this side of the Atlantic. Clinicians should be aware of the need to undertake cultural studies, for without isolation and identification of the pathogen the diagnosis remains presumptive and the choice of therapy largely empirical. Serological studies, both complement fixation and precipitin tests, are of considerable value with the diagnosis and management of histoplasmosis. It is also noteworthy, that contrary to what the authors imply, mucicarmophilina is not a constant characteristic of cryptococci, particularly of the actively proliferating small forms that produce little capsular mucopolysaccharide; because of its small size this is the form most likely to be confused with a histoplasma.

Histoplasmosis is not an opportunistic infection. *H capsulatum* is a primary pathogen in its own right. Latency is not uncommon among systemic mycoses in general and symptoms may appear several decades after infection.

The suggestion that parts of the UK may be climatically suitable for survival of *H capsulatum* can hardly be taken seriously if it is intended to imply that the organism may be established in as yet unsuspected environmental reservoirs in south-western England and north Wales. There is simply no basis for such a speculation and the presence of this and the other errors and omissions in the paper by Dr Jariwalla and his colleagues is no tribute to the standard of reviewing and editing during its processing.

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¹ Symmers, W S, *Annales de la Société Belge de Médecine Tropicale*, 1972, 52, 435.

"Experience not essential"

SIR,—Dr T H Howell (2 April, p 904) deserves congratulations for bringing into the limelight the serious anomaly that exists in connection with the appointment of lecturers in geriatric medicine. This, however, is not confined to lecturers' posts. A number of consultants and senior registrars in geriatrics have been and continue to be appointed without any experience or with inadequate experience of the specialty of geriatrics. The interest of geriatric patients appears to be the last, if any, consideration in such appointments.

If the interest of geriatric patients is to be held supreme, I suggest that it should be made mandatory that no consultant or senior registrar should be appointed with less than a minimum of four years and two years experience in geriatrics respectively. Failure to do so would be unjust for the geriatric patient, may result in public outcry, and may initiate a demand by the Patients' Association for their representation on interviewing subcommittees.

S S H WASTY

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Mobility for the disabled

SIR,—Without wishing to defend the mobility allowance I feel it should be pointed out to Drs M Anne Chamberlain and Jean Buchanan (2 April, p 902) that the Employment Services

Agency (ESA) can, under certain circumstances, provide financial assistance with travel-to-work costs of a disabled person, regardless of whether that person receives a mobility allowance. Details are given in leaflet DPL 13 of the ESA. It's a "chicken or egg" situation, of course, since you must have a job before you apply for the assistance, but may not be able to obtain a job without it.

It may be wondered whether the mobility allowance has given rise to more anomalies than it was supposed to resolve. One of the local paradoxes is seen after retirement, when old age pensioners are provided with free bus passes by the local authority (Birmingham). Thus at the age of 65 (60 for women) some people who can use public transport are provided with free use of it, whereas those who cannot use it because they cannot walk have the cash allowance to provide access to other forms of transport (for example, taxi) withdrawn.

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Publicity and Huntington's chorea

SIR,—A publicity drive on television and in several newspapers made by the Association to Combat Huntington's Chorea (Combat) led to correspondence in your columns last year. Drs Gillian M and N W Glendinning (3 July, p 36) questioned the ethics of publicity which was directed towards the lay public and made the point that the best person to help families is the family doctor. Members of Combat, who wrote the second letter (Dr A J Caro and others, 14 August, p 419), agreed but commented that all too often the family doctor does not know that a man or woman on his list is at risk of developing the disease and so individuals in Huntington's chorea (HC) families may need to be warned directly of their risk and the need to seek medical help.

The letters received by Combat after the publicity drive provide some answers to the points raised and the information, although not from specific questions, is informative. The 296 letters received included 176 from families, 150 of them known to have an affected member.

Of the 150 letters from members of families containing an HC patient, 28 writers made it plain that they were, and 30 made it plain that they were not, in touch with their family doctor. The remainder did not mention him and the following extract illustrates how family doctors can be in ignorance unless a patient explains that the disease is in the family:

"My mother has had this complaint for the past 10 years but the diagnosis has only recently been made. We are a large family, eight children and 22 grandchildren, scattered all around the world. . . ."

The 176 letters from all families asked for information on: both inheritance and the disorder, 92; inheritance only, 42; symptoms and prognosis, 19; specific practical problems, six. The number of requests (138) for genetic information is striking. Six writers say that they did not appreciate the hereditary nature of the disease before the publicity, and only four say that they have been to a genetic clinic. There is much confusion about "skipping" generations and the age of onset. An extract from a typical letter illustrates this:

"I am one of five children, my father had HC.

I am now 50 and do not seem to have any symptoms. I have two boys, 26 and 23 years. Now could you please tell me if I don't have the symptoms up to now does it mean that I am clear? If I am clear will HC not come out in my sons either? Can it come through past generations?"

Using the 150 letters which gave family details an estimate (almost certainly an underestimate) of relatives at risk can be made. There are 186 adults and 72 children with a half chance of developing HC and 20 adults and 203 children with a quarter chance.

If these letters are any guide HC families badly need better contact with their family doctors so that they can get genetic counselling and more knowledge of the onset and progress of the disease. Until families consult family doctors, as they could and should, some publicity may be justifiable. By being alerted in this way at least some of those at risk can learn enough about the disease to be able to make positive choices about family planning. Although Combat's main aim is to support families, its members are also anxious to help with research, and small grants for research projects can be made from the association's funds.

KATHLEEN EVANS
on behalf of the Executive
Committee of the Association to
Combat Huntington's Chorea.

Sunbury on Thames, Middx

Concentration of thyroxine-binding globulin

SIR,—The emphasis placed by Dr W A Burr and his colleagues (19 February, p 485) on the cases in which the Thyopac-3 test gave falsely low results compared with their measured levels of thyroxine-binding globulin (TBG) obscures the excellent correlation that they demonstrated between TBG and Thyopac-3 for Thyopac-3 values up to about 135%.

I should like to make two observations. First, the incidence of the very high TBG levels of which Dr Burr and his colleagues saw 21 examples in 12 months seems very low in the area covered by our laboratory (the Southampton District and surrounding areas, including the Isle of Wight). Of 2400 patient requests recently seen 0.7% showed Thyopac-3 values of 130-134% and 0.5% showed values of 135% and above (only non-hypothyroid patients are considered). None of these patients had total thyroxine (T4) levels (measured by radioimmunoassay kit, Radiochemical Centre Ltd) anywhere nearly high enough to make misclassification into the thyrotoxic group possible on the basis of a free thyroxine index calculation.

My second point concerns the application of a rational strategy to cover situations in which Thyopac-3 values are far outside the usual range. In the 18 months since we began measuring T4 by radioimmunoassay we have seen results from four euthyroid patients with Thyopac-3 values above 130% (out of over 8000 new requests) where a calculation of the free thyroxine index would have resulted in a false "toxic" classification. We do not use the free thyroxine index, but the mapping technique (Radiochemical Centre booklet). On the T4 versus Thyopac-3 map the four sets of results fell just in the "toxic" region but, because the pairs of values were so unusual, precise classification was possible only by extrapolating a borderline which was well

defined where the population of points was densest to the very sparsely populated area concerned. A further test was obviously required: the triiodothyronine (T3) level. The T3—Thyopac-3 pairs plotted on a T3 versus Thyopac-3 map fell in each case clearly in the euthyroid region, though again some extrapolation was necessary because of the high Thyopac-3 values. The resolution of the difficulty here reflects the well-known superiority of the level of T3 (which should be related correctly in some manner to Thyopac-3 or TBG for maximum discrimination) over that of T4 as a discriminator of high thyroid hormone output states. Only one of the sets of results seems likely to have been caused by familial high TBG levels; the others were caused by identifiable factors (pregnancy or oestrogen administration).

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Localised airway obstruction

SIR,—Your leading article entitled "Localised airway obstruction" (12 March, p 669) should strictly have been called "Upper airway obstruction" in accordance with established usage and as shown by Harrison, whom you quote.¹ The use of the term "localised airway obstruction" should be restricted to describe an obstruction in an airway at any level distal to the carina. Thus the term implies that as well as the localised obstruction, causing localised reduction in airflow, there is also some other airway without a reduced airflow. This situation is most commonly encountered in carcinoma of the bronchus.

Since generalised airways obstruction is accepted as the greatest single cause of post-operative cardiopulmonary complications in surgery for carcinoma of the bronchus the assessment of the functional state of the lungs prior to thoracotomy in this condition resolves into displaying whether or not there is significant generalised airways obstruction attributable to bronchitis as well as the localised airway obstruction due to the tumour. The situation was first put in those terms in 1964 by Simonsson and Malmberg,² and investigations since then have been directed at improving methods of discriminating between the contributions to lung dysfunction of the two disease processes.

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

² Simonsson, B G, and Malmberg, R, *Thorax*, 1964, 19, 416.

Prevention priorities

SIR,—Your leading article (16 April, p 989) supports the false hope of the House of Commons Expenditure Committee that "preventive medicine might save money." Surely "investment in prevention" will never "pay off in financial terms"—not even in "15 or 20 years."

It is likely that man will always die sometime, and if in old age the more will he be subject to illness, the more drugs will he

consume, and the more appliances will he require, and time spent in a long-stay geriatric ward will cost more than a pneumonectomy.

Prevention certainly, and the necessary finance must be found, for we are a caring society, but in the interest of its members in 20 years' time the BMA should warn MPs now that adequate health care of an older population will cost more. The Government will also need to finance more pensions⁷

RONALD SAVIDGE

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Breast size and cancer

SIR,—We were most interested to read the letter from Professor B N Catchpole (19 March, p 776) indicating the present lack of information on breast volume in relation to cancer.

As part of a study on breast carcinoma we have been recording breast volume and computed tumour volume,¹ in all stage I-III (TNM classification) patients undergoing mastectomy. Our present results, from 14 cases, show a breast volume range of 200-1150 (mean 562) cm³, a tumour volume range of 0.36-23.4 (mean 7.95) cm³, and a tumour : breast volume ratio, expressed as a percentage, of 0.08-6.78 (mean 2.18).

There has been no evidence so far of a correlation between any of the values recorded, the clinical stage, or the aggressiveness of the tumour as assessed by the percentage lymph node involvement by metastases. It remains to be seen whether long-term studies will reveal breast volume to be of importance in the eventual outcome of the disease.

ALISTAIR J ROBERTSON

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¹ Pathology Working Group, Breast Cancer Task Force, *American Journal of Clinical Pathology*, 1973, 60, 789.

The bedpan round

SIR,—With Telstar in the sky the wasteful manner in which nurse manpower is deployed in the wards of Britain's nationalised hospitals is surely a blot on management. In an age when children are carrying goldfish swimming in water in polythene bags nurses in the wards of Britain's nationalised hospitals are being made to use metal bedpans weighing 4 lb each to transport a few ounces of bulk or liquid excreta in a manner which no employee of a firm in industry would tolerate.

This is not all. The unhygienic traditional manner in which bedpans are stored in between use in ward sluices is still in use. Because these bedpans after use cannot be guaranteed to have been made bacteria-free before being placed for use between the sheets of other patients it does not require much imagination to conclude that the procedure provides a channel whereby infection is transferred from one patient to another.

In no other situation would taxpayers be content to foot the bill for the increasing incidence of postoperative cross-infection

which is not only causing pain and distress to patients and their relatives but is responsible for the prolonged use of hospital beds, the extra time spent on care by medical men, nurses, and auxiliary staff, as well as the extra cost of hospital supplies.

In the year 1961, when I first had the idea of introducing a polypropylene bedpan with a detachable polythene liner which would take the place of the bedpan, I discussed the matter with the matrons of the main London hospitals. They all said they would never allow such a thing as bedside storage of bedpans. These inflexible attitudes have persisted and have led to all of the costly new hospitals being provided with ward sluices which are equipped with the old-fashioned metal bedpans weighing 4 lb, metal racks for storing them in between use, as well as bedpan washers and machines for macerating papier maché bedpan inserts, both of which use millions of gallons of water as well as thousands of pounds worth of electricity every day in the nationalised hospitals.

I wonder if your readers will think as I do that innovators have been under a delusion in thinking they would get any encouragement to invent new equipment and methods which could bring increased productivity, reduce unpleasantness, and obviate the danger of cross-infection for both nurses and patients.

E M GRANT

Albury, Surrey

Colour blindness and arithmetic

SIR,—I recently saw a case which I thought would be of interest to many of your readers. A bright young boy of 6 was found to be backward at arithmetic. The headmaster of the school explained to the parents that the system that they were using to teach the children was the Fletcher system, which uses colours, and he wondered whether the boy had a colour vision defect. On examination I confirmed that he was incompletely red/green blind; I also got a family history that he had an uncle with the same complaint.

Various authorities give different figures for the incidence of colour blindness, but I would say that the most generally accepted one is that 8% of males and 2% of females do have some form of inherited colour defect. If, therefore, a system like this is going to be used widely to teach arithmetic to youngsters then 5% of them are going to be backward through no fault of their own. I wrote to the specialist in community medicine drawing his attention to this point and had a most helpful letter in return. He is certainly taking action at a local level, but I thought that the issue raised was of such importance that it might be as well if more of my colleagues knew of this problem.

L H G MOORE

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Diet and coronary heart disease

SIR,—Professor A G Shaper and Miss Jean W Marr (2 April, p 867) have recommended a dietary change to postpone coronary heart disease in the British community. They recommend reduced intakes of foods high in saturated fats and replacement with foods relatively high in polyunsaturated fats. These