wound primarily in perforated appendicitis and possibly in purulent and gangrenous cases too. (When else would one sew up tissues steeped in faecal pus?) An acceptable alternative is delayed primary suture, with a wet gauze pack to the intermuscular layers for four days.

I am grateful to my colleagues who kindly allowed me to examine their patients' records, so illustrating the need for another look at appendicectomy.

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¹ Gilmore, O J A, and Martin, T D M, *British Journal of Surgery*, 1974, **61**, 281.

² Magarey, C J, et al, *Lancet*, 1971, **2**, 179.

School pregnancies

SIR,—Caroline Woodroffe suggests (18 September, p 694) that multiple youth advisory clinics on the lines of "the Brook" should be set up by the NHS. She apparently expects doctors to accept under-16 sexual intercourse as the norm and that we should therefore provide girls under that age with both contraception and abortion.

Do the Brook Advisory Centres produce any publicity to warn young adolescents of the health hazards (physical and emotional) of early sexual intercourse (for example, cervical disease) and the positive benefits of restraint? Do they help parents, teachers, and youth workers to understand the considerable health risks and emotional stresses from sexual pressures on this immature age group? We know after all that delinquency and precocious sexual activity are closely associated. The only "Brook" literature I have seen was entitled "Safe Sex," which is apparently the current euphemism for contraception and abortion.

As doctors we need to scrutinise much more closely the "brain-washing" of adolescents by the media, including teenage magazines, and some of our own profession. It sometimes appears as though "sex" is the current exploitation by some adults of the immature young, rather as though it was intended as a drug. Can we wonder at the consequences in terms of misery and distress to schoolchildren and their parents? Who is really benefiting?

ELIZABETH ELLIOTT

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Early diagnosis of breast cancer

SIR,—Dr Gisela Gästrin from Finland reports a more efficient method of self-examination in the early diagnosis of breast cancer (25 September, p 745). As a result 76 of 62 000 women were found to have breast cancer and she states that there was no exaggerated fear of cancer among the participants.

Experience in Britain shows a very different picture. The majority of women with breast lumps whom I see are absolutely terrified of cancer. Why is this so? It is because they fear they may lose a breast and die from the disease. If treatment were highly effective the public would soon reflect the optimism few of us have at the moment. The late Sir John Bruce¹ put the position well: "For, sadly, few of us today approach the treatment of breast cancer with any real confidence in what we have to offer."

Further, Baum² stated that most cases of breast cancer seen in practice must be considered incurable and cites evidence that a tumour 1 cm in diameter originated 2-8 years before clinical presentation.

Until our treatment of breast cancer improves we owe a duty to the public to stop advertising the "importance" of early diagnosis of this disease. Those who fear that such a policy would lead to an increased incidence of "late" cases can rest assured. Our misguided propaganda has so terrified the public that it will be 20 years before this is likely to happen and by then treatment may be more effective.

ROGER H ARMOUR

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Stevenage, Herts

¹ Bruce, J, *Journal of the Royal College of Surgeons of Edinburgh*, 1975, **20**, 287.

² Baum, M, *British Medical Journal*, 1976, **1**, 439.

Successful treatment of choking

SIR,—I have been asked by my colleagues to report on a boy of six whom I saw on 20 November 1975 dying of asphyxia and on whom I tried a new first aid manoeuvre from the U.S.A.¹

I was called to a school two minutes from my house and found this boy unconscious and cyanosed. Since I was told he had been choking I assumed someone would have already banged him on the back. Before embarking on a tracheostomy I tried the new first aid method, which consists basically of sharply pushing the upper abdomen upwards.

Immediately he coughed, brought up half a green pea, and recovered consciousness. In hospital later no further foreign bodies were found and he has gradually recovered from a collapse of his right lower lobe.

While in hospital he remembered that a month before, while playing with a pea-shooter, he had sucked instead of blown and inhaled a dried pea.

NICHOLAS RICHARDS

Caerphilly, Mid Glamorgan

¹ Heinlich, H J, *Journal of the American Medical Association*, 1975, **234**, 398.

Antibiotics and purulent sputum

SIR,—Drs N C H Stott and R R West deserve to be congratulated for their well-conceived and executed trial (4 September, p 556). Their demonstration of the closely parallel natural history of antibiotic- and placebo-treated respiratory illness where purulent sputum is the principal abnormality reported or found should encourage many more doctors to treat such illnesses expectantly.

During last winter we attempted a similar study on male patients in a number of practices in the Aberdeen area. The number of patients who completed the study (28) was too small to merit detailed statistical analysis, but the overall trends appear to confirm the Cardiff findings except in one aspect—the effect of smoking. A summary of the morbidity in tetracycline- and placebo-takers and in smokers and non-smokers in our study is shown in the table.

These findings suggest that whereas there is no obvious clinical advantage in being an antibiotic-taker as against a placebo-taker, there is a benefit in being a non-smoker as

	Patients	Mean duration of purulent sputum (days)	
		After starting treatment	Total illness
Non-smokers	13	4.7	7.2
Antibiotic-takers	12	6.3	11.1
Placebo-takers	16	6.8	10.3
Smokers	15	8.1	13.6

against a smoker. Further analysis showed that smoking antibiotic-takers produced purulent sputum for significantly longer than did non-smoking placebo-takers. These results are in keeping with the trend reported in a previous study of similar design¹ (to which Drs Stott and West referred) and it is perhaps surprising that they have not been confirmed in the Cardiff paper. Could it be that the inclusion of female patients has masked another of the disadvantages of being male?

It is a pleasure to acknowledge the help given by ICI Ltd for the provision of materials and finance for this study.

J G R HOWIE

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¹ Howie, J G R, and Clark, G A, *Lancet*, 1970, **2**, 1099.

Chronic urticaria

SIR,—I was delighted to hear that Dr Anne E Solomon and Miss J Macaulay (25 September, p 758) have established a separate clinic to study patients with urticaria and do hope that some new ideas in aetiology and treatment will evolve.

They mention some of their results in 37 patients with chronic urticaria and I would like to make some comments on these. Using a challenge test battery they had reactions in only four patients. In 1976¹ we recorded that out of 111 patients with chronic urticaria tested, 15 had shown a reaction to brewer's yeast, 12 to sodium benzoate, and 14 to tartrazine. It was at this time pointed out that these results were very much less than those recorded in previous reports, but it is certainly surprising that Dr Solomon and Miss Macaulay did not have more patients with reactions. However, what worries me much more about their results is that apparently only one patient reacted to test doses of aspirin. I simply do not understand this as it is completely against previous figures for patients with chronic urticaria who have shown exacerbations after having test doses of aspirin.²⁻⁶ In all these series the numbers of patients who have shown a reaction to salicylate test doses has ranged from 20% to 40%—the latter figure occurring when very high doses were given. Moreover, it has been demonstrated in the past few years that a large number of asthma sufferers show a similar exacerbation after salicylates.⁷⁻¹⁰

Assessment of the challenge test battery in patients with chronic urticaria can be difficult because chronic urticaria fluctuates so much and exacerbations may well occur after emotional upsets or upper respiratory tract infections, etc. Attacks of the weals during the test period may therefore have explanations other than a reaction to the particular chemical being tested and, indeed, at times attacks may coincide with taking the placebo capsules. It is therefore essential that the tests are repeated at least once, preferably administered in a

different order. Such false-positive reactions will not, of course, explain the fact that 36 out of the 37 patients reported by Dr Solomon and Miss Macaulay did not respond to test doses of aspirin. Only one of their patients had an immediate response (type 1) to candida antigen and I wonder if any had a type 3 response, as it was this type which occurred in 25 out of the 36 patients reacting to candida in our series.¹¹

I look forward to hearing further details about the tests and the further experience of Dr Solomon and Miss Macaulay. I do wish them every success in their work in this field.

ROBERT P WARIN

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Bristol Royal Infirmary,
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¹ Warin, R P, and Smith, R J, *British Journal of Dermatology*, 1976, **94**, 401.

² Warin, R P, *British Journal of Dermatology*, 1960, **72**, 350.

³ Moore-Robinson, M, and Warin, R P, *British Medical Journal*, 1967, **4**, 262.

⁴ James, J, and Warin, R P, *British Journal of Dermatology*, 1970, **82**, 204.

⁵ Michaelsson, G, and Juhlin, L, *British Journal of Dermatology*, 1973, **88**, 525.

⁶ Doeglas, H M G, *British Journal of Dermatology*, 1975, **93**, 135.

⁷ Samter, M, and Beers, R F, *Journal of Allergy*, 1967, **40**, 281.

⁸ Valentine, M D, Sheffer, A L, and Austen, K F, *Immunological Diseases*, p 906. Boston, Little, Brown, 1971.

⁹ Stenius, B S M, and Lemola, M, *Clinical Allergy*, 1976, **6**, 119.

¹⁰ Dalaney, J C, *Clinical Allergy*, 1976, **6**, 177.

¹¹ James, J, and Warin, R P, *British Journal of Dermatology*, 1971, **84**, 227.

Community health councils and the public

SIR,—My attention has been drawn to the letter from Dr S L Sacks (18 September, p 701). I should like to assure your readers that the state of affairs described in that letter is not universal. The practice of Central Birmingham Community Health Council, of which I am the secretary, and, I believe, of virtually all CHCs in this region is to provide, for the benefit of anyone who attends our meetings, copies of the agenda and of any papers under discussion. The press is, in any case, legally entitled to receive them.

Most CHCs whose practice I am aware of, including my own, make provision for the council to be addressed by members of the public, although the details vary; some CHCs set aside a part of each meeting for questions or speeches from members of the public, whereas others permit members of the public, subject to the chairman's discretion, to take part in debates. I think that the vast majority of CHCs are acutely conscious of the need to involve the public in their work and wish to give every encouragement to the relatively small number of people who are sufficiently interested to attend meetings, and I have little doubt that the experience of your correspondent is untypical.

EUAN PORTER

Birmingham

Careers in geriatrics

SIR,—I was expecting that somebody more competent than I would draw the attention of the people concerned with the future of geriatrics to the significance of the findings of Professor J Parkhouse and Mr C McLaughlin (11 September, p 630) in their paper on the

subject of career preference of doctors graduating in 1974. Out of 2022 graduates contacted not even one was prepared to take up geriatric medicine as a career. It is known that a substantial number of consultants in geriatric medicine appointed over the past few years are overseas-born. Over 50% of our hospital beds are occupied by patients over 65 years of age and it is estimated that by the year 2000 80% of beds will be occupied by patients in this age group. Since British graduates are not willing to come forward to man the service I presume it will remain for overseas doctors to carry on with the thankless job.

The only solution to this intractable problem is to offer a cash incentive in the form of a higher differential salary scale for anyone concerned with geriatric medicine and to throw away the mythical distinction award and replace this with an automatic seniority award. No doubt people could suggest other inducements. The British Geriatrics Society should be asked to put forward our case fairly and squarely to the Royal Commission and to the negotiating subcommittee of the CCHMS while they are discussing the new consultant contract.

S B DATTA

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Venereologists and distinction awards

SIR,—With reference to Dr R S Morton's letter regarding the distribution of new distinction awards (4 September, p 588) I agree with your comment that the amended figures are unlikely to cause any great excitement among venereologists. In fact, the very faint chance of obtaining a distinction award is the final discouragement to recruitment to the specialty. In the training posts there are few legitimate opportunities for extra duty payments and consequently the trainee is at a great financial disadvantage compared with his confreres. This disadvantage is maintained in the consultant grade, where there is little private practice and no domiciliary visits which normally, in other specialties, form a considerable part of the remuneration. Mrs Castle, in her letter to the Central Committee for Hospital Medical Services (22 February, 1975, p 496) might have had venereologists in mind in her reference to career structure supplements.

I can only hope that the CCHMS, during their consideration of proposals for the new consultant contract, will remember that there are specialties like venereology which are at the bottom of the tree as regards remuneration, and if we hope to attract successors this will have to be rectified.

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Keeping tabs on trainers

SIR,—I have read with great interest the correspondence on this subject (4 September, p 589; 18 September, p 704; and 25 September, p 759) and indeed the letter from my regional adviser, Dr D J Price (18 September, p 698), who, while recognising my intuitive brilliance, still feels I should attend a course—perhaps, do you think, to discuss the format of a questionnaire to be sent to trainees about trainers and of course vice versa.

We are not objecting to a "norm" being established or an audit being carried out but to the method being used. Trainers and trainees must feel free to make arrangements between themselves, seeking help from other trainers and trainees and a regional adviser if a problem cannot be resolved. If reports on trainers and trainees are to be sent to the regional adviser then let it be done openly so that all may benefit.

PAUL MASON

Camberley, Surrey

Official secrecy

SIR,—The refusal of the DHSS to agree to independent recording of negotiations (11 September, p 654) and the non-availability to the general public of the *Regional Chairmen's Enquiry into the Working of the DHSS* (p 599) are indicative of the bureaucratic passion for official secrecy which is one of the factors helping to keep the NHS in its present sorry state.

Surely an important publication paid for by the taxpayer should be readily available to those concerned with it. In the early days of the NHS a "Brown Book"—I think that was the Hitlerian name given to it—was brought out discussing hospital staffing, but this was for bureaucrats only and was not available to those working in hospitals.

BRYAN WILLIAMS

Chichester

Closing the ranks

SIR,—We are dismayed to see factions within our profession still pursuing their sectional interests when the future of the Health Service, and indeed of the profession itself, is in jeopardy. Even if we do not destroy ourselves, politicians will have no difficulty in manipulating such a fragmented and short-sighted group.

Most seriously, the hospital service is in danger of disintegrating because it is starved of necessary money and saddled with a new and ponderous administrative structure but is also lacking the authoritative leadership of a united medical profession. One need look no further to explain the disastrous drop in morale and the rise in emigration.

Both junior and senior hospital doctors should resolve, in the interests of the Health Service and their own future, never to act separately. Such a simple resolution, supported by a genuinely representative and fully executive body able to act quickly and authoritatively on behalf of *all* hospital doctors on *all* issues, would raise morale and improve our negotiating position. No organisation has yet done this for medicine.

It is simple common sense that our present representatives should abandon their independent factional activities and close ranks in this way. There is not much time to repair damage already done, and our successors are unlikely to forgive destructive inactivity in the present crisis. We appeal to the leaders of all organisations representing doctors in the hospital service to meet together, suppress their differences, and act in this matter.

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