What did they say? Where did they come from?

SIR,—In Dr M B Skirrow's valuable account of campylobacter enteritis (2 July, p 9) we read that "several patients stated that they lost over 6.5 kg." Did no one say, "Doctor, I lost over 6.35029 kg" or even "Doctor, I lost over a stone"?

Standardisation may hamper expression. What are we to make of one patient who was "a fit 32-year-old Caribbean woman" and the next who was "a 30-year-old Caucasian male" (Mr M Harris and Mr J P Rood, p 20)? The words seem to be used in different ways. As her picture does not suggest that the woman is a Carib the adjective is presumably applicable to the sea of that name, so she comes from somewhere in Central America, or the West Indies, or the northern part of South America. But he, did he really come from the Caucasus (on a Russian passport?) or is the meaning simply that he is Indo-European? ("Now discarded" was the premature comment of the *Shorter Oxford English Dictionary* in 1933.)

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* * In fairness to Dr Skirrow it must be stated that his original text read "... they lost over a stone (6½ kg)." The published version was the result of an excess of subeditorial zeal for metrication and decimalisation—ED, *BMJ*.

Shortage of anaesthetists

SIR,—Ten years ago I suggested¹ that the science of anaesthetics was now sufficiently advanced for much of our routine work in operating theatres to be delegated, provided that satisfactory candidates for the work could be recruited. I had in mind, I wrote, those who had reached a standard of education close to that required for acceptance at a university—or graduates, preferably in science. Such people, I added, might also solve the problem of providing anaesthetists for work in dentists' surgeries.

In January 1970 I repeated² this suggestion in the correspondence columns of the *Lancet*, opening a debate that continued throughout the year. Surprisingly, the idea received some support from anaesthetists. My suggestion was also debated in the autumn of that year at a gathering of about 100 anaesthetists and was supported by 15 or more of those present, including two professors of anaesthetics. This was still more surprising since, as one speaker put it, to vote that way amounted to professional suicide.

Now that there is a serious shortage of anaesthetists, perhaps the time has come to reconsider the possibility of training and employing the kind of paramedical anaesthetists I had in mind.

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¹ Bourne, J G, *Studies in Anaesthetics*, p 159. London, Lloyd-Luke, 1967.

² Bourne, J G, *Lancet*, 1970, 1, 38.

SIR,—Mr Charles Langmaid (25 June, p 1665) and Dr T R Austin (9 July, p 120) call attention to, and the latter invites reports of personal experience with, alternatives to the usual methods of modern anaesthesia.

More than 40 years ago, as a final-year

student, I was privileged to be associated with the late Dr Howard Jones and the late Mr Norman Lake when, together, they were evolving and perfecting the use of the light spinal anaesthetic. From them I learned the technique, the pitfalls, the limitations, and the advantages of this method of anaesthesia, a knowledge which proved of utmost value when appointed to the Colonial Medical Service and posted to remote areas where the alternatives were either a "rag and bottle" in the hands of a local assistant or no surgery at all.

In the earlier years of a professional lifetime spent in developing countries I used spinal anaesthesia in hundreds of operations in situations of varying degrees of isolation. When, later and in less primitive conditions, skilled assistance became available and one handed over this responsibility to anaesthetist colleagues, at no time did I feel that spinal anaesthesia was thereby outdated. Similarly with regional block, of which Mr Lake was a superb exponent and teacher, and I remain convinced that these methods still have a place in the disciplines of surgical anaesthesia.

If, as your correspondence columns indicate, there is a grave and growing shortage of anaesthetists it would appear reasonable that these specialists should concentrate on those fields of surgery where their experience, skill, and knowledge are most needed, which would still leave a vast amount of elective surgery which could be performed under spinal or regional block administered by the surgeon or his assistant.

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Primary amenorrhoea

SIR,—The review of "primary amenorrhoea: the ambiguous non-entity" by Dr Jean Ginsburg and her colleagues (2 July, p 32) contains interesting data from patients with primary amenorrhoea, but the following comments are pertinent.

The 10 patients who had no ovarian biopsy data (50% of the series) include five of the six patients with elevated prolactin levels, four of the five patients with enlarged pituitary fossae, and apparently one of the six patients who achieved human menopausal gonadotrophin (HMG)-induced pregnancies. The value of accurate and informed reports on ovarian biopsy specimens from patients with primary amenorrhoea¹ should not be underestimated.

The authors properly define primary amenorrhoea but inaccurately define secondary amenorrhoea² and make no mention of oligomenorrhoea,³ primary or secondary. They make the bold statement that "the division of amenorrhoea into primary or secondary has no aetiological, diagnostic, or therapeutic basis" and go so far as to suggest that "the conventional distinction between primary and secondary amenorrhoea be abandoned. . . . Primary amenorrhoea should instead indicate an abnormality of the gonad itself and secondary amenorrhoea an abnormality that results from hypothalamic-pituitary dysfunction." But menstruation merely is shedding of the endometrium and a menstrual abnormality, whether this be absence of menstruation or an upset cycle, is no more than a symptom or sign associated with a legion of pathological conditions of which abnormality of the gonad and hypothalamic pituitary dysfunction are but two.

Dr Ginsburg and her colleagues have valid points to make, but they have overstated their cases, to the detriment of their good intentions, by taking a narrow view of this complex subject. Perhaps, with reflection, they can couch their ideas in terms just as cogent but less pejorative. The title of their paper is misleading. Primary amenorrhoea has a precise definition and embraces a complex multiple entity.

Their suggestion that "the conventional distinction between 'primary' and 'secondary' amenorrhoea should be abandoned" is unacceptable from the wider view of medical practice whatever the "current practice for other endocrine glands" happens to be. Perhaps the authors should tread lightly when they venture into the more or less fertile fields of gynaecology and obstetrics and their endocrinology, just as we are wont to do when we choose to explore territory more familiar to medical endocrinologists.

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¹ Black, W P, and Govan, A D T, *British Medical Journal*, 1972, 1, 672.

² Black, W P, and Govan, A D T, *American Journal of Obstetrics and Gynecology*, 1972, 114, 739.

³ Govan, A D T, and Black, W P, *European Journal of Obstetrics and Gynaecology, Reproduction and Biology*, 1975, 5/6, 317.

Prognosis of Henoch-Schönlein nephritis in children

SIR,—The paper by Dr R Counahan and others (2 July, p 11) makes a valuable contribution to our appreciation of the hazards of the Henoch-Schönlein syndrome.

In 1956 Dr Margaret Rogerson and I reviewed 94 cases of the syndrome seen at this hospital between 1943 and 1955.¹ Approximately 6% developed chronic nephritis. It seems likely that a longer follow-up would have revealed more cases with severe renal damage. In the cases we reviewed and in others seen by me since 1956 it has been evident that neither the age of the child nor the severity of the initial illness had any bearing on the likelihood of later renal sequelae. A special interest in this condition over many years has taught me one thing—the outcome in the majority of cases is unpredictable.

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¹ Derham, R J, and Rogerson, M M, *Archives of Disease in Childhood*, 1956, 31, 364.

Parallel aging of Achilles tendon and coronary artery

SIR,—Sir John McMichael (30 April, p 1155) correctly criticises the use of "dietary fat manipulation" to reduce the risk of coronary heart disease (CHD). Adams *et al*¹ at Guy's Hospital Medical School, have shown by necropsy studies that the connective tissue of the Achilles tendon and coronary artery age along parallel lines. This explains the rising popularity of formal marathon training in cardiac rehabilitation programmes (22 January, p 229), since the 42-km foot race is a good test of the integrity of the Achilles tendon. "Distance covered on foot" can be used as an index of both cardiac status and the state of the connective tissues of the Achilles tendon.