ratios above 1:1 at about 32 weeks "would probably have been induced at 32 weeks' gestation; but combining such serious prematurity with severe haemolytic disease had resulted in almost a 40% neonatal mortality." It seems that you misread this very easily understood statement. It is a pity that your readers should be thus misinformed.

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¹ Whitfield, C R, *et al*, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1972, **79**, 931.

² Palmer, A, and Gordon, R R, *British Journal of Obstetrics and Gynaecology*, 1976, **83**, 688.

³ Fairweather, D V I, *et al*, *British Medical Journal*, 1967, **4**, 189.

*We regret an error in the reference numbers. The statement in our leading article that "most series treated by intrauterine transfusion alone record a 40% survival" should have referred to the paper by Professor Whitfield and his colleagues,¹ and the reference to the neonatal mortality at 32 weeks is, of course, derived from Palmer and Gordon's paper.² The report by Palmer and Gordon does raise serious doubts about the value of intrauterine transfusion, and we consider that a re-examination of its value in relation to the new development of plasmapheresis is indicated. This conclusion is independent of any discussion of the exact mortality figures of the untreated disease, which we agree are difficult to obtain.—ED, *BMJ*.

Overheated wards

SIR,—Why are hospital wards invariably overheated? It seems paradoxical that patients, cured of their life-threatening illnesses, are becoming endangered by that fiendish species—the NHS radiator. All too often I have witnessed prostrate patients perspiring away their water and electrolytes, which are enthusiastically replaced intravenously by harassed house officers who fail to understand why their patients are so dehydrated. Please, before this summer's heatwave, will someone in the heating department have a brainwave, and economise?

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What to tell the employer

SIR,—Dr John M Goldman in his letter (7 May, p 1221) raises some very interesting points, and I feel the following personal case is probably worth reporting.

Some years ago an old student of my own, who now was an assistant medical officer of health in a certain county in England, came to see me when on leave. I was horrified to find that he had an advanced cancer with secondaries in his liver, and all that one could do to relieve his obstruction was to bypass it, but this of course did not in any way prevent the fatal onset, which was only going to be 2, 3, 6 months ahead. While the young man was in hospital I had a letter, in confidence, from the chief medical officer of the county asking *in confidence* for the medical details of the case. I replied very fully, again in strict *confidence*, pointing out that the man had less than some six months to live. I got no acknowledgment

of my letter, but one can guess the reaction when my patient some weeks later read in the *Journal* that his appointment was now being advertised. I don't think I have ever had such a case of bad faith, and it naturally has made me very careful of what to tell the employer.

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What to tell the occupational physician

SIR,—I was distressed to read Dr J M Goldman's letter (7 May, p 1221), in which he discussed communication with occupational physicians, such as me, and even more distressed to read the headline "What to tell the employer." Please let me emphasise that a consultant or a family doctor corresponding with an occupational physician is *not* corresponding with an employer any more than I am corresponding with the area health authority when I write to a consultant. Dr Goldman's first paragraph contains the offensive suggestion that occupational physicians are not primarily concerned with the welfare of their patients and do not preserve medical confidence. And what would Dr Goldman say if I were to write, "An inquiry from an oncologist can sometimes best be answered by a telephone call—one has then the opportunity to satisfy oneself about the doctor's essential good faith"?

I suggest that Dr Goldman refers to the BMA publication *Medical Ethics*, 1974, p 31: "The doctor in occupational medicine and the general practitioner have a common concern—the health and welfare of the individual workers coming under their care. Less often, this concern may be shared with the hospital doctor, the community physician or some other professional colleague. As in all cases where two or more doctors are so concerned together the greatest possible degree of consultation and co-operation between them is essential at all times—subject only to the consent of the individual concerned."

No person, neither employer nor doctor, is entitled to any medical information whatever from a doctor about an employee or a candidate for employment without the consent, explicit or implied, of the patient. No occupational doctor will tell an employer anything without such consent, and even with consent he will tell the employer only what he properly needs to know. So when an occupational doctor asks, with the consent of the patient, for detailed medical information it is entirely proper for him to be given it. It is his job, in which he is a specialist, to interpret that information honestly and in the interest of his patient.

Dr Goldman's second paragraph discussed what should be told an employer who asks for a patient's medical history. He says that a prospective employer is not entitled to full medical information but "he is (presumably) entitled to be forewarned against the risk of taking on an employee who will very soon be incapacitated. . . ." He goes on to say that the patient's own doctor may properly give a favourable report without the consent of the patient. Few doctors I hope would be prepared to give any information, favourable or unfavourable, without the consent of the patient. A moment's reflection would make it plain that, if it were permissible for a doctor to report favourably without consent, his refusal to report could immediately and rightly be

assumed to be equivalent to an unfavourable report. Dr Goldman also suggests that the patient's family doctor and not the occupational physician should decide in all cases whether a man will be accepted into employment as fit to do any particular job. I find this a very strange suggestion, and one unlikely to appeal to many prospective employers. Dr Goldman's suggestions are—shall we say?—ingenuous, but then if I were to address you on the chemotherapy of leukaemia I would hardly do better.

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Hot flushes and cold turkey

SIR,—The recently increased interest in the menopause encourages me to draw attention to the similarity between features associated with this state and those related to withdrawal of drugs of addiction or dependence. The characteristic features of the menopause are classified into three groups: autonomic instability, emotional and psychological instability, and biochemical changes. Of these the first two are also prominent characteristics of the addicted subject who is exposed to acute, or even phased, denial of his narcotic, nicotine, or alcohol. That the autonomic instability is in the one instance typified by "hot flushes" and in the other by "cold turkey syndrome" could be reflective merely of the different sites of activity of the agent of dependence. If relief of the emotional and autonomic symptomatology associated with the menopause is not completely provided by substitution therapy, this could indicate simply that the critical compound was an apparently minor metabolite of one of the female sex hormones.

A similar picture is surely to be seen in the puerperal subject. Indeed, I have for some years referred to the puerperium as the "mini-menopause," and would respectfully suggest that those intensively engaged in investigation of the menopause might benefit from a consideration of the postpartum patient as a "model" for study.

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Oral contraceptives and the uterine vessels

SIR,—Your leading article on pregnancy and oral contraceptives and the uterine vessels (30 April, p 119) asks if oral contraceptives cause disease of the uterine arteries.^{1 2} We have previously found that changes in small uterine vessels, those in the endometrium, are one of the earliest effects of taking oral contraceptives. Proliferation of endometrial arterioles is related to headache and migraine incidence,³ distended sinusoids to tiredness and dilated leg veins, and stromal condensation round sinusoids to leg cramps.⁴ Sinusoid changes and headaches usually precede development of thrombosis. One patient had particularly large sinusoids after 43 years of treatment. She had developed migraine for the first time in her life during cycle 40 and bilateral phlebitis in cycle 43.

There has seemed little doubt to me that oral contraceptives cause generalised vascular over-reactivity, probably by alteration of immune mechanisms. These changes are

usually rapidly reversible if the early symptoms are taken as an indication to discontinue the oral contraceptives. Some patients do, however, have difficulty in regaining good health after stopping the pill. We have recently found that oral contraceptives and smoking are the most important contributory factors to patients requiring emergency treatment at an acute migraine clinic.⁵ Both men and women smokers come to the clinic after smoking for an average of 20 years, while women taking oral contraceptives come for treatment after an average of less than three years of exposure to the pill. This suggests to me that oral contraceptive use is a more potent cause of vascular disease than smoking, and this has not been generally realised because of the very high oral contraceptive discontinuation rate.

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¹ Gillman, T, in *Biological Aspects of Occlusive Vascular Disease*, ed D G Chalmers and G A Gresham. London, Cambridge University Press, 1964.

² Osterholzer, H O, et al, *Obstetrics and Gynaecology*, 1977, **49**, 227.

³ Grant, E C G, *British Medical Journal*, 1968, **3**, 402.

⁴ Grant, E C G, *British Medical Journal*, 1969, **4**, 473.

⁵ Grant, E C G, et al, *The Migraine Trust International Symposium*, 1976. in press.

A case of twisted logic

SIR,—In your "Clinics in General Practice" (14 May, p 1260) a patient with a three-week-old injury to the ankle requests an x-ray. In spite of the fact that there is no clinical evidence of a fracture the GP trainee is advised to refer her for x-rays for medicolegal and psychosocial reasons.

There are no medicolegal reasons for taking x-rays. There are, however, medicolegal reasons for making an adequate examination and recording the findings on the notes, including a statement that there is no clinical evidence of a fracture. And, if there is any doubt, there are medicolegal reasons for asking the patient to attend for review. Having fulfilled these obligations, no doctor should order x-rays because of an imagined legal obligation. His obligation is to the patient, not to his lawyer. To order x-rays for psychosocial reasons may indeed cut short a consultation and save time on a particular case, but the general effect will be to perpetuate the myth that x-rays are needed in all injuries, thus increasing the work load for the future. In this case the consultant admitted there was no physical indication for radiography but had no hesitation in consenting to an x-ray in order to put on "an impressive show of strength" and convince the patient that there was no fracture. In effect he was putting on an impressive show of weakness by implying that his clinical diagnosis was not reliable and that the patient was right after all to insist on an x-ray.

We surely have a duty to educate our patients. Even if we fail to persuade them that a fracture of the ankle can be diagnosed clinically we will have little difficulty in persuading them that there are possible harmful effects of taking too many x-rays. And we can remind our patients that the exercise of clinical judgment is recommended by the International Commission on Radiological Protection.¹

It is ironical that we tend to blame the legal profession for our failure to avoid unnecessary x-rays, whereas in fact the legal profession is

dependent on the evidence of medical witnesses to establish negligence. Therefore, until we educate ourselves in the need for balanced judgment in ordering x-rays then there is little hope of improvement.² Balanced judgment depends on our being well informed of the pitfalls in the clinical diagnosis of fractures, and in this connection it is vital that casualty departments should have clear instructions on the principles that should govern discretionary policies in ordering x-rays.³

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¹ ICRP Committee, *Protection of the Patient in X-ray Diagnosis*. Oxford, Pergamon Press, 1970.

² Thomas, D F, *British Medical Journal*, 1971, **2**, 105.

³ Fowler, A W, *British Medical Journal*, 1970, **1**, 362.

Heating human milk

SIR,—Your leading article (28 May, p 1372) comments on the results of our study on pasteurisation of human milk and suggests that differences in technique account for the differences in our findings and those of Ford et al.¹ Our detailed procedure for pasteurisation was as follows: since we wished to simulate a technique which might be used in routine practice, we used whole milk direct from the milk kitchen. This was not processed in any way. Aliquots of 1 ml were transferred to glass tubes (75 mm × 10 mm) in a water bath at 62.5°C for 30 minutes. The samples for protein assays were then frozen at -40°C. Because of the small volumes used, we did not monitor the temperature at the centre of the sample, as suggested in your leader, since we considered that the temperatures would rapidly equilibrate.

The sterilisation procedure appears very similar to that used by the Shinfield group, the principal difference in technique being their use of high-speed centrifugation and filtration to prepare the samples. We consider it unlikely that removal of fat and debris would have a major effect on the heat penetration of such a small sample, and we would suggest that it is most likely that the initial processing may in some way render the lactoferrin and IgA more susceptible to heating.

It is clear from these preliminary studies that, as you suggest, a combined exercise to evaluate the more subtle aspects of the use (and abuse) of human milk is urgently needed.

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¹ Ford, J E, et al, *Journal of Pediatrics*, 1977, **90**, 29.

Amniotic fluid AFP in multiple pregnancy

SIR,—Our observations on alpha-fetoprotein (AFP) values in multiple pregnancies agree with those of Dr Sheila L B Duncan and her colleagues (21 May, p 1354). In 14 cases of normal twins, the amniotic fluid AFP levels were within the normal range for singleton pregnancies. The maternal serum AFP levels were, however, elevated.

These findings agree with the fact that a very high proportion of twins, even those which are monozygotic, are in separate amniotic sacs. Only about 2% have a common amniotic cavity.¹ Thus, as far as the amniotic

fluid is concerned, twins in separate sacs may be considered as singleton pregnancies, with one fetal liver producing AFP per sac. At the placental interface, however, there is the AFP produced by two fetal livers to pass into the maternal compartment; hence the maternal serum AFP is higher than in a singleton pregnancy.

It is the 2% of twins which are mono-amniotic which should in theory have an elevated amniotic fluid AFP. A recent case of ours shows that this is so. A patient underwent amniocentesis at 30 weeks because the ultrasound findings were equivocal. The AFP level of the amniotic fluid was 9 µg/ml (normal < 1 µg/ml). The patient was subsequently delivered of twins who were joined side by side. All organs were enclosed and there were no defects of the neural tubes. There were two pancreases, two duodenums, and a single large multilobed liver, which appeared to consist of two fused parenchymas.

Thus in a situation where there was the equivalent of two livers and an indisputably single amniotic sac there was an elevated amniotic fluid AFP level. However, since most multiple pregnancies are not monoamniotic, it is anticipated that almost all amniotic fluid AFP values in multiple pregnancies will not differ from those of singleton pregnancies.

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¹ Morison, J E, *Fetal and Neonatal Pathology*, 3rd edn. London, Butterworth, 1970.

Is this a record?

SIR,—I was recently asked to see a patient with the most extensive bilateral Dupuytren's contractures I have ever seen. He is now aged 70 and apparently was placed on the waiting list for surgical correction of the deformities in 1952. Perhaps the best way to describe the increasing deformity is his progressive inability to play musical instruments. When he first presented 25 years ago he was a keen clarinetist and saxophonist. As his Dupuytren's progressed he lost his ability to play these instruments and turned to the drums. He now has difficulty in holding the drum sticks.

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Insurance companies' attitude to psychiatric illness

SIR,—In his letter referring to recent suggestions that insurance companies may be prejudiced in their loading of minor psychiatric illness (21 May, p 1350) Dr Andrew Sims says that the neuroses carry a slightly increased risk of premature mortality. Such an assertion demands formidable diagnostic severity. A random survey of a hundred patients taken after three consecutive years of admissions to a neurosis unit with which I was associated