I have recently cared for a 37-year-old patient in my practice, para 3+0, who had no antibodies at booking or in previous pregnancies. In this, her fourth pregnancy, she had an amniocentesis to exclude chromosomal abnormality, but no anti-D was given as the Kleihauer test was negative. At 32 weeks her anti-D titre was 1/512 and amniocentesis showed the bilirubin level to be in the severely affected category. The baby was delivered by caesarean section at 33 weeks but did well.

It has now become policy in Oxford to give anti-D to all rhesus-negative mothers having amniocenteses and to increase the dose if the Kleihauer test is positive. This policy is also recommended by the Department of Health and Social Security.¹

Amniocentesis is performed in early pregnancy to reduce the incidence of abnormal children. To cause an otherwise normal pregnancy to result in a handicapped child as a result of the test would be a tragedy. Anti-Rh(D) immunoglobulin is very effective and safe. It should surely be given in all cases, whether the Kleihauer test is positive or not.

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¹ Department of Health and Social Security, Standing Medical Advisory Committee, *Haemolytic Disease of the Newborn*, revised version, para 4.7. London, DHSS, 1976.

Vitamin B₁₂ for vegans

SIR,—Your expert errs in stating (11 June, p 1525) that "there are no measurable amounts of vitamin B₁₂ in any known plant." Seaweeds, including those growing round our shores, are good sources,^{1,2} about 100 g a day furnishing the daily requirement of the vitamin (as well as useful amounts of vitamins A and B₂ and arachidonic acid). The nodules on the roots of nitrogen-fixing plants are very rich sources of Vitamin B₁₂,³ although they are not usually eaten. Yeast from wine-making contains the vitamin, and a pint of cider may contain nearly 1 µg. Even vitamin D occurs, in water-soluble form, in some plants.

We would be happy to provide doctors and dietitians with our list of commonly available vegetarian and vegan sources of vitamin B₁₂.

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¹ Chapman, V J, *Seaweeds and their Uses*, 2nd edn. London, Methuen, 1970.

² FAO/US Department of Health, Education and Welfare, *Food Composition Tables for Use in East Asia*, 1972.

³ Blondeau, R, *Comptes Rendus Hebdomadaires des Séances de l'Académie des Sciences*, 1971, **272D**, 2781.

Tetracycline and toxoplasmosis

SIR,—Drs P L Grossman and J S Remington (25 June, p 1664) criticise our short report on toxoplasmosis (23 April, p 1064) because we did not give details of the oxytetracycline dosage used and because we ventured to suggest that one of the tetracyclines should be considered for the treatment of severe lymphadenopathic forms of toxoplasmosis.

In our article we were primarily concerned with the epidemiology and natural history of

the disease, but felt that the problems of treatment also deserved some attention. In the interests of brevity we omitted from our case descriptions whatever could be taken for granted. Thus the omission of all drug dosages clearly denoted that standard therapeutic doses were given. In the case of oxytetracycline the dosage was 500 mg four times a day. We prefer oxytetracycline to demethylchlorotetracycline (which was used in the experimental work we referred to) because the former is considerably less expensive and is less likely to cause gastric disturbance and photosensitisation. Nevertheless, possible differences in the activity of the various tetracyclines in human—as opposed to murine—toxoplasmosis should certainly be explored, as should the use of relatively large doses of these antibiotics.

We are not alone in our dissatisfaction with the standard treatment regimen, with or without corticosteroids.¹ We were therefore impressed by the rapid clinical improvement both with oxytetracycline used alone (but evidently for an inadequate length of time) and then when used for a longer period with prednisolone. This was in sharp contrast to the total lack of response in the two severely affected patients to a month's course of pyrimethamine and sulphadiazine, even though these drugs have proved so successful in murine toxoplasmosis.²

We were particularly interested in the probable source of infection in this small outbreak. The only communal meal eaten by the three affected men was also attended by four others who suffered no ill effects. This distribution was surprising but by no means unprecedented in infections due to ingested food. We have, however, subsequently elicited information on the varying degree of exposure to infection in the seven individuals. The unaffected four had already eaten well before the meat course and they ate only a small portion of inadequately grilled lamb on skewers. In contrast, the three men who developed primary toxoplasmosis eight days later had consumed large amounts of the meat and are assumed to have swallowed a relatively high infective dose of *Toxoplasma gondii*.

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¹ Beverley, J K A, *British Medical Journal*, 1973, **2**, 475.

² Eyles, D E, and Coleman, N, *Antibiotics and Chemotherapy*, 1955, **5**, 529.

Sclerosing peritonitis due to practolol

SIR,—Sclerosing peritonitis due to practolol therapy can present diagnostic difficulties and the excellent paper by Dr R P H Thompson and Mr B T Jackson (28 May, p 1393) is to be welcomed for recording the unfortunate fact that many cases are not diagnosed until laparotomy is performed. All six cases described by them had at least two laparotomies and one patient underwent six operations.

Dr Thompson and Mr Jackson do not say whether small-bowel barium studies were performed on their patients, but they do insist that they found radiology to be unhelpful. This has not been our experience at this hospital, where barium studies form part of the investigation of patients with subacute small-bowel obstruction.^{1,2} We have observed distinctive

radiological appearances in all the patients with symptoms due to practolol peritonitis whom we have examined. In two of our patients the disease was first suggested by the barium findings, and a past history of practolol therapy was elicited after the radiological investigation. There were no adverse effects due to barium examination.

In view of the poor results of unsuspecting laparotomy and the impaired cardiac status of many of these patients it is obviously important to make the diagnosis of sclerosing peritonitis before abdominal surgery. Small-bowel barium examination is indicated in patients with clinical evidence of practolol peritonitis to help confirm the diagnosis and to define its extent.

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¹ Lee, R E J, *et al*, *Clinical Radiology*, 1977, **28**, 119.

² Marshall, A J, *et al*, *Quarterly Journal of Medicine*, 1977, **46**, 135.

Solitary perforated diverticulum of ascending colon

SIR,—I would like to report an unusual case of perforated solitary diverticulum of the ascending colon.

A 29-year-old woman was admitted with a two weeks' history of epigastric pain, which later localised to the right iliac fossa. The clinical examination revealed an ill-defined, tender mass in the right lower abdomen with guarding. Rectal and pelvic examinations confirmed the presence of a mass in the right side of the abdomen, arising from the pelvis. She had had appendicectomy 10 years before this admission. The other relevant past history was that she had been having similar attacks of pain, though of less severe nature, for the past five years.

At laparotomy the pelvic viscera were normal. There was a hard, adherent mass in the ascending colon extending to the hepatic flexure upwards and to the pelvic downwards. An ulcer crater was felt in the centre of the mass. In view of the doubtful nature of the mass radical right hemicolectomy with end-to-end anastomosis was performed. Macroscopic and microscopic examinations established the diagnosis of perforated solitary diverticulum of the ascending colon with chronic pericolic abscess.

A review of the literature¹⁻³ revealed that perforated solitary diverticulum of the ascending colon is rare. The correct diagnosis is almost never made preoperatively. Even at laparotomy it is often difficult to recognise this abnormality; often malignancy is suspected, as in the above case. Although this is a rare clinical entity, surgeons should be aware of it so that major colonic resection is not needlessly undertaken.

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¹ Chughtai, S Q, and Ackerman, N B, *American Journal of Surgery*, 1974, **127**, 508.

² Wagner, D E, and Zollinger, R W, *Archives of Surgery*, 1961, **83**, 436.

³ William, K L, *British Journal of Surgery*, 1960, **47**, 351.

"Baby alarm" in hospital care of infants with pertussis

SIR,—With the controversy over pertussis immunisation causing a sharp decline in the numbers of infants immunised we may expect

a decrease in herd immunity and an increased number of cases of pertussis, including children under 1 year. These infants frequently require hospital care during the acute phase of their illness. They are obviously a cross-infection risk and are normally nursed in isolation cubicles. It has been a cause of concern to us that a severe coughing spasm requiring suction clearance of secretions or other immediate attention may easily pass unnoticed because the child is in a cubicle. Even if these children are nursed in cubicles close to the nursing station few wards are sufficiently well staffed for the nursing station to be constantly manned day and night.

We therefore installed a standard, commercially available "baby alarm" as used by parents in the home. The receiver is in the cubicle and the speaker is in the corridor. When the nursing staff are all occupied in other cubicles the speaker volume is turned up. Coughing spasms are then readily audible in neighbouring cubicles.

We have found this simple device very helpful; we believe it has been successfully used for this purpose in some other paediatric units and would commend its more widespread use in paediatric infectious disease units.

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Common waiting lists in NHS hospitals

SIR,—The Health Services Board has recently published its report on common waiting lists¹ and has invited comments upon its recommendations.

Having given careful consideration to this document we should like to submit views on this matter which we feel may be shared by consultants in other areas. We do not support the recommendations made by the Health Services Board in their report on common waiting lists as we believe that it is very questionable for the reasons outlined below whether any benefit will accrue to NHS patients awaiting admission for non-urgent surgical procedures.

The proposals penalise: (1) those surgeons who are undertaking a comprehensive range of work for the NHS—for example, a surgeon engaging in vascular surgery or urology in addition to his commitment as a general surgeon; it is inevitable that the additional work load involved in such situations will result in a larger number of patients awaiting non-urgent and relatively minor procedures; (2) single-handed specialists in whose fields demands greatly exceed the facilities available; (3) newly appointed consultants who "inherit" a waiting list from a predecessor; and (4) consultants heavily involved in administrative work in addition to their clinical responsibilities.

In each of these groups individuals are giving services to the NHS over and above that normally required and yet would undoubtedly be penalised if the recommendations of the Health Services Board were adopted. In their report the board acknowledges "that successful implementation of common waiting lists will depend crucially on the co-operation and goodwill of consultants at hospital level," but such co-operation and goodwill can hardly be

expected, and least of all from the many consultants who fall into one or other of the groups mentioned above.

While it is appreciated that the main aim of the proposals of the board is to prevent private patients with non-urgent surgical conditions receiving treatment in NHS hospitals sooner than non-paying patients with similar non-urgent conditions, we feel that this is paltry when viewed against the waiting-list problem as a whole. In an ideal situation there should be no waiting list at all. There is in fact no waiting list in this area for any patient with cancer, in pain, or requiring urgent treatment for any reason. As demand greatly exceeds the facilities available there is inevitably a waiting list for patients awaiting non-urgent surgical procedures.

The high percentage of urgent and emergency admissions, ward and operating theatre closures (for upgrading, decorating, and holiday periods), staff shortages, geriatric and long-stay occupancy of acute surgical and orthopaedic beds, together with industrial action have all contributed to lengthen waiting lists very considerably in the past few years in this and no doubt in other areas also.

While we would give our wholehearted support to any measures whose true aim is to improve the facilities required to reduce the waiting time for all patients, we believe that the present proposals if adopted would have an insignificant effect in this respect and would for the reasons given create greater problems than those which already exist.

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¹ *Common Waiting Lists for NHS and Private Patients in NHS Hospitals: Report of the Health Services Board made under Section 6 of the Health Services Act 1976.* Cmd 6828. London, HMSO, 1977.

GMSC and the Court Report

SIR,—We write to deplore the reactions of the General Medical Services Committee to the Court Report (11 June, p 1552), particularly in respect of the general practitioner paediatrician, whose role seems to have been widely misinterpreted (recommendation 1). We conceive that it was never intended that GPs should abandon their care for the family as a whole nor devolve the care of their children to one particular partner but that in each practice there should be a partner who, by virtue of his keenness and experience, should have a "special interest" in children. Clearly the suggestion of "70% of time doing paediatrics" is negotiable and will vary with varying circumstances. Why is the GMSC opposed to the idea of a "special interest" when it is a de-facto situation in many practices throughout the country today and not only in paediatrics? And why are they so opposed to the idea of a child health practitioner treating their patients in the surgery when they admit the need for these doctors to remedy the deficiency of those GPs who are failing to do developmental surveillance themselves (recommendation 6)? Again, this is happening in many practices in this country with complete success and amicability.

The same applies to the school medical service (recommendation 7). The GMSC cannot be cognisant of the content of modern

educational medicine, where "treatment" has a very minor role. The detection and assessment of hearing difficulties, the placement of those with special educational needs, and the management of behavioural problems are perhaps the most important aspects of educational medicine and beyond the competence of most GPs. This is perhaps the most complicated aspect of the Court Report and requires much further consideration.

The GMSC has also failed to understand the concept of the consultant community paediatrician (recommendation 12). It was not intended to create "a new breed of paediatrician—merely a new species": an ordinary paediatrician but with "special skills in educational, developmental, and social paediatrics." In the same way that not all GPs want to develop a "special interest" in children, so not all paediatricians wish to develop these "special skills." And if they support the idea of a district handicap team (recommendation 15) how can it be run without a CCP? This would be a recipe for muddle and confusion.

The recommendations of the GMSC would appear to be as superficial as their apparent perusal of this vitally important report and exemplify how they, along with similar bodies, are divorced from the views of their members, not least those who have made a positive contribution to the improvement of primary child care in this country.

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G H CURTIS JENKINS	M H HANDFORD
MARGARET POLLAK	D J TWINHAM
SAM VAKIL	P F WOOD
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Court Report and community medicine

SIR,—I should like to add my comments to those of Dr Agnes M Gordon and others (2 July, p 49) in which they refer to the rejection by the Central Committee for Community Medicine of the consultant community paediatrician appointments.

It seems to me that the role of the consultant community paediatrician has been variously interpreted. Some consultant paediatricians already regard themselves as fulfilling this function and see no reason to create a new type of consultant. However, what they regard as their community involvement rests on their concern with the broader environmental and social problems inextricably entwined with the practice of modern paediatrics. On the other hand what most senior medical officers see as a consultant community paediatrician is a child specialist who in fact has first-hand experience in the actual practice of developmental paediatrics and educational medicine and sufficient knowledge of learning problems to participate usefully in discussions with teachers and educational psychologists.

There is room for both these types of consultant paediatrician and their responsibilities would run parallel and not cut across each other. Professor Court's suggestion that a suitably qualified and experienced senior medical officer might fill the role as a community consultant paediatrician seems to me very realistic and desirable. However, some senior medical officers, even if suitably qualified, would probably not wish to take on the post of consultant community paediatrician. They would still be able to fill the much-needed posts that they hold at present and these should be recognised.