royal colleges and faculties and hope that in due course further co-ordination between specialties will be achieved.

We have no wish to set up yet another medical association. We wish to provoke the support and encouragement of senior colleagues in the royal colleges which is so necessary to combat the mounting threat to the standards of hospital care in Britain. The art and science of medicine remain the sole responsibility of the royal colleges and they have a clear duty to defend standards. The pre-eminence of British practice has been achieved by the efforts of previous generations of doctors and we must not betray the past.

DAVID SKIDMORE

Manchester University

PATRICK SMITH

St Martin's Hospital,
Bath

Plight of the older consultant

SIR,—Mr S A Jenkins's letter (25 September, p 760) merits detailed discussion by the Association's public relations staff. "The total deductions from my salary are 63% of my gross pay and leave me with a net take-home pay of £2.40 per hour," writes Mr Jenkins. But of course this is not the end of the story, for out of this miserable remnant of a salary he will have to buy essential commodities at greatly inflated prices and submit to further taxation in the form of VAT on nearly all the goods and services which are indispensable to moderately civilised living. It is true that these circumstances apply in some degree to everybody, but they are perhaps most oppressive to members of the professions employed on a full-time basis.

Against this background it is interesting to note that when applications are invited (in this journal and elsewhere) for appointments, the salary is stated baldly as the untaxed annual payment; and this is the "income" which the general public associate with the job. I should like to suggest that the BMA should devise a more appropriate method of communication. For example, alongside the figure giving the gross salary offered there could be added the approximate net salary (that is, after tax) that would be received by the appointee if married and with two dependent children. This practice would, one hopes, gradually lead to awareness of what is really meant by income, and critics of the profession might thus be persuaded to consider hard facts before making pronouncements about the doctor's pay. Is it not time that at least one of the learned professions decided to abandon fantasies which would be condemned as extravagant even at the Mad Hatter's Tea-party?

STANLEY ALSTEAD

Dunblane,
Perthshire

L-tryptophan and sexual behaviour

SIR,—I was interested in the findings of Drs G P Egan and G E M Hammad, who described unexpected behavioural effects of preparations containing L-tryptophan (18 September, p 701). If anything, L-tryptophan should correct hypersexuality¹ and reduce normal sexual activity² in human subjects. In fact it has

been shown that a decreased serotonergic tone in the central nervous system increases and an increased serotonergic tone decreases sexual activity in experimental animals.³ Therefore sexual disinhibition in patients under the treatment with L-tryptophan does not fit in the available hypothesis about the role of brain serotonin for sexual behaviour.

We recently treated multiple sclerosis patients with 1.5-2.0 g of L-tryptophan daily for one month. They did not show any significant changes of sexual motivation when compared with placebo treatment, though L-tryptophan accelerated brain serotonin turnover.² Sexual disinhibition caused by treatment with L-tryptophan was found in psychiatric patients, in whom adverse effects of aromatic amino-acids (like tryptophan) are possible, since deviations from the normal synthesis of neurotransmitter amines in psychiatric disorders have been suggested by psychopharmacologists for many years. Alternatively, L-tryptophan in high doses for long periods of time can be metabolised into substances which react as so-called false transmitters in the brain.

Acute effects of an intravenous infusion of L-tryptophan on a series of psychological and physiological measures are very modest.⁴ I have an own personal experience of a loading dose (100 mg/kg) of L-tryptophan, which caused increased drowsiness together with slight and short-lasting lightheadedness. Neither I nor my colleagues who participated in the test felt changes in sexual motivation.

MARKKU T HYYPÄ

Third Clinical Institute,
University of Turku,
Finland

¹ Sicuteri, F, *Pharmacological Research Communications*, 1974, 4, 403.

² Hyypä, M, et al, in *Sexual Behaviour: Pharmacology and Biochemistry*, ed M Sandler and G L Gessa. New York, Raven Press, 1975.

³ Gessa, G L, and Tagliamonte, A, in *Sexual Behaviour: Pharmacology and Biochemistry*, ed M Sandler and G L Gessa. New York, Raven Press, 1975.

⁴ Greenwood, M H, et al, *Clinical Pharmacology and Therapeutics*, 1974, 16, 455.

Renal amyloidosis and schistosomiasis

SIR,—A recent paper by Omer and Wahab¹ suggests that infection with *Schistosoma mansoni* may lead to secondary renal amyloidosis. A spectrum of glomerular changes has been detected in patients with advanced schistosomiasis² and therefore it seems important to determine whether amyloid changes are also included. Such data might help to understand the pathogenesis and immunopathology of both schistosomiasis and amyloidosis.

Recently we studied renal tissue from 245 necropsies performed in Egypt during 1972-3 by Dr Allen Cheever.³ One hundred and fifty-five (63.3%) of the cases had schistosomiasis (*S haematobium* and concomitant *S haematobium* and *S mansoni* infections) and 90 (36.7%) were non-infected controls. The prevalence of renal amyloidosis was 4.5% in the infected and 3.5% in the non-infected group.

In our routine hospital material renal amyloidosis is rare. However, we agree with Omer and Wahab that amyloidosis can be missed if not specifically looked for. We examined kidney sections stained for amyloid from 53 necropsy cases with hepatosplenic schistosomiasis (24 males and 29 females,

from Bahia, Brazil). The amyloid stains included Congo red, methyl violet, and the fluorescent technique with thioflavine-T.⁴ The slides were examined under polarised light and under UV light in a Vanox-Olympus microscope. In the 53 cases, which were randomly selected, there were six cases of membranous proliferative glomerulonephritis, one case of membranous glomerulopathy,⁵ two cases of chronic proliferative glomerulonephritis, and one case of acute proliferative glomerulonephritis. In three cases there was a diffuse Congo red staining of the amorphous and fibrillar mesangial matrix. However, these sections failed to show fluorescence with thioflavine-T or Congo red stains when examined under UV light. These sections were also negative when observed under polarised light, which was in clear contrast to positive control slides from cases with amyloidosis. We have concluded that classical amyloidosis was not present in this series of cases of hepatosplenic schistosomiasis.

Secondary amyloidosis has been reported in isolated cases of human schistosomiasis.^{1,6} In mice with a tendency to develop amyloidosis experimental infection with *S mansoni* can potentiate the disease, but the infection per se does not seem to induce amyloidosis.⁷ Thus, it is our opinion that more controlled studies are needed to clarify the relationship between schistosomiasis and renal amyloidosis than is suggested by the studies of Omer and Wahab.

MOYÉS SADIGURSKY
ZILTON A ANDRADE

University of Bahia Faculty of
Medicine,
Salvador, Bahia,
Brazil

¹ Omer, H O, and Wahab, S M A, *British Medical Journal*, 1976, 1, 375.

² Andrade, Z A, et al, *American Journal of Tropical Medicine and Hygiene*, 1971, 20, 77.

³ Sadigursky, M, et al, *Transactions of the Royal Society of Tropical Medicine and Hygiene* (in press).

⁴ Hobbs, J R, and Morgan, A D, *Journal of Pathology and Bacteriology*, 1963, 86, 437.

⁵ Andrade, Z A, et al, *Revista do Instituto de Medicina Tropical de São Paulo*, 1974, 16, 171.

⁶ Lichevitz, B, and Cavallo, T, *Revista do Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo*, 1964, 19, 43.

⁷ Andrade, S G, *O Hospital (Rio de Janeiro)*, 1965, 67, 761.

Sickness certification

SIR,—Having given full vent to the anger I had provoked, Scrutator (9 October, p 892) conceded that "selected quotes can be used to damn most reports." If this is true when one has actually read the report under review, it is that much more likely when the reviewer relies on the publisher's press release and selects quotations from that.

Scrutator's anger is too extensive for me to answer all his points, but may I reply on two matters that particularly irritated him/her? First, I never pretended that I had interviewed a random sample of doctors. Having talked to a dozen Bristol GPs about a range of welfare interventions—not just in respect of sickness benefit but also for supplementary benefits and council housing—I was surprised that their views on sickness certification were at such variance with those of the British Medical Association. There seemed to be two possible explanations: the BMA's campaign was more unrepresentative than outsiders might expect; or our respondents were every bit as unrepresentative as medical and social scientists alike might predict. For help on the first