we have written to the presidents of the royal colleges recommending that recognition for postgraduate training for their examinations should be withdrawn from all establishments where laboratory services are not headed by a consultant pathologist or in certain cases by a scientific officer of equivalent standing.

J A MACDOUGALL

Chairman,
Consultants' Committee,
Wolverhampton Area Health Authority

New Cross Hospital,
Wolverhampton