possible whether or not: (a) the drug affects the production of milk; (b) the drug is excreted in the milk and, if so, whether the amount is of clinical significance; and (c) the amount excreted would adversely affect the neonate or infant. The information would then be readily at hand when the increasing number of lactating mothers consult their practitioners. I am trying to assemble such data to produce a useful reference to drugs which are safe rather than the negative lists which currently predominate.

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¹ Lewis, P, *Journal of Maternal and Child Health*, 1978, 3, 128.

² Harvey, D, *Modern Medicine (Great Britain)*, 1978, 23, 87.

Serum trypsin concentrations in diabetes mellitus

SIR,—The paper by Dr P Dandona and others on serum trypsin concentrations in diabetic subjects (21 October, p 1125) is an interesting contribution to the accumulating evidence of dysfunction of the exocrine pancreas in diabetes. Their observation that serum trypsin concentrations are low in insulin-dependent diabetic patients, with a lesser decrease in diabetic patients treated with oral hypoglycaemic agents, certainly corresponds to the pattern of reduced pancreatic trypsin output described in similar groups of diabetic subjects.¹ (Exocrine pancreatic function in these patients was in fact studied in response to an intravenous infusion of secretin and cholecystokinin-pancreozymin and not to a Lundh test meal as the authors state.) However, while serum trypsin concentrations vary in different clinical conditions,² the value of this measurement as an index of the secretory capacity of the exocrine pancreas can only be inferred. Their interpretation that low serum trypsin concentrations in diabetic subjects are indicative of exocrine pancreatic deficiency would be strengthened if a direct correlation could be demonstrated with stimulated outputs of pancreatic trypsin in the same patients. It would also be interesting to know if the authors found a relationship between the serum trypsin concentrations and the duration of diabetes in each group of patients.

The authors further refer to our study demonstrating a direct relationship between exocrine pancreatic function and endogenous insulin secretion³ (as measured by C-peptide concentrations) to support their premise that the abnormality of serum trypsin concentrations parallels the degree of beta-cell deficiency in their diabetic patients. We observed a significant correlation between endogenous insulin secretion and the outputs of pancreatic amylase and bicarbonate in a group of insulin-dependent diabetic patients but could not demonstrate a relationship with pancreatic trypsin output, although the latter was undoubtedly diminished in diabetes.³ Animal studies have also failed to show that insulin will enhance pancreatic protease enzyme secretion in alloxan diabetic rats.^{4,5}

The effect of endocrine factors on pancreatic trypsin production and secretion are not well established and dietary carbohydrate restriction in diabetes is another factor which may influence trypsin secretory capacity and serum trypsin levels. Therefore, while it is likely that low serum trypsin concentrations in diabetes are secondary to exocrine pan-

creatic dysfunction, the suggested relationship to the severity of beta-cell deficiency cannot be supported by present evidence.

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¹ Frier, B M, *et al*, *Gut*, 1976, 17, 685.

² Elias, E, Redshaw, M, and Wood, T, *Lancet*, 1977, 2, 66.

³ Frier, B M, *et al*, *Diabetologia*, 1978, 14, 301.

⁴ Ben Abdeljlil, A, Palla, T C, and Desnuelle, P, *Biochemical and Biophysical Research Communications*, 1965, 18, 71.

⁵ Adler, G, and Kern, H F, *Hormone and Metabolic Research*, 1975, 7, 290.

Repeatability and reliability

SIR,—Discussing observer variations in their useful series of articles about epidemiology Drs Geoffrey Rose and D J P Barker note (7 October, p 1006) that repeatability is less satisfactorily known as reliability.

If reliability is defined as the degree of agreement between different observations it is possible to distinguish test-retest reliability, or repeatability, when the observations are made on different occasions by the same or different observers, and single test inter-rater reliability, when the observations are made on the same occasion by different observers; these two measures have produced different results regarding the presence of a psychiatric symptom.¹

Reliability is thus a more generic concept than repeatability.

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¹ Wing, J K, *et al*, *British Journal of Psychiatry*, 1967, 113, 499.

Autoimmunity in juvenile diabetics and their families

SIR,—Dr Eva Kohner (19 August, p 568) has criticised our paper (15 July, p 165), in which we tentatively suggested that autoimmune diabetes has a stronger tendency to run in families and might be more liable to complications than in non-autoimmune families. She states that diabetic microangiopathy is a manifestation of the duration of the disease and also points out that the seven patients in our study developing proliferative retinopathy were all diabetics of long standing.

HLA typing of the patients with retinopathy has, however, provided a little further evidence that some diabetics may be more liable to complications than others. The 10 patients in our study with diabetic retinopathy (who were all members of autoimmune families) had a significantly higher frequency ($P < 0.05$) of HLA-B8 than diabetics without complications (see table). There is also a tendency, not

Distribution of HLA antigens in diabetics with and without retinopathy

Antigen	Retinopathy (n = 10)	No complications (n = 70)
A1	6 (60%)	26 (37%)
B7	2 (20%)	14 (20%)
B8	8 (80%)	29 (41%)
B15	2 (20%)	30 (43%)
BW35	1 (10%)	8 (11%)
A1 B8	5 (50%)	21 (30%)
B8	2 (20%)	8 (11%)
without A1		

statistically significant, towards a higher frequency of B15 among diabetics without complications. This is, of course, a very small series, but the frequency of B8 among our patients with retinopathy is virtually identical to that reported recently by Dr R G Larkins and his colleagues (29 April, p 1111) among 16 patients with proliferative retinopathy in Australia.

We agree entirely with Dr Kohner about the importance of both duration and degree of control in determining the development of complications but suggest that there is at least some evidence that a subgroup of diabetics (those with serological evidence of autoimmunity and HLA-B8) may be more liable. This suggestion certainly warrants further investigation, since if this is shown to be correct diabetologists might pay special attention to such patients.

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Tetracycline preparations for children

SIR,—It should by now be common knowledge among practitioners that tetracyclines stain and deform the developing teeth. The antibiotics section of the current edition of *MIMS* is headed by the statement, "Tetracyclines should not be used in the latter half of pregnancy or in children up to 12 years of age." However, the following tetracycline preparations are listed in the same publication with recommended dosages for children: Achromycin V syrup (Lederle); Deteclo syrup (Lederle); Ledermycin drops; Ledermycin syrup; Megaclor syrup (Pharmax); Mysteclin syrup (Squibb); Terramycin syrup (Pfizer); Vibramycin syrup (Pfizer). There are a number of other tetracycline preparations, manufactured by Berk, Glaxo, and ICI, in syrup form and therefore liable to be prescribed to children.

It is therefore small wonder that we continue to encounter cases of tetracyclines being prescribed to pregnant mothers or children.

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Paget's disease of bone among British migrants to Australia

SIR,—Earlier this year (24 June, p 1655) we reported on the radiological prevalence of Paget's disease in British migrants to Australia, showing it to be higher than in a comparable Australian resident population and lower than in a British resident population. We have since completed a case-control study on age at migration and place of origin in Britain among the British migrants, exploring further the possible reasons for these differences in prevalence rates. The particular aims were to ascertain whether migrants with Paget's disease had emigrated at a later age and came more often from areas of higher prevalence within Britain in comparison with migrants without Paget's disease.

Forty-eight cases of Paget's disease were identified among the British migrants in the

study and they were followed up to obtain data on place of birth and date of migration. Eighteen of them had died and four could not be traced through hospital records, electoral registers, telephone directories, or other means. From the remaining 26 cases the required information was obtained, and 78 sex- and age-matched controls (three British migrants without Paget's disease for each case) were likewise followed up. Data were obtained from 54 of these controls.

The average age of the patients at migration was 31.0 years compared with 32.1 years for the controls, and the proportions of cases and controls migrating under any stated age were similar. Among the patients 27% emigrated from the north of England (an area of high prevalence of Paget's disease), 65% from the south, and a small proportion (8%) from Scotland, Wales, or Ireland. Among the controls the corresponding percentages were 28, 59, and 13.

These results give no support to the suggestion that British migrants to Australia who develop Paget's disease originate from areas of higher prevalence within Britain or leave at a later age in comparison with migrants who do not develop the disease.

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Spinal cord transection in utero

SIR,—(28 October, p 1231) Dr Gillian P Chapman has made a presumption which is not borne out by the facts of the case to which I referred (16 September, p 835). The antenatal history of the case in question was very suggestive of spinal cord damage which occurred before birth and the neurological findings are not necessarily incompatible with a spinal cord transection sustained shortly before birth.

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Royal College of Surgeons of Edinburgh: reform of fellowship examinations

SIR,—As a teacher deeply concerned with postgraduate surgical education I was horrified to read in Professor A W Wilkinson's letter (4 November, p 1301) that the Royal College of Surgeons of Edinburgh proposes to impose yet another examination on surgeons in training—this time towards the end of their senior registrar appointment. To do so would be to inflict serious damage on a training programme which, with the help of the Joint Committee on Higher Surgical Training, is producing young surgical consultants of considerable distinction.

If a senior registrar will have to spend most of his period of higher surgical training in preparation for a terminal examination how can we also encourage him to engage in research leading to a Master of Surgery thesis? How can he be prevailed upon to spend a year abroad—perhaps in the USA or in a developing country—or spend a period of training in depth in some particular aspect of

his chosen specialty, in microsurgery for example?

By all means let us supervise our surgeons in specialist training, as most of us do already, by regular, meticulous, and critical counselling sessions, but—please—no more examinations!

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The Safety Net and preregistration posts

SIR,—The Safety Net system for allocation of preregistration posts (21 October, p 1136) is to be applauded as an advance in efficient staffing. The table of expected medical school outputs compared with preregistration posts is particularly useful in highlighting the London area as an overproducer of doctors. It was a pity that data about influx of doctors from outside England and Wales could not also be incorporated. It could certainly be argued that overseas graduates and those from Eire and Northern Ireland should not expect to find posts in England and Wales, though figures for migration would be interesting.

The position in Scotland is different: 620 doctors are expected to graduate from Glasgow, Edinburgh, Aberdeen, and Dundee in 1978 compared with 2595 in England and Wales. This gives a graduation rate of doctors per head of population twice as high in Scotland as in England and Wales even if a wastage rate of 9% is allowed on these Scottish figures. Despite the rather more lavish provision of medical facilities in Scotland there is still a considerable excess of graduates who must expect to seek posts in England. In Dundee, for example, there should be more than 100 graduates this year with 63 approved preregistration posts in the area. Furthermore, many graduates from Scottish medical schools are English students who intend to practise south of the border, having moved north for training purposes only.

Surely Scotland, which is an integral part of the NHS, should feature in all statistics about distribution of posts and resources if meaningful assessments are to be made.

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Remuneration of NHS occupational health physicians

SIR,—Early this year I was appointed occupational health physician to build up an occupational health service for the York Health District. The remuneration offered was, pro rata for three sessions per week, that for the clinical assistant grade, and though this is considerably below the BMA's recommendations for doctors working in this specialty I accepted because I required only a part-time job and it was the type of work, with the right challenge, that I wished to do.

On inquiring from the BMA about these low levels of remuneration paid by the NHS I was informed that the BMA "have been pressing the Government for the past five or six years to do something about this unsatisfactory state of affairs, but at present the progress we

have achieved is limited to commenting on a draft circular purporting to lay out certain guide lines for the establishment of an occupational health service." But since the Tunbridge Report was published in 1968 the Department of Health and Social Security has given encouragement to the NHS to set up occupational health departments. Many health districts have done so and more are starting a service, so that matters have gone well beyond "laying out certain guide lines for establishment of" a service.

Surely occupational health requires the same standards of knowledge and medical care whether it be undertaken in industry, shops and offices, or in the NHS, and the remuneration should be the same. Why should the DHSS set a level of remuneration for occupational health doctors in the NHS so much lower than is paid in other ministries—for example, the Ministry of Defence? If industry or commerce advertised occupational health posts below the BMA recommended scale of salaries action would be taken and the advertisements possibly banned. Why is not the same done for NHS occupational health posts? Surely a ban on such advertisements might be a lever with which to press the DHSS to start thinking realistically and take action to bring such salaries into line with those paid outside the NHS.

The BMA seems to have spent five or six years getting nowhere in this matter and it is time more positive action was taken.

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Clinical medical officers

SIR,—Dr Shelagh Tyrrell (28 October, p 1233) is far from being the only clinical medical officer who is concerned by your recent report (7 October, p 1038) on the Working Party on Community Health Doctors with its suggestion that we should revert to being "Jacks of all trades."

What appears to have been lost in the present discussion about our future is its origin, which was the response to the Court Report. The Court Report was about improving services for children. The Secretary of State's reply recommends the development of an integrated service for children within available resources. One of the recommendations of the Court Report that has received unanimous acceptance is that those doctors who work in the future child health service should all be adequately trained and experienced. If time and money are to be spent on reaching the required level of expertise, then it is wasteful to expect the doctor at the end of it to spend a proportion of her time in totally unrelated activities, such as geriatrics or occupational or port health.

In arguing for an adequately trained and staffed child health service I do not deny that there are other areas of community health work which merit similar consideration. But these also need their own expertise and training and neither one will benefit from dilution with the other, with the possible exception of the child health/family planning combination.

I for one would like those negotiating on our behalf, however selected, to bear in mind that we are not all solely concerned with our future career structure, important though this