prescribed, as "we are already too far down that path to turn back." In "an issue in which there is more emotion than reason" we would make a plea for continued evaluation of therapy. If acceptable studies do not provide evidence of the superiority of oestrogens over placebo then we should stop prescribing them.

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¹ Mulley, G, and Mitchell, J R A, *Lancet*, 1976, 1, 1397.

Volvulus of the small bowel in a diabetic patient

SIR,—Following the recent description by Dr H Freund (11 September, p 641) of primary small-bowel volvulus in association with diabetes mellitus we wish to report a similar case.

A 60-year-old man was recently admitted with a 72-hour history of vomiting, constipation, and abdominal bloating. He had been a diabetic for 11 years and had noticed increasing polyuria and polydipsia in the week preceding admission. His compliance with insulin and dietary advice was poor. He was on no other medication but had a heavy brandy intake until 1972.

On examination he was icteric and moderately obese. His pulse was 90/min and regular and no bruits were audible. The abdominal girth was 112 cm and rigidity was absent. Bowel sounds were hyperactive and the rectum was empty. Blood sugar was 20.5 mmol/l (370 mg/100 ml), sodium 122 mmol (mEq)/l, potassium 3.7 mmol (mEq)/l, and chloride 103 mmol (mEq)/l. The blood pH was 7.34, P_{O_2} 11.8 kPa (89 mm Hg), P_{CO_2} 5.05 kPa (38 mm Hg), and standard bicarbonate 20.5 mmol (mEq)/l. Ketonuria was present. His diabetes was controlled, but the abdominal symptoms persisted and laparotomy was performed. A necrosed 17-cm segment of jejunum, which was resected, was thought to represent an untwisted volvulus. No other aetiology was apparent. A preoperative liver biopsy showed macronodular cirrhosis.

The "acute abdomen" of diabetic ketosis resolves rapidly with diabetic control and may occasionally mimic an upper intestinal obstruction. In addition, vomiting may further confuse the picture by rendering the patient alkalotic. Although conclusive proof of volvulus was absent in this case, it emphasises the importance of considering a mechanical cause for abdominal complaints which fail to respond to metabolic correction in the diabetic.

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¹ Goyal, R K, and Spiro, H M, *Medical Clinics of North America*, 1971, 55, 1031.

² Zitoner, B R, et al, *Metabolism*, 1968, 17, 199.

³ Lin, K C, and Walshe, C H, *British Medical Journal*, 1976, 2, 19.

Hyposensitisation with house dust mite vaccine in bronchial asthma

SIR,—Dr J Gaddie and his colleagues (4 September, p 561) were unable to demonstrate an improvement following hyposensitisation therapy in a group of patients with "asthma sensitive to house dust mite." Unfortunately,

the selection of patients and conduct of the trial make interpretation of the results impossible.

No definition of asthma or demonstration of bronchial lability was included and therefore some of the patients may have had fixed airways obstruction. Moreover, bronchial allergy to the house dust mite cannot be inferred from positive allergic reactions in other organs, such as the skin or nose. Up to 50% of patients with positive skin tests¹ and 14% with positive nasal challenges² show negative bronchial responses to the same allergen. The asthma in these patients would not be expected to "improve" with specific therapy.

The patients were reviewed on only five occasions over one year and the pretreatment period of observation is not given. No mention is made of the method of recording the symptoms and treatment. Only a continuous diary card record of symptoms, treatment, and twice-daily peak expiratory flow rates would be valid.³ The five spirometric tests in the year are of little value in a variable condition such as asthma.³ The forced expiratory volume in one second is abnormal only with moderate to severe asthma and obstruction in smaller airways may not be detected by this test. Maximum mid-expiratory flow, maximum expiratory flow volume curves, or thoracic gas volume (by plethysmography) are more sensitive indices of small airway obstruction and likely to remain abnormal more consistently.⁴

Trials of treatment in bronchial asthma are always difficult because of the heterogeneity and intermittent nature of the disease. Therefore careful selection and assessment of patients are necessary if reasonable conclusions are to be drawn on the efficacy of any therapeutic regimen.

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¹ Spector, S L, and Farr, R S, *Medical Clinics of North America*, 1974, 58, 71.

² Aas, K, *The Bronchial Provocation Test*. Springfield, Thomas, 1974.

³ Chai, H, et al, *Journal of Allergy*, 1968, 41, 23.

⁴ Hill, D J, et al, *Archives of Disease in Childhood*, 1972, 47, 874.

Pulmonary complications of measles

SIR,—The first two sentences of your leading article (2 October, p 777) imply that "disease in the respiratory tract" is invariably a cardinal feature "not only of wild measles . . . but also of the mild reactions occasionally encountered with modern attenuated measles vaccines." What evidence is there for this statement?

In 1962 and 1963, during studies¹ of Wellcome's early measles vaccines MV/16 and MV/20, a daily record was kept about the severity of malaise, loss of appetite, headache, disturbed sleep, coryza, running eyes, cough, sore throat, rash, and fever (taken 2-4 times daily) in each child for two weeks after vaccination against measles.

After MV/16 high fever (39.2-40.6°C) and a roseolar rash² invariably occurred, while malaise or headache or disturbed sleep also occurred in every child. In contrast respiratory symptoms or signs in the eyes, nose, throat, or chest just as invariably did not appear for the first time during the reaction phase from day 5 to day 12, even if recorded in a few children

once or twice before or after the reaction period; on most charts they were absent throughout the whole fortnight. MV/20, though less virulent than MV/16, was still far more reactive than the modern attenuated measles vaccines. Its use was followed by less malaise and less fever (37.6-39.2°C); rashes occurred less frequently. Like MV/16, this vaccine also produced no respiratory symptoms or signs. From these records I conclude that, even though the reactions to these earlier vaccines were otherwise far from "mild," no disease was caused in the respiratory tract.

The accuracy of this interpretation was underlined by the complete absence of respiratory symptoms and signs in home contacts of wild measles vaccinated early enough during their incubation period to prevent them catching the disease,³ even though their vaccine reactions were associated with fever and roseolar rash.

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¹ Watson, G I, *British Medical Journal*, 1965, 2, 13.

² Watson, G I, *Journal of the College of General Practitioners*, 1966, 11, suppl 1.

³ Watson, G I, *British Medical Journal*, 1963, 1, 860.

BMA representation in hospitals

SIR,—It may look from Dr E M Rosser's letter (25 September, p 760) as though my appointment as BMA recruitment officer for King's College Hospital (or, as I would prefer it, King's Health District, one of the three in the Lambeth and Southwark BMA Division) was to solve some of the problems set out in the letter from Dr J M Cundy (of the other BMA division in our AHA(T)) and myself (18 September, p 702).

But, of course, it merely clarified them. One can dragoon people into the BMA if one's temperament is right, with adequate data, but one cannot recruit. For recruitment one needs up-to-date data about the names, grades, specialties, and workplaces of one's existing members so that their subscriptions can produce for them things that non-members do not get—namely, regular local medicopolitical consultation and information as well as social and scientific activities which they may or may not want. The general practitioners seem to get this from their divisions, the presently most local BMA structures, but the hospital doctors do not, as many of their homes lie in other divisions. So no hospital recruits. My one constructive act has been to supply BMA literature to every new graduate (not previously done!) through the kindness of the medical school office.

My plea, therefore, is for the BMA to locate a willing hospital-based BMA member in every health district, to answer his calls for data promptly, to make sure that applications for membership go through him, and to help him to communicate easily with his constituents, who should really elect him (the unions object—so do I—to non-elected professional representatives). He should, of course, also be in touch with, if not on, his divisional executive.

Whatever the cost, this level of activity is what the BMA needs right now and not further spending on regional councils which must be almost as remote, psychologically, as Tavistock Square.

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