Cervical Cytology in General Practice

SIR,—In the summer of 1963 a cytological service became available. I have since taken routine smears at post-natal examinations and whenever vaginal examination was indicated. On a few occasions I have failed to obtain a suitable specimen. No attempt has been made to screen patients who would not otherwise have been examined, and I have only started taking smears from patients on oral contraceptives this month. No request has been made for a smear in spite of the widespread publicity.

Practising in a group it is not possible to state the exact number of patients for whom I am responsible, but a fair estimate would be 2,800. When it occurred to me that the figures might be of interest, our cytologist Dr. Margaret Wolfendale kindly analysed the smears I had sent in.

To the middle of November 1964 141 smears had been taken of which 47% were post-natal specimens. The monthly rate was nine, and I had picked up one carcinoma in situ, subsequently confirmed. Assuming that 25% of my patients are women in the significant age-group, without modifying my pattern of practice 20% of my patients have been examined, and within three years of starting the figure may rise to half my population. Some women will be re-examined, but I believe my monthly rate will rise as I add the contraceptive-taking group.

It is only fair to state that my rate is rather higher than that of other family doctors making use of the service; facilities for the examination of smears are limited anyway.

The *Lancet*, discussing Professor Scott's Mackenzie Lecture,¹ points out that general practice is perpetually if inconspicuously absorbing the techniques of the hospital, thereby relieving special departments of part of their load. This can only happen if practitioners are not too heavily burdened to accept new responsibilities, and at present few of us feel our lot is so comfortable that we can extend our services in new directions without restrictions elsewhere.

I have not seen estimates of the rate of screening in routine family practice previously, but I now feel that progressive examination of a practice population can be carried out. It is probable, however, that this can only be done in practices that at sacrifice to themselves have kept their list size within bounds and employed adequate ancillary help.—I am, etc.,

Bletchley, Bucks. GEOFFREY RIVETT.

REFERENCE

¹ *Lancet*, 1964, 2, 1161.

Immunofluorescent Diagnosis of Amoebiasis

SIR,—The recent article by Dr. J. D. Fulton and Dr. A. Voller (7 November, p. 1173) dealing with the application of the indirect fluorescent-antibody technique to the detection of specific *Toxoplasma* antibodies prompts me to give a preliminary report on the results of similar studies made in this department in cases of systemic infection with another protozoon, *Entamoeba histolytica*.

Sera giving a positive amoebic complement-fixation test were obtained from three patients with evidence of hepatic amoebiasis. In

addition, control sera were obtained from six healthy subjects, eight patients with non-amoebic liver disorders, and 21 patients with other non-amoebic conditions. Smears of *E. histolytica* were treated first with a 1/8 dilution of each of the 38 sera, and subsequently with fluorescein-labelled anti-human-globulin. Microscopic examination of the smears was made using ultra-violet light excitation in conjunction with a dark-ground condenser. Brilliant (++++) fluorescence of the amoebae was obtained with the sera from each of the three patients with amoebiasis (see Fig.), in striking contrast to the weak fluorescent staining obtainable with the control sera.

Positive immunofluorescent staining of *Entamoeba histolytica* obtained with 1:8 dilution of serum from patients with hepatic amoebiasis. ($\times 2,000$.)

Further tests of sensitivity and specificity are in progress, and we would be very glad to receive sera from colleagues with known or suspected cases of intestinal or hepatic amoebiasis. In the meantime it seems likely that this versatile technique is capable of playing a useful part in the elucidation of what may, as stated in your leading article (25 July, p. 206), be a difficult diagnostic problem.

I wish to thank Dr. G. L. Robinson, of the Dreadnought Seamen's Hospital, Greenwich, who performed the complement-fixation tests and provided me with two of the test sera and also with cultures of *E. histolytica*. I also thank Mr. F. J. Gibbs, F.I.M.L.T., for his assistance.

—I am, etc.,

A. L. JEANES.

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London S.E.1.

Fires and Explosions

SIR,—I notice that Mr. K. J. Carroll in his memorandum on "Unusual Explosions During Electrosurgery" (7 November, p. 1178) mentioned that such explosions have occurred as the result of the eruption of inflammatory gases.

I recall a case referred to me by Dr. Ronald Hartley many years ago. The patient was a parson who became alarmed when he noticed that his breath took fire every time he blew the altar candles out. I performed a Polya-gastrectomy for a duodenal ulcer causing pyloric stenosis, following which he was able to carry out his duties in a more decorous fashion.—I am, etc.,

STEPHEN POWER.

Royal London Homoeopathic
Hospital,
London W.C.1.

Abdominal Paracentesis

SIR,—The trocar and cannula for abdominal paracentesis¹ referred to in the leading article of 26 September (p. 774) is an elegant instrument. House-physicians are rarely offered such equipment and many use an unnecessarily large trocar and cannula which is unpleasant for the patient and leaves a track for infection. Aspiration is very easy with a serum needle attached to clamped tubing, and sterile equipment is readily available by adapting a plastic drip set. Only a weal of local anaesthetic is required. Patients who require repeated aspiration find this a very simple procedure.—I am, etc.,

Glasgow N.1.

I. I. J. M. GIBSON.

REFERENCE

¹ Kerr, D. N. S., Pearson, D. T., and Read, A. E., *Gut*, 1963, 4, 394.

Circumcision and Cervical Cancer

SIR,—As pointed out in your leading article on "Circumcision and Cervical Cancer" (15 August, p. 397), the value of male circumcision in the prevention of cancer of the cervix is still uncertain. It would be wrong, however, to dismiss its possible beneficial effect. In a 10-year (1954–64) survey from the Sudan¹ comparison has been made between Khartoum Civil Hospital series and a district hospitals series. Almost 100% of women attending the Khartoum Civil Hospital were married to Muslim men, who are fully circumcised at an early age, whereas in the district hospitals series an unknown proportion, estimated at 10 to 15%, were from the Southern Provinces, where male circumcision is not practised commonly. The findings of a frequency-ratio study based upon surgical biopsy material showed a lower incidence of cervical carcinoma in the Khartoum Civil Hospital series. It also disclosed a pattern of site distribution more approximating that of Western countries than those of other African states. Thus breast cancer formed 23.3% and cervical cancer 13.1% of the total malignancy in the Khartoum Hospital series (see Table). Since

Site Distribution and Percentage Incidence of Cancers of the Genital Tract and Breast in Sudanese Women (1954–1964)

Site	Khartoum Civil Hospital		District Hospitals		Total	
	No.	%	No.	%	No.	%
Vulva ..	14	2.1	15	1.6	29	1.8
Vagina ..	2	0.3	7	0.7	9	0.6
Corpus ..	31	4.7	36	3.8	67	4.2
Cervix ..	86	13.1	170	18.0	256	16.0
Chorion-epithelioma ..	8	1.2	18	1.9	26	1.6
Fallopian tube ..	2	0.3	0	0.0	2	0.1
Ovary ..	30	4.6	77	8.2	107	6.7
Breast ..	153	23.3	203	21.5	356	22.2
Other sites ..	331	50.4	419	44.3	750	46.8
Total ..	657	100.0	945	100.0	1,602	100.0

Note: The above table is reproduced by kind permission of the Editor, *Sudan med. J.*

several alleged causes of cervical cancer (early and multiple marriages, coitus at a young age, malnutrition, liver disease) probably operate in the Sudan to a greater extent than in Western countries, it was concluded that the

lower incidence of cervical carcinoma probably was related to the universal practice of male circumcision amongst the Muslim community. That male circumcision is unlikely to be the only factor involved in reducing cervical carcinoma is evident from the conflicting literature on the subject. As Elliott³ points out, "No more can be said for the argument than that it is a hypothesis which fits the facts." As such it deserves consideration.—I am, etc.,

JOSEPH A. VERZIN.

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University of Khartoum,
Sudan.

REFERENCES

- ¹ Lynch, J. B., Verzin, J. A., and Hassan, A. M., *J. Obstet. Gynaec. Brit. Cwlth.*, 1963, 70, 495.
- ² Verzin, J. A., *Sudan med. J.*, in press.
- ³ Elliott, R. I. K., *Lancet*, 1964, 1, 231.

Histoplasmosis in Cyprus

SIR,—In reply to the letter of Dr. P. J. Cusins (21 November, p. 1328) I can confirm that repeat lumbar puncture three weeks after the start of the encephalitis in my Case 1 revealed a normal cerebrospinal fluid. Whilst I accept that it cannot be proved that *Histoplasma capsulatum* was the cause of the central nervous signs without isolation of the yeast, I should like to question some other points.

Untreated disseminated histoplasmosis is usually a fatal disease, but it is by no means always so, and Furcolow¹ has reported survival of 4 of 24 untreated patients, with follow-up periods of between 3 and 15 years. Histoplasmosis of the central nervous system only occurs in disseminated forms of the disease, but it could scarcely be otherwise when most authorities define dissemination as disease occurring outside the lungs.

The suggestion of a universally fatal prognosis in histoplasmosis of the brain began as a result of early reports being on necropsied cases.² In the same way as symptomatic benign histoplasmosis can occur in other organs,³ so can granulomata occur in the central nervous system without the involvement of other organs apart from the lungs.⁴

Finally, should we not avoid too rigid a division into benign non-fatal and disseminated fatal groups, lest we fail to discern those cases, perhaps few in number, who fall somewhere in between.—I am, etc.,

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D. J. STOKER.

REFERENCES

- ¹ Furcolow, M. L., *J. Amer. med. Ass.*, 1963, 183, 823.
- ² Schulz, D. M., *ibid.*, 1953, 151, 549.
- ³ Christie, A., *Ann. intern. Med.*, 1958, 49, 544.
- ⁴ White, H. H., and Fritzen, T. J., *J. Neurosurg.*, 1962, 19, 260.

Plantar Warts and Athlete's Foot

SIR,—It has been said, I believe by Lord Adrian, that dermatology, unlike beauty, is more than skin deep. This being so, I am disturbed by the superficiality of Dr. F. J. C. Roe's reasoning (14 November, p. 1268), and I would plead for a slightly more profound consideration of the subject before, as he requests, we have the heads of school medical officers, headmasters, and headmistresses

rattling together like castanets. The general idea is most laudable but not for the reason he proposes.

Presumably these educational authorities are advised by their physical training experts that the best exercises for muscles and joints of the lower limbs (and particularly the feet) are only possible in the absence of shoes. This I personally believe to be very true, and the greatly-lowered incidence of flat-foot now as compared with 30–40 years ago must to a great extent be due to improved foot posture —though pointed-toe shoes could well reverse the trend.

If bare-foot gymnastics bring a small increase of plantar warts to my skin clinic I regard this as but a small price to pay for their general benefit. Athlete's foot, of course, is reduced rather than increased by baring the feet.—I am, etc.,

ALASTAIR AITKEN ROSS.

Portsmouth, Hants.

Electrocardiography with Music

SIR,—Dr. D. S. Lewes's suggestion (24 October, p. 1077) that his cardiograph picks up the Light Programme from the ward-radio system is theoretically possible if the wiring is not enclosed in conduit or steel trunking and if an earth fault has occurred on the wiring of a system having an earthed centre tap, so causing a magnetic field to be set up. The strength of the audio signal would then be related to the area enclosed by the leads.

An alternative explanation of direct radio pick-up is, however, I think, the more likely. At Bedford, the medium-wave B.B.C. signals are too weak to cause interference, but the long-wave Light Programme transmitter gives a field of around 40 millivolts per metre. Inside the hospital the signal strength will vary considerably, being increased close to metal pipes, structural steelwork, etc. The reduced pick-up in the chest (V) position is possibly due to the fact that resistors are switched into the circuits in this position and these will act as radio-frequency filters. I am unable to agree with Dr. H. R. A. Townsend (14 November, p. 1268) that radio pick-up is invariably due to high-resistance electrode contacts; however, his cure can be quickly put to the test. A high-resistance electrode contact would reduce the in-phase-rejection ratio of the cardiograph and so lead to 50 c/s electrostatic pick-up which the technician would recognize and correct, but would not lead to increased radio-frequency pick-up.

A permanent cure for radio-frequency interference is the addition of a series resistor (e.g., 10,000 ohms) and shunt capacitor (470 picofarads) at the input grids of the first stage.

In investigating cases of interference to hospital-sensitive equipment it is essential to determine at the outset whether the interference is electrostatic, magnetic, or radio-frequency in origin. This can be done with suitable small amplifiers (e.g., obsolete valve deaf-aids) with appropriate pick-up devices; the basic information is then obtained in a matter of minutes and the correct measures can be applied to cure the interference.—I am, etc.,

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London S.E.1.

A. K. DOBBIE.

Family Planning in London Teaching Hospitals

SIR,—Mr. E. E. Philipp's comments (31 October, p. 1132) on the teaching of contraception in London teaching hospitals deserve further examination. In this hospital the subject of contraception is dealt with at a theoretical level in the course of gynaecological lectures and informally in gynaecological out-patient clinics. Medical students, many of whom are married nowadays, are usually well informed on the subject, and if they are not ample information is freely available in most modern gynaecological textbooks. There is no excuse for a lack of theoretical knowledge. The question of instruction on the practical aspects of contraception, including advice as to the most suitable method, the fitting of diaphragms, cervical caps, and intrauterine contraceptive devices, and family planning based on "the pill" is a different problem, and in my view too specialized a subject to be taught to the undergraduate. Our students may "sit in" at one of the local F.P.A. Clinics if they wish, but those who propose to undertake family planning work after qualification are advised to attend one of the excellent courses of instruction arranged by the F.P.A. Competence in the practical aspects of family planning, like competence in forceps delivery, is best obtained by postgraduate rather than undergraduate study.

Mr. Philipp says that criminal abortions are the aftermath of failure in contraception, implying that this in turn is the result of a lack of contraceptive instruction to medical students. In my experience most patients admitted with self-induced abortions are well aware of contraception but do not choose, through laziness or stupidity, to avail themselves of it. Certainly the suggestion that abortion does not have the same impact on teaching-hospital consultants as it does on those working in non-teaching units is unwarranted. This hospital (and many other London teaching hospitals) is so well aware of the need to bring the student into contact with acute cases of all kinds, medical and surgical as well as gynaecological, that it has gone to great lengths to obtain, by designation, control over a "non-teaching" hospital for this very purpose. At this hospital we are now in the position of accepting the most severely ill septic abortions from peripheral non-teaching hospitals who have not the facilities to cope with the problems of urinary suppression. The idea of a teaching-hospital gynaecologist as one who lives in a rarefied atmosphere divorced from contact with the "realities" of non-teaching hospital gynaecology is as outmoded as it is unreal. The barriers between "teaching" and "non-teaching" gynaecology are down.—I am, etc.,

Dulwich Hospital,
London S.E.22.

J. M. BRUDENELL.

Dangerous Anaesthetic Device

SIR,—I would like to raise one point regarding the letter from Dr. J. Fraser-Jones and his colleagues (28 November, p. 1396). The combination of the "Bosun" whistle and the Manley ventilator is only dangerous if the "Bosun" whistle is set to go off at about 1½ lb. per square in. (0.11 kg. per square cm.). The two pieces of equipment