would agree that the alternative investigation, a skeletal survey, is more time-consuming and expensive and considerably less accurate. What a shame, therefore, that in attempting to compare these two methods Dr S J Williams and his colleagues (16 April, p 1004) base their conclusions upon such poor evidence.

Not only did they restrict their routine scans to the spine, pelvis, and upper femora (and therefore almost certainly missed lesions in the skull and ribs) but in only six of the 44 patients whom they considered to have definite metastases did histological evidence become available. We are also told that 21 patients were assigned to this group on the basis of their bone pain, and yet from the figures it is apparent that an almost equivalent number of patients with similar symptoms were thought to be free of metastases. Surely they must be aware that the severity of pain (which must be extremely difficult to assess) is no guide to the presence of disease, as evidenced by the frequent demonstration of occult painless metastases.

Nevertheless I am sure that, however unsupported, their general conclusions on the value of isotope bone scanning are correct. The more effective demonstration of metastases may certainly affect the management of such patients, but does it, I wonder, ever affect their prognosis?

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Raised mean cell volume and *Mycoplasma pneumoniae* infection

SIR,—I read with interest the report by Dr Peter Kopelman (2 April, p 881) of a case of *Mycoplasma pneumoniae* infection in which the diagnosis was suspected owing to a raised mean cell volume (MCV) in the Coulter S counter.

In our laboratory we have found that a raised MCV, together with an abnormally raised mean corpuscular haemoglobin (MCH), is almost diagnostic of the presence of cold agglutinin, whether specific or non-specific. In all cases we have noticed macroscopic or microscopic autoagglutination of red cells. The same sample of blood when put through the Coulter S after warming to 37°C shows a significant reduction in the MCV and MCH together with a rise in total red cell count.

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Gross oedema during treatment for depression

SIR,—With reference to the case report by Drs A Goonewardine and P J Toghill (2 April, p 879) I wish to report a similar case seen in general practice.

The patient, aged 61 and disabled, has been suffering from depressive psychosis for several years and has received several psychotropic drugs, including imipramine, amitriptyline, a monoamine oxidase inhibitor (MAOI), and various tranquillisers and sedatives in different strengths and combinations. Last August he was prescribed isocarboxazid 10 mg twice a day increasing to a total dosage of 30 mg daily. Along with this he was also given

a combination of amitriptyline 25 mg and chlordiazepoxide 10 mg (Limbital) two capsules at night. He religiously followed the dietary restrictions necessary for MAOIs. Within two weeks of the start of this treatment he showed signs of massive oedema from the ankles up to the thighs. His blood pressure was 110/70 mm Hg.

There was no sign of any other disease to account for this oedema. All the investigations were reported as normal. The isocarboxazid was withdrawn and he was given injections of frusemide 80 mg intramuscularly (supplemented with the usual oral potassium) for four days and then switched over to 120 mg of frusemide daily by mouth. His oedema disappeared within a week and he has been free of any ankle or leg swelling since then.

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Test antiserum for group B meningococci

SIR,—In your leading article on "Partly treated pyogenic meningitis" (5 February, p 340) you state that satisfactory test antisera for group B meningococci are not available. May I refer you to a recent article by Semgen *et al*¹ in which it is reported that *Escherichia coli* K1, the capsular polysaccharide similar if not identical to the meningococcal B group antigen, is readily detected by an equine meningococcal group B globulin.

This antiserum was prepared by the repeated intravenous injection of formaldehyde-treated group B meningococci, strain B-II, by well-known methods for the production of diagnostic antisera. Horse serum gives adventitious precipitin reactions in agar gel with the buffer systems commonly employed for counter-current immunoelectrophoresis. Accordingly the serum fraction precipitated between 34% and 50% saturated ammonium sulphate and then exhaustively dialysed against 0.05 M NaCl and centrifuged clear is used.

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¹ Semgen, G, Ørskov, I, and Ørskov, F, *Acta Pathologica et Microbiologica Scandinavica*, Section B, 1977, 85, 103.

"Insects and history"

SIR,—The review of my book *Insects and History* (26 March, p 849), although generally quite favourable, nevertheless criticises it unjustly in two respects.

The reviewer states: "The interpretation of fevers, agues, plagues, and other epidemic diseases of the past is a fascinating problem but perhaps not so easily undertaken as the author indicates." On p 35 of the book, however, I have written as follows: "Especially with old records, it is almost impossible to determine with any certainty what disease was actually involved, whether there were one or more epidemics raging concurrently and to what extent the various plagues exerted a direct effect by destroying man and supplies, or an indirect effect through men's minds." Later in the review we read: "The impression is created that a fever from the past was mosquito-borne and that flies were responsible

for fluxes, cholera, and dysentery. This is a real weakness in the book. . . ." Yet throughout I have stressed the point that fevers only *may* have been caused by particular pathogens. For instance, even in the introduction I write: "Hannibal was halted in Syracuse by the inroads of bubonic plague, smallpox or malaria among his troops." On p 131 your reviewer could have seen the following: "Surely one of the most terrifying of all diseases, cholera, like typhoid, is spread in epidemic form largely by contaminated water, but flies may also play a part in its transmission"; or on p 140, "Most often, dysentery resulted from taking contaminated water on board ship, but no doubt the innumerable flies, breeding in the filthy bilges of wooden ships, would have contributed to the spread of the disease."

It is a serious weakness of the review that its author cannot have given my book much more than a cursory glance before penning these criticisms.

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Gluten-free diet in dermatitis herpetiformis

SIR,—We were interested to read the paper by Drs Christine I Harrington and N W Read (2 April, p 872) on the effects of a gluten-free diet (GFD) in dermatitis herpetiformis. However, we were disturbed to see that they attribute to us a report of "no significant difference in the reduction of the dose of dapsone between patients on a gluten-free diet and a control group of patients on a normal diet." In fact our own paper¹ indicated quite the converse—a greater reduction in dose was clearly established in our GFD-treated patients. In addition, more of our GFD-treated patients than controls were able to cease drug therapy altogether, although this difference was not statistically significant. Nevertheless, the benefits of the diet with respect to drug dosage were unequivocal.

The observations by Drs Harrington and Read thus broadly confirm our own experience and we share with them a belief that GFD treatment is of value in dermatitis herpetiformis. However, the assessment of individual patients remains difficult. While reduction in medication is certainly a definable goal, common sense indicates that a highly motivated patient who subjects himself to the inconvenience of a GFD hoping for a reduction in his drug requirements is likely to do all he can to convince himself (and thus his physician) that he is succeeding. In these circumstances apparent reductions in drug dosage are likely to overestimate the benefits of the diet, and their use as "a yardstick against which to gauge progress" may be misleading.

Drs Harrington and Read make several statements about the effect of a GFD on the jejunal mucosa of their nine patients without apparent regard for the reported patchiness of the small-bowel abnormality in dermatitis herpetiformis.² It remains to be shown that improvement in the jejunal mucosa of individual patients may be reliably assessed from Crosby-capsule biopsy specimens and thus an assertion that any individual patient shows improvement is questionable if it is based on single biopsies before and after treatment. At present, it seems that multiple

biopsies are necessary if such a claim is to be made.

The changes in subepidermal IgA deposition reported in the paper would thus provide a useful additional basis for the assessment of a patient's progress. However, one would need to know that the pattern of IgA deposition did not show spontaneous variation before changes occurring over a period of six months could be confidently accepted as evidence of improvement. In consequence we are not yet convinced that the changes represent "a more objective and sensitive index of improvement in the skin than the ability to reduce dapsone," though the need for such an index is undisputed.

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¹ Heading, R C, *et al*, *British Journal of Dermatology*, 1976, **94**, 509.

² Scott, B B, and Losowsky, M S, *Gut*, 1976, **17**, 984.

Emergency treatment of hypercalcaemia

SIR,—I noted with interest the report from Drs A R Behn and T E T West (19 March, p 755) of the successful emergency treatment of hypercalcaemia with calcitonin in two patients with myelomatosis. While the concurrent administration of steroids in these cases made it somewhat difficult to assess the effects of calcitonin per se, my own experience is that calcitonin alone is an effective agent in this situation.

However, following preliminary studies in the treatment of osteolytic myelomatosis using mithramycin,¹ I have found this drug to be consistently the most effective agent—with rapid action for "emergency" therapy; in the relatively low doses used, bone marrow toxicity is rarely a problem.

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¹ Stamp, T C B, Child, J A, and Walker, P G, *Lancet*, 1975, **1**, 719.

The anaesthetist's visit

SIR,—“Surgeon” (Personal View, 16 April, p 1026) expresses the wish that “all anaesthetists would visit all patients before their operation” and cannot “understand why they all don't routinely.” Since the anaesthetist would be in theatre starting the morning operating list before the patient arrived in the hospital at 9 am I wonder how “Surgeon” thought a preoperative visit was possible, unless he is suggesting that the anaesthetist should leave his anaesthetised patient in the care of the orderly during the visit. The same contribution also illustrates the point that, however socially desirable it may be, the preoperative visit is not essential for the safe and effective conduct of every anaesthetic. Preoperative assessment of the patient's health, however, is essential and is routine.

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What to tell the employer

SIR,—As a practising oncologist I am frequently puzzled about how to reply to letters I receive from medical practitioners acting for the employers of one or other of my patients. Such letters usually request details of diagnosis, of treatment, and sometimes, most difficult to answer, of prognosis. The purpose for which this information is required is not usually stated, but presumably it will be used to help non-medical personnel make decisions concerning the employee's job responsibility, promotion, or relocation. Such inquiries can sometimes best be answered by a telephone call to the doctor concerned—one has then the opportunity to satisfy oneself about the doctor's essential good faith and to discover the use for which the information may be intended. All this, it seems to me, must take place only after the patient's express permission has been obtained.

More difficult is the situation when details of a patient's medical history are requested by a prospective employer. It requires no great stretch of the imagination to deduce that statements, for example, that a patient has been treated for Hodgkin's disease (and may now be cured) or that he is in the chronic (and asymptomatic) phase of chronic granulocytic leukaemia may be used to discriminate against him when it comes to deciding whether or not to offer him employment. What then can I answer? Presumably some compromise must be reached. The assumption that a prospective employer is entitled to full medical information must be false. Conversely he is (presumably) entitled to be forewarned against the risk of taking on an employee who will very soon be incapacitated for an indefinite period or who can reasonably expect to spend the bulk of the coming year in hospital. The compromise may be this—the prospective employer should be entitled to ask the patient's regular doctor a general question such as, Is the prospective employee's medical condition such as to allow him to work with the minimal interruptions over the next 12 months? If the answer is yes, no specific permission to reply need be solicited from the patient and no discrimination should be exercised in selecting him for employment. If no, detailed consultation between patient, prospective employer, and doctor will be required. It follows that a request for medical history on the original job application form should be answered with only a general statement—for example, “Please refer to Dr X.” The essence of the compromise is that it removes from the employer's medical adviser to the patient's own doctor the responsibility for judging his overall fitness for work in the short term.

What seems clear is that no employer, present or prospective, is entitled to medical information as of right. The exact amount of information that should legitimately be given to him is difficult to define.

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Closure of GP maternity units

SIR,—The closure of small maternity units in Birmingham will lead to the break-up of teams with special experience. I am pleased that Dr

G W Taylor (16 April, p 1043) has drawn attention to the disadvantages to patients from the trend of closing small GP-orientated units and subsequent displacement of mothers to centralised “consultant-orientated” units. The problems of intensive obstetrics find echoes in the problems of intensive coronary care. I believe that ultimately there will be a return to more personalised systems of delivery and that it will be shown that impersonal mechanistic deliveries stand at risk of producing more complications of uterine inertia and fetal distress than they set out to cure. The mother likes to think she gets the credit for the delivery. The obstetrician's triumph, after monitoring a successful delivery, is at the expense of this mother. She needs that feeling of self-sufficiency and support from which to form the mother-child bond on which the child's successful upbringing will presumably depend.

Obstetrics, by its nature, is also neonatal paediatrics and preventive psychiatry. These latter aspects may not be well served by large remote units.

ANTON R DEWSBURY

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Urgent action needed

SIR,—The West Berkshire District Medical Committee has received the reports of eight health care planning teams. These represent the expenditure of considerable amounts of time and thought by a large number of individuals. If one word were to be used to sum up the state of the National Health Service as evidenced by these reports that word would be “inadequate.” This is epitomised by the latest report from the last paragraph of the mental illness Health Care Planning Team:

“Most of the above-mentioned needs have long been recognised and in some cases positive steps have been taken towards their implementation. Despite the current needs for financial restraint generally, the Health Care Planning Team sees its recommendations as essential for the maintenance of adequate psychiatric care for the community with which it is concerned. Failure to implement the measures will lead to a stagnating or even deteriorating service with the mounting cost to the community of inadequately treated illness.”

The response by the authorities to the reports of the health care planning teams is that the needs and gaps in the NHS have long since been recognised, but they cannot be implemented because of other priorities and lack of finance.

We are well aware of the considerable weight of evidence recently printed in the *BMJ* (29 January, p 299; 5 February, p 399) and presented to the Royal Commission on the NHS. Consideration of all the evidence obtained must be lengthy if this is to be done efficiently. If the experiences of other district medical committees is similar to that of the West Berkshire DMC the medical profession and the Department of Health and Social Security cannot afford to wait for the Royal Commission, and comments from other district medical committees would be appreciated in an endeavour to promote urgent action.

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CHRISTOPHER HUGHES
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West Berkshire District
Medical Committee

Reading, Berks