(2) The bacteriological method used for isolation of *Klebsiella* was as follows: Standard aliquots of faecal samples were cultured on a differential medium containing 1% inositol, 1% Lab Lemco, 1% bacteriological peptone, 1.2% agar, and bromothymol blue indicator incubated at 37°C for 18 hours. Inositol fermenting colonies were identified using API 20E.

(3) There was no difference between the average number of visits from rheumatoid arthritis patients with one positive sample and the number of visits from patients who provided only negative samples.

(4) Analysis of positive cultures in males and females was carried out on a patient and not a sample basis: 13 out of 33 men who provided samples on two or more occasions had two positive cultures compared with six out of 58 women who were examined in a similar way. This difference is significant.

(5) The comparison among rheumatoid arthritis patients with HLA-B7 CREG antigens was carried on a patient and not a sample basis.

(6) The reference to the work of Eastmond and coworkers¹ was misquoted as this group clearly found an association between isolation of faecal *Klebsiella* and uveitis ($p < 0.01$) and peripheral synovitis ($p < 0.05$) in HLA-B27-positive patients with ankylosing spondylitis. Since we took the presence of uveitis and peripheral synovitis in ankylosing spondylitis as clinical evidence of disease activity we consider the results of this group as providing independent confirmation of our observations.

(7) The association of faecal *Klebsiella* with disease activity in ankylosing spondylitis has been made not only on clinical but also on biochemical criteria such as elevated erythrocyte sedimentation rate and C-reactive protein levels.²

We agree that further studies are clearly indicated, and currently we are carrying out a survey on the prevalence of *Klebsiella* in faecal samples obtained from tissue-typed healthy controls not associated with a hospital environment.

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- ¹ Eastmond CJ, Willshaw HE, Burgess SEP, Shinebaum R, Cooke EM, Wright V. *Ann Rheum Dis* 1980;**39**: 118-23.
² Cowling P, Ebringer R, Cawdell D, Ishii M, Ebringer A. *Ann Rheum Dis* 1980;**39**:45-9.

Admission of old people to psychiatric units

SIR,—Dr D J Jolly and his colleagues in their letter (1 November, p 1214) quite rightly mention the large number of undetected scandals in the Health Service, with only the top of the iceberg ever reaching the surface.

The ill-conceived Royal Commission report,¹ together with present Government policy, encourages the provision of sizable isolated geriatric ghettos containing a still greater proportion of the elderly needing hospital care. Quite apart from the greatly increased effectiveness (measured by throughput) of those geriatric departments in district general hospitals,²⁻⁴ the public must be reminded that a vast majority of Health

Service scandals have been unearthed in isolated sizable single-specialty hospitals such as Normansfield and Ely.

Apart from the ethical considerations, if the Government really wants cost effectiveness in the Health Service it should promptly reverse its decisions and not encourage the increase of such establishments.

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- ¹ Royal Commission on the National Health Service. Report. Cmnd 7615. London: HMSO, 1979.
² Silver CP. In: Isaacs B, ed. *Recent advances in geriatric medicine*. London: Churchill Livingstone, 1978:126.
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Recurrent abdominal pain in a patient on haemodialysis

SIR,—We note with interest the case report by Dr Douglas Leece (1 November, p 1215). In our experience recurrent abdominal pain soon after commencement of dialysis (10-15 minutes) was not an uncommon problem in patients on regular dialysis treatment. However, since we have started reusing the dialyser inclusive of the extracorporeal blood tubings the problem seems to have subsided altogether.

It is our assumption that the reuse of the dialyser and the extracorporeal system allows the deposition of proteinaceous material¹ within the dialyser and tubings. This in turn reduces the release of plasticiser diethyl-phthalate² from the polyvinyl chloride tubings, which may account for the "new dialyser syndrome."

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- ¹ Kolff WJ. *Dialysis and Transplantation* 1979;**8**:835.
² Gerstoft J, Christiansen E, Nielsen IL, Nielson B. *Proc Eur Dial Transplant Assoc* 1979;**16**:739-40.

Response of antidiuretic hormone to chlorpropamide

SIR,—Dr M C Champion and his colleagues (6 September, p 645) have estimated serial blood concentrations of antidiuretic hormone, sodium, and osmolality in diabetics on chlorpropamide and concluded that in long-term use it seemed unlikely to act centrally. They have not, however, estimated urinary excretion of antidiuretic hormone, which was increased after chlorpropamide medication.¹ But it was only in about 4% of patients, who had an underlying tendency to retain fluid, having conditions such as cardiac failure or cirrhosis of liver, that hyponatraemia developed.² The interrelationship of sodium, osmolality, and antidiuretic hormone is thus far from clear.

When Verney injected pitressin in dogs he noticed increased excretion of chloride.³ It has been shown that hypokalaemic alkalosis cannot be corrected without adequate chloride supplementation.⁴ Of more related interest is the chronic hypotonic volume expansion induced by water and vasopressin administration that stimulates distal hydrogen ion excretion, maintaining normal plasma bicarbonate levels mediated by increased aldosterone secretion.⁵ Not surprisingly in the syndrome of inappropriate secretion of antidiuretic hormone plasma bicarbonate always remains normal or near normal. It has been

further shown that vasopressin has an effect on chloride transport in the medullary thick ascending loop of Henle.⁶

To help clarify this problem the authors should devise a protocol that does not include the estimation of blood sodium and osmolality only. Probably in pathological states nature corrects acid-base imbalance by increased secretion of antidiuretic hormone, and chlorpropamide might be just providing a helping hand.

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² Weissman PN, Shankman L, Gregerman RI. *N Engl J Med* 1971;**284**:65-71.
³ Verney EB. *Proc R Soc B* 1947;**135**:25-106.
⁴ Aber GM, Sampson PA, Whithead TP, et al. *Lancet* 1962;**17**:1028-30.
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⁶ Hall DA, Varney DM. *J Clin Invest* 1980;**66**:792-802.

Infectivity of tuberculosis

SIR,—I have read with interest the recent letters of Dr R H Townshend (4 October, p 942) and Dr D B Gravatt (8 November, p 1286) concerning the infectivity of tuberculosis. The British Thoracic Association research committee considered this problem in 1973 and undertook a large study of the role of contact tracing.¹ The results confirmed that the widespread screening of work contacts was not justified unless there was evidence of high infectivity in the index case or particularly close contact. Studies from the United States have shown that the early discharge of patients on chemotherapy who are sputum-smear positive does not convey an increased risk of infection to their close contacts.² Contact tracing in tuberculosis is important but should be based on the known pattern of infectivity in the community and work place.³

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- ¹ The Research Committee of the British Thoracic Association. *Tubercle* 1978;**59**:245-59.
² Gunnels JJ, Bates JH, Swindell H. *Am Rev Resp Dis* 1974;**109**:323.
³ Davies BH. *Thorax* 1980;**35**:481-3.

A plea for clinical epidemiology

SIR,—Your leading article "A plea for clinical epidemiology" (1 November, p 1163) states that the community physicians were unhappy about the gradual disappearance of epidemiology from their training. This statement is rather incomprehensible for those of us who have undergone training recently. Among the two components of the training—academic and in-service—it certainly does not apply to the academic component. In the in-service training, we do not get as much training in epidemiology as we would like; but we get involved in epidemiological studies much more than our trainers themselves do.

We are bound to run into conceptual problems in the terminology used, but as a doctor recently trained in community medicine I like to think that clinical epidemiology is clearly my field as a practitioner in community medicine. I would like to dispel the fear that the practitioners in community medicine at present are opting out of this most important part of our specialty by suggesting that there will be a somewhat different emphasis for