by a letter inciting others to inflammatory correspondence." When, after 20 years' membership of the IMLS, I deemed it necessary to criticise the education policy (*IMLS Gazette*, April 1974) I was told that "sweeping and incorrect statements are not justified by emotive language."

The Scottish delegates who attended a recent IMLS symposium in Dundee certainly found no reassurance about this controversy from the president-elect, who seemed unwilling to admit that problems exist. May I reassure Dr W A J Crane and his colleagues (12 February, p 441) that many members of the IMLS, including chief technicians from district hospitals, disagree with the official dogma? Care of the sick is a team effort and verbatim quoting of Whitley Council regulations (PTB 273) is not required to remind myself or my colleagues that ultimate medical responsibility for laboratory investigations on our 1500 patients plus the GP service, health centres, etc, rests with the senior consultant and his four colleagues.

At the moment it would seem that the IMLS is unwilling to clarify further the statement of its aims in the light of recent correspondence and is content to write broad statements suggesting that a letter containing soundly based comment is an incitement to mutiny. It is to be hoped that our medical colleagues realise that there is a bigger reserve of goodwill among the technical staff than is apparent from official pronouncements.

A R HAXTON
Chief technician

The Laboratory,
Stracathro Hospital,
Brechin, Angus

repetitive role as an educator of junior staff or a "clinical fire alarm." Discussion on possible developments in training can be found in the published reports of the first meeting.^{1,2} A time of clinical responsibility in specified fields is an important part of training for the clinical pathologist. Prospective clinicians would also undoubtedly benefit from time spent within the laboratory. The setting up of laboratory-clinical rotations could be an important advance and should be encouraged at both local and national levels.

The decline in recruitment to chemical pathology² and microbiology brings with it the prospect that senior posts will become altered to posts for non-medical graduates in default of medical applicants. We believe a medical influence, properly trained both scientifically and clinically, is vital within the laboratory and should successfully complement the work of the non-medical scientist.

The initiative which led to interchangeable primary qualifications between the MRCP and MRCPATH examinations has not been enough. We would like to suggest that an open working party be set up by the Royal College of Pathologists, involving the other royal colleges, to consider the steps needed to improve and encourage an appropriately integrated training. An improvement in recruitment would surely follow.

ANDREW GRANT
RODERIC WARREN
R M SANDLER

John Bonnett Clinical Laboratories,
Addenbrooke's Hospital,
Cambridge

¹ *Lancet*, 1976, 2, 945.

² Association of Clinical Biochemists Ltd, *News Sheet*, March 1977.

* * * This correspondence is now closed.—ED,
BMJ.

Laparoscopic sterilisation with Silastic bands

SIR,—Experience in Wolverhampton confirms the findings of Mr A A Templeton and his colleagues (16 April, p 1008) that laparoscopic sterilisation with Silastic bands is a useful technique and probably safer than laparoscopic tubal diathermy. During the past five years two patients sustained burns of the small intestine during tubal diathermy. Regrettably one died, but the other was rescued by timely laparotomy and bowel resection. The Silastic band technique also carries some risk.

Recently a 29-year-old woman who had previously had her gall bladder removed underwent laparoscopy and the application of Silastic bands. The applicator was inserted through a separate canula. No obvious difficulty was encountered and there were no pelvic adhesions. Twenty days later she was readmitted with a painful, tender mass in the left iliac fossa. A moderate neutrophilia was associated with a raised erythrocyte sedimentation rate (73 mm in the first hour). At laparotomy an abscess was found bounded by the left tube, ovary, and pelvic colon. The left ovary and both tubes were excised. Previous damage to the bowel wall was suspected so that a corrugated drain was inserted down towards the pelvic colon and the abdomen closed. Histological examination showed acute inflammation of the walls of the left tube and ovary, while the right tube was chronically inflamed. *Escherichia coli* was cultured from the pus. By the 35th day there was an obvious small faecal fistula in the left iliac fossa. The fistula was confirmed by barium enema, which also excluded other disease of the large bowel. The fistula has

since closed slowly, and the patient only regained normal health five months after the first operation.

It is probable that the pelvic colon was pierced by the Verres needle or one of the two trocars used. It is unlikely that the pelvic colon was injured by either the Silastic band applicator or the ring itself, but the exact way in which the bowel was damaged remains unknown.

I thank Mr H J Fisher for access to the records of his patients.

ALAN M SMITH

New Cross Hospital,
Wolverhampton

Swimming goggles causing severe eye injuries

SIR,—With reference to the report by Dr F Jónasson of three cases of severe ocular trauma caused by swimming goggles (2 April, p 881) I wish to report a similar case.

A 3-year-old boy was hit in the left eye by a swimming goggle. He presented to this department three days later, on returning from holiday, complaining of a sore eye. He had had no treatment before his hospital visit. Examination revealed a large penetrating corneal laceration of the left eye with prolapse of the iris. He had only perception of light in that eye.

The laceration was repaired, excising the necrotic iris. Careful examination under anaesthesia also revealed moderate commotio retinae near the macula and suspected anterior lens capsule damage. The eye subsequently healed uneventfully, but on removal of the corneal sutures three weeks later a sectorial cataract had developed across the visual axis.

Not only is future visual impairment inevitable from the injury but the probability of amblyopia in such a young child is high. I can only reiterate the sentiments of Dr Jónasson about redesigning the type of strap used for swimming goggles.

R J LAMB

Ophthalmic Department,
Princess Mary's Royal Air Force
Hospital,
Halton,
Aylesbury, Bucks

Disseminated histoplasmosis in Britain

SIR,—In the case of the patient described by Dr A Jariwalla and his colleagues (16 April, p 1002), a diagnosis of disseminated histoplasmosis was made from the histological appearances of biopsy sections of the oral ulcer and the presence of hepatosplenomegaly. Several aspects of this report warrant comment.

The authors have failed to realise that this form of histoplasmosis in the United Kingdom was well described by Symmers.¹ All 48 cases in Symmers's series were in White Europeans who had been in southern or south-eastern Asia for periods of a year or more. Their illnesses developed overseas or up to 33 years after their return to Europe. Men outnumbered women by about three to one. The clinical picture was distinctive, being characterised by painful ulceration of mucocutaneous junctions or mucosae near bodily orifices. A second feature of this form of histoplasmosis is acute adrenal cortical insufficiency, responsible for 11 of the 23 deaths in Symmers's series.

It should be made clear that the expertise required for recognising *Histoplasma capsulatum* in tissue sections is readily available on

SIR,—Your leading article (2 April, p 866) emphasises the importance of the medically qualified graduate within the laboratory. Professor L G Whitby and his colleagues (23 April, p 1082) tend to blur the distinction between the medical and non-medical graduate. We would argue that they have complementary roles, but the difference needs to be more clearly defined. As trainee pathologists we view with concern the decline of recruitment of the medical graduate to pathology and consider there is a need for a reappraisal of the role and training of the clinical pathologist which fully justifies his medical training and the importance this has to the laboratory.

The advances made in haematology by correlation of laboratory and clinical expertise are now well known. Poor recruitment to the other branches of pathology is occurring just at the time when the rapid and sophisticated development of these services requires a strong laboratory-clinical interface. There is a continuing need for the central influence of the medical graduate in the direction of development, the monitoring of the usefulness of new technical advances, and the control of the soaring work load.

Recently two meetings of trainees in chemical pathology have discussed training; last October in Cambridge and this March at the Royal College of Pathologists. Two major frustrations were, firstly, the failure to clarify the overlapping roles of the medical and non-medical graduate; secondly, the similar failure to define the clinical role and responsibility of the medical graduate. This may relegate him, if the contact is too superficial, to being a "textbook physician" or, if the responsibilities are too many, restrict him to a

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, mucicarmophilic 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.

D W R MACKENZIE

Mycological Reference Laboratory,
London School of Hygiene and
Tropical Medicine,
London WC1

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

Tickhill Road Hospital,
Doncaster

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.

T MARSHALL

Department of Social Medicine,
University of Birmingham

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