lymphocyte PHA responsiveness¹ this might prevent sensitisation occurring.

Our first patient had had a skin eruption for 25 years which was diagnosed as mycosis fungoides in 1974. She was started on PUVA therapy in 1976, since treatment with electron beam, cyclophosphamide, ICRF 159, and localised irradiation had failed. This was highly successful until this year, when relapse occurred—including the development of tumorous lesions between the fingers, in the natal cleft, under the axillae and breasts, and in the groin (that is, areas shielded from the UVA, a not-uncommon observation with photochemotherapy). There was no lymphadenopathy, but her skin lesions and diminished lymphocyte responses to PHA suggested that she had incipient stage III disease at this time. It was decided to start her on daily topical nitrogen mustard therapy (200 mg/l) and continue her thrice weekly PUVA. The disease was completely cleared after four weeks' treatment, but at five weeks she developed a severe contact dermatitis. She has had a total PUVA dose of 333 J cm².

The Scandinavian findings are important, but we question whether they could be due to the development of anergy due to disease progression,² since retesting to mustine was carried out many months or years after the original contact sensitivity occurred.

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¹ Kruger, J P, Christophers, E, and Schlaak, M, *British Journal of Dermatology*, 1978, **98**, 141.

² du Vivier, A, et al, *Cancer*, 1978, **42**, 209.

Persistent excretion of salmonellas

SIR,—Your note on "Persistent excretion of salmonellas" (12 August, p 509) was very instructive, but we would like to give some additional information.

In the case you described the presence of salmonellas was only determined qualitatively and the method was not indicated. We have carried out an investigation on the quantitative aspects of salmonella excretion in both infants and adults (the data will be published shortly). Typical excretion patterns are presented in the graphs. In general, infants may excrete high numbers of salmonellas for a much longer period of time than adults, but high numbers

(10^3 – 10^7 per g) of salmonellas may also be found in the faeces of adults for several weeks after clinical salmonellosis. From laboratory quality assurance programmes carried out by the regional public health laboratories we know that with the direct plating procedures salmonellas will be detected only when their number exceeds more than 10^3 bacteria per gram. With our method, using pre-enrichment prior to selective enrichment and plating, less than one salmonella per gram can be detected (when more than 1 g of faeces is examined). Especially during the last period of excretion, when the numbers are frequently 1 – 10^3 , the method of examination becomes of utmost importance with regard to the "free from salmonellas" declaration and the consequent procedure.

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Grommets and swimming

SIR,—I feel I must also take issue with your expert's advice (5 August, p 420) that children with grommets in their ears "should not be allowed to swim because of the danger of water-borne bacterial otitis media." The hole in the grommet is too small for water to pass through it unless there is a marked pressure difference between the middle ear and meatus, a condition the grommet prevents. I have allowed hundreds of children with grommets in their ears to swim and have not had a case in which I have found it responsible for otitis media. In fact, I believe that it is safer for children with a tendency to otitis media to swim with a grommet than without one, as the middle ear infection in these cases is usually initiated by irritation of the nasal and postnasal mucous membrane by the chlorine of the swimming pool water, leading to swelling of the eustachian tube lining, eustachian obstruction, and subsequent middle ear infection. A functioning grommet prevents the damaging effect of eustachian obstruction on the middle ear and thus makes it safer for these children to swim in chlorinated pools. Swimming is a healthy and often favourite exercise in the age group in which glue ears are common, and in the interest of these children it is high time that the commonly held belief that they should not swim with a grommet was debunked.

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Royal College of Surgeons of Edinburgh: reform of fellowship examinations

SIR,—At the annual meeting of the Fellows of the Royal College of Surgeons of Edinburgh on 18 October it was resolved by a large majority of those fellows present and voting that "the Council be hereby empowered (1) to introduce a new examination in the surgical specialties to be taken after the Part II fellowship and leading to the award of an additional diploma distinguished by the name of the specialty; (2) to decide on an appropriate title for the new diploma." There has been so much misunderstanding about the proposals which Council made last year for the reform of the fellowship examinations that I shall be grateful if you will allow the space to

explain what were the proposals that we made last year.

The new Part I examination was to comprise the applied basic sciences and the principles of surgery in general, and was to be taken when the basic training in surgery had been completed about three years after registration. The new Part II examination was to be taken in one of the recognised specialties, and the suggestion was that the candidates should have completed a minimum of three years' training in their chosen specialty in posts approved for this purpose by the college.

Last year the fellows asked Council to consult widely with the other colleges, the Association of Professors of Surgery, and the specialist associations. We have done this, but we have not been able to persuade the other colleges and some of the specialist associations to accept our original proposals for the revision of both parts of the examination. We realised that, if we introduced this revision without the co-operation of the other colleges, we would be isolated and the reciprocity which at present exists between the British colleges would be lost. This reciprocity is a very important aspect of the relationships between the colleges.

The training programmes administered by the Joint Committee on Higher Surgical Training have had a remarkably beneficial effect on the development of the surgical specialties and on British postgraduate surgical training. The Council feels very strongly that the fellowship examinations in their present state do not bear a proper relationship to British surgical postgraduate training and to the requirements for specialist recognition. We very much regret that the proposals which we put to our fellows last year for the reform of the fellowship examinations have had to be shelved. We therefore tried to find an alternative which would improve the present situation while not disturbing the present arrangements for the examinations. Although the present form of the fellowship examination is constantly under review the basic structure has not been changed during the last 15 or 20 years, during a period when there has been a rapid increase in the sophistication and complexity of every field of surgery. Therefore some formal assessment of the standard achieved by those in training ought now to become the proper responsibility of the colleges. The proposals which we have now been empowered to implement are the first step in what we firmly believe will be a gradual movement towards the achievement of the proposals which we made last year. There can be no doubt that this must not only be a gradual movement but that it is also one which is long overdue—we must make this change and make it now.

These proposals mean, firstly, that the present Parts I and II of the fellowship examination should continue undisturbed and that they will be taken at the same stages in training as at present. Secondly, in addition there will be an examination in the chosen specialty to be taken during specialist training. This will consist of an oral examination in the applied basic science of the chosen specialty, a clinical examination, and a systematic oral in the surgical aspects of the specialty. The advantages of this proposal are, firstly, that they do not disturb the present arrangements for the diploma of fellowship or the reciprocity with the other British colleges, and, secondly, that the specialist diploma will open the way to securing reciprocity with the

Typical salmonella excretion patterns in infants and adults.