delivery. The patient was maintained on oral warfarin for six months. The hemiparesis and dysphasia rapidly disappeared in the puerperium. At seven months the patient reported a few brief attacks of diplopia, but there were no abnormal physical findings. She remained well 10 years later.

From the obstetric viewpoint it is possible that circulating plasminogen activated by streptokinase might have been responsible for the onset of premature labour, but there seems little doubt that anticoagulation was justified to treat a major and disabling cerebral vascular lesion.

The circumstances of this case were unique but serve to illustrate your contention that streptokinase, despite its hazards, remains a valuable drug for use in carefully selected patients.

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¹ Amias, A. G. *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, **77**, 312.

Glibenclamide and nocturia

SIR,—The report by Dr P L Yap and others (30 April, p 1137) concerning the treatment of inappropriate ADH secretion draws attention to the diuretic effect of the oral hypoglycaemic agent, glibenclamide. In a recent analysis of the symptoms of treated diabetics¹ we observed a significant increase ($P < 0.01$) in the incidence of nocturia in patients on glibenclamide compared with other treatment groups (see table).

Percentage of patients with nocturia (total numbers in parentheses)

Group	Age < 60	Age ≥ 60
On glibenclamide	90% (20)	90% (29)
On chlorpropamide	60% (47)	77% (64)
On insulin or diet alone	55% (89)	83% (41)

Nocturia increasing with age is a common complaint in diabetics, but the table confirms the diuretic effect of glibenclamide although not supporting the antidiuretic effect of chlorpropamide.² It would appear that up to 30% of young patients taking glibenclamide may have nocturia as a result of treatment, but this proportion falls to only about 10% in patients over 60.

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¹ Shaw, K. M., Bulpitt, C. J., and Bloom, A. *Journal of Chronic Diseases*, 1977, **30**, 39.

² Moses, A. M., and Miller, M. *Annals of Internal Medicine*, 1973, **78**, 541.

"Non-responsive" coeliac disease

SIR,—We were interested to read the observations on jejunal mucosa from patients with coeliac disease made by Drs P E Jones and T J Peters (30 April, p 1130), but it is difficult to interpret their use of the term "non-responsive coeliac disease" without more information—for example, clinical and other laboratory

response, length of time on gluten-free diet, change in epithelial and lamina propria cell counts, etc. Indeed, if the patients showed no improvement in their jejunal histology after gluten withdrawal, then by the Hammersmith definition they did not have coeliac disease.¹ However, our own definition of the disorder is less restrictive,² while Rubin *et al.*³ claim only a flat mucosa on biopsy and a "dramatic clinical improvement" on gluten-free diet.

Clinical and morphological improvement after gluten withdrawal do not necessarily run parallel. We have encountered six patients (8% of our series) who have made an excellent clinical response to a gluten-free diet (average time on diet 12 years) but whose jejunal mucosa has nevertheless remained flat, although the cellular infiltration has diminished. Conversely, in seven poor clinical responders the histological appearances have improved to near normal. Furthermore, patients with a flat mucosa on biopsy but without evidence of malignancy or other complication who show steady deterioration irrespective of what treatment is given are excessively rare.

We believe that it would be regrettable if the term "non-responsive coeliac disease" were allowed to creep into an area where terminology is already greatly confused.

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¹ Booth, C. C. *British Medical Journal*, 1970, **3**, 725.

² Cooke, W. T., and Asquith, P. *Clinics in Gastroenterology*, 1974, **3**, 3.

³ Rubin, C. E., Eidelman, S., and Weinstein, W. M. *Gastroenterology*, 1970, **58**, 409.

Paget's disease of bone in 14 British towns

SIR,—Though I am no longer in radiological practice, Paget's disease, that most mysterious of bone conditions, retains its fascination for me and so I was interested to read the article by Dr D J P Barker and others (7 May, p 1181) in which they confirm the wide variation in its prevalence even in a small country like ours. I was only sorry that they were not able to include any data from Scotland.

At the time when I was recording information that formed the basis of the article they quote of 20 years ago¹ I was told by one of my then registrars, Dr P F J New, who is now at the Massachusetts General Hospital, that the prevalence in Aberdeen, where he had then been recently working, was considerably greater than in north-west London. A comment from such an acute observer would be worth checking even though it was made 25 years ago.

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¹ Pygott, F. *Lancet*, 1957, **1**, 1170.

Confidentiality and the three wise men

SIR,—I was disappointed to read the view of your legal correspondent (14 May, p 1291) that he deplored the decision of a court to compel the disclosure of documents relating to a previous "three wise men" investigation.

The public must be seen to be protected from the ministrations of unfit doctors. The "wise men" procedure works well in practice and I hope it will continue. However, in the interests of justice their findings must be admissible as evidence in any future legal action. If I were an unstable doctor—an alcoholic or drug addict for example—I would most certainly not be deterred from collaborating voluntarily with a panel of colleagues; plainly it would be in the interests of my patients and myself to do so.

Furthermore, were I a member of such a panel future possible exposure of our proceedings would in no way deflect me from my duty, and in such circumstances I hope I would always conduct myself objectively.

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Advice to senior registrars

SIR,—I am a newly appointed consultant on the first point of the incremental scale. To take up my present post I have had to accept a cut in salary of 25%.

In view of this may I be allowed to offer some financial advice to senior registrars? Do not apply for a consultant post until you are forced to. Not only are you likely to earn considerably more as a senior registrar than as a newly appointed consultant, but as age is a factor in the granting of discretionary increments by your employing authority, the older you are on appointment the more likely you are to be granted these increments. So if you are doing well as a senior registrar, stay put.

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Professional indemnity

SIR,—Dr G Russell (14 May, p 1287) is quite right when he describes the absurd situation whereby doctors are expected to provide their own insurance against possible errors for services performed upon behalf of their employers. This must surely be almost unique, although it is in the long tradition of doctors carrying little for each other's working conditions.

The situation becomes more absurd when individuals like myself, a full-time research student, decide to work for three or four weeks per year as locums to pad out the student grant. The medical insurance of £40 per year then becomes no less than £10 per week. This disincentive hardly helps to reduce the chronic shortage of locums. What is required is not, however, reduced rates for part-time doctors (any more than increased rates for doctors in particularly vulnerable specialties such as neurosurgery) but rather for insurance to be paid by the NHS to the defence societies, the total amount being simply calculated on the basis of the total number of doctor-weeks worked for the Service. Such a system would also encourage doctors to work for the Health Service, as presumably those working in private practice would have to obtain their own cover for this work.

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