with safety, without the help of anaesthetists, in many thousands of administrations in the recent past when they undertook this treatment themselves.

Undoubtedly ventilation is more easily carried out through a tracheal tube when the likelihood of apnoea lasting 30-90 minutes is probable, but in most hospitals an anaesthetist can be called to employ his expertise with a laryngoscope at his early convenience if the obstetrician thinks it necessary and fails to pass a tube himself, bag and mask ventilation being maintained until he arrives.

There may be good reasons why extradural analgesia in labour should remain in the hands of the anaesthetists, but the very rare risk of death from apnoea through the inability of the obstetrician to intubate is not one of them.

J ALFRED LEE

Southend-on-Sea, Essex

Disseminated histoplasmosis in diabetes

SIR,—Dr D W R Mackenzie's letter (14 May, p 1281) has recently come to our attention. He is to be thanked for his interest in our case (16 April, p 1002) and for finding a reference not covered by the number of excellent reviews available in the more widely read English language journals¹⁻³ and the anecdotal book.⁴ Some clinical points are, however, worthy of reply, particularly as they reflect his divergence of opinion from experienced writers in endemic areas.

(1) *Serological studies.* Both complement fixation tests and precipitin tests are negative in up to 40% of patients with disseminated histoplasmosis, possibly reflecting a state of immune anergy to the overwhelming infection.^{2,3,5}

(2) *Opportunistic infection.*⁵ As judged by conversion to positive skin tests, some 500 000 patients per year receive primary exposure to histoplasma antigen in endemic regions of America.⁶ Of these only 1-2 per 1000 present as the disseminated form,³ and of these one series recorded factors which diminish host resistance in 65%.³ With reference to the patient reported this change in host resistance may be related to the onset of his diabetes mellitus, and with cases referred to elsewhere^{3,5} this picture may hope to explain the "latency" which Dr Mackenzie cites for systemic mycoses. Presumably in the other cases exposed to the antigen the fungus is either overwhelmed by host resistance or lives as a saprophytic commensal awaiting immune paresis. In this it shares features with both accepted commensals (monilia) and accepted pathogens (*Mycobacterium tuberculosis*).

(3) *Endemic histoplasmosis in the United Kingdom.* Not having studied the soil of the north-west, we are in no position to comment on Knight's interesting speculation that histoplasmosis is potentially endemic in the United Kingdom as it is in Norway.⁷ Perhaps in denying Knight's data Dr Mackenzie will be able to comment on other possible endemic United Kingdom cases, including the cotton-mill worker in the Manchester area who had two colleagues with positive skin tests.⁸ Since the Manchester region has been the port of entry for thousands of tons of cotton, including cotton from the histoplasma-infected Mississippi and Ohio River valleys, Dr Mackenzie will no doubt be able to help in confirming the absence of *Histoplasma capsula-*

tum from the starling roosts near the Stretford City Hall, where the patient reported works as a doorman.

(4) *Reviewing.* Finally, it would seem appropriate to observe that the choice of referees must be the prerogative of the editor of the journal concerned. Perhaps such decisions are influenced by experiences in the past such as those published in a recent *BMJ* article.⁹

BRIAN R TULLOCH

Division of Endocrinology,
Department of Internal Medicine,
University of Texas Health Science
Center,
Houston, Texas

A JARIWALLA

University Department of Medicine,
Royal Infirmary,
Manchester

¹ Goodwin, R A, and Des-Perz, R M, *Southern Medical Journal*, 1973, **66**, 13.

² Smith, J W, and Utz, J P, *Annals of Internal Medicine*, 1972, **76**, 557.

³ Reddy, P, et al, *American Journal of Medicine*, 1970, **48**, 629.

⁴ Symmers, W StC, *Curiosa*. London, Baillière Tindall, 1975.

⁵ Furcolow, M, *Laboratory Investigation*, 1962, **11**, 1134.

⁶ Broome, W, Hutchinson, R, and Mays, E J, *Periodontics*, 1976, **47**, 95.

⁷ Knight, R K, *Guy's Hospital Reports*, 1968, **11**, 309.

⁸ Miller, A, Ramsden, F, and Geake, M R, *Thorax*, 1961, **16**, 388.

⁹ Horrobin, D R, *British Medical Journal*, 1974, **2**, 216.

Starting on the pill

SIR,—Dr Nancy B Loudon's letter (20 August, p 521) should, I believe, produce a much-needed change in the routine advice given to patients starting on oral contraceptives. Some of us have, in special cases where low motivation and intelligence would combine to cause complex instructions to destroy the patient's confidence, already discarded the "traditional" instruction to use additional contraception for the first 14 days of pill-taking. Was this folk-lore? Was it based on a very small number of early failures which, in the light of more recent knowledge, could perhaps have been due to drug interaction? Whatever the reason, we have probably wasted tons of rubber and thousands of pounds sterling (as well as deterring many timid potential pill-users) over the past 15 years. I would endorse a massive effort to ensure that this practice is quickly discarded by all doctors and nurses advising on birth control.

ELIZABETH H GREGSON

Liverpool

Acute gastric dilatation in anorexia nervosa

SIR,—I was interested in Dr G K Brooks's report of acute gastric dilatation in anorexia nervosa (20 August, p 499) and would like to make some observations as to its possible causation.

Case 1—A 16-year-old girl was admitted to hospital in November 1972 with a diagnosis of anorexia nervosa. She was treated with chlorpromazine and a high-calorie diet and told that discharge would be entertained once she had gained a certain weight. On 23 December, realising that she would not be discharged for the Christmas holiday, she hoarded food and secretly overate. Early next morning she vomited, collapsed, and assumed a catatonic state. She was found to have acute gastric dilatation, aspiration pneumonia, and some pulmonary oedema. Seven litres of fluid were aspirated from the stomach and after treatment

with antibiotics and hydrocortisone she recovered fully.

Case 2—A 19-year-old girl admitted shortly before Whitsun 1973, having realised that she would not be discharged for this holiday period, undertook a similar gastronomic excess and soon complained of severe epigastric pain. Four litres of fluid were aspirated from the stomach before vomiting started. She later used overeating and impending acute gastric dilatation as a means to achieve hospital admission on several occasions.

It would appear that acute gastric dilatation occurs in anorexia nervosa, that it may result from attempts to gain weight quickly, sufficient to warrant discharge, and that similar episodes may be consciously provoked to gain hospital admission when external social pressures prove too great.

I would like to thank Dr H C Hamilton for allowing me to report these two of his patients.

DAVID BOSSINGHAM

Nuffield Orthopaedic Centre,
Headington,
Oxford

Anxieties and fears about plutonium

SIR,—I hesitate before accusing Dr R H Mole (17 September, p 743) of the bias he so dislikes in others, but I fear that in his attempt to allay fears about plutonium he has himself fallen into this trap. Probably he was not intending to do so, but he has implied that those who object to its use are over-reacting to misrepresented and misunderstood evidence of its likely effect on the outside population.

As a member of one of the environmental organisations I have heard many arguing against the use of nuclear energy but very few of them using arguments so obviously distorted as those quoted. Most base their opposition on the known facts—Dr Mole himself states them—that plutonium is a long-lived α -particle emitter capable of causing cancer, especially of the lung, and that any radiation can cause genetic damage.

I disagree with his implication that because environmental radiation exists more will not do harm. If this were the case we would not need to be concerned about the effect of repeated exposure to x rays. Any increased radiation, whether from a nuclear power station or an x-ray machine, increases the risk of genetic damage. Neither do I agree that the natural occurrence of the long-lived potassium-40 in any way proves plutonium less dangerous. The importance of the long half life of this α -particle emitter is that any which escapes into the environment will be there for a long time—not a pleasant prospect if the amount released, whether by accident or terrorist activity, is large.

Basically Dr Mole and I disagree not so much on the facts as on the importance we place on them as compared with the benefits of nuclear energy. Whether the benefits outweigh the risks is obviously a matter of opinion, but this must be well informed. It is in this context that the Windscale inquiry is so important as it is the first time in my recollection that there has been a chance for all interested parties to put their views before an impartial judge. Naturally it will take time: there is a great deal to be said on both sides. It is to be hoped that it will result in an objective assessment of both the advantages and dangers involved in nuclear technology. It may be a mistaken belief that "the only experts to be trusted are those not