"Rule of Three"

SIR,—Some official rebuke from the B.M.A. should surely be made to the Minister of Transport in his recommendation that three drinks should be taken before driving at Christmas. His "rule of three" must surely be the most imprudent advice given to motorists for many a decade. The rule of "none for the road" should always apply.—I am, etc.,

London W.1.

GUY BEAUCHAMP.

SIR,—We would urge you to use your influence to try to undo the damage done by the Minister of Transport in the television interview when he propounded his so-called Rule of Three. We are quite sure that the B.M.A. would never support the implication that it is safe as a general rule to drive after taking three drinks. To suggest, for instance, that a young man or woman of 18 is safe after taking three whiskies or three sherries is flying in the face of facts.

The only safe slogan is "If you drink, don't drive."—We are, etc.,

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D. A. J. NEDEN.

Ramsgate, Kent.

Urinary Infection in Childhood

SIR,—I should like to take issue with some of the conclusions drawn by the authors of the article entitled "Clinical and Radiological Features of Urinary Infection in Childhood" (14 November, p. 1222).

They describe as "unselected" the cases of urinary infection discovered in a paediatric out-patient department. The work of Kunin *et al.*,¹ which shows that significant bacteriuria is present in the urine of 1% of a schoolgirl population, makes it obvious that most urinary infections never reach hospital. They are presumably treated by the general practitioner, with or without a diagnosis, only a small proportion being referred to hospital. The cases referred to in the article are thus markedly selected in that they are children whose general practitioners have felt for one reason or another that they needed help with the managements of their illnesses. It seems obvious that if the actual incidence of urinary infection in children is taken then the proportion having radiological evidence of abnormality will be much smaller.

The point I am making is that the conclusion the authors draw, that every urinary infection in a child should be investigated by

full radiology, applies only to those urinary infections discovered in hospital and not necessarily to urinary infections in general practice. Surely the important point in dealing with any urinary infection is to obtain bacteriology of the urine, to institute therapy with an appropriate antibacterial agent for an adequate time, and then to have adequate follow-up bacteriology of the urine to ensure that it remains sterile. In any child with any important degree of structural abnormality relapse will occur, and this would then be an indication for full investigation.

Thus many normal children would be saved the consequent discomfort and radiation hazard involved in intravenous pyelography and urethro-cystography, procedures which in the primary infection are of only prognostic value.—I am, etc.,

Milngavie, Glasgow.

KENNETH HARDEN.

REFERENCE

- ¹ Kunin, C. M., Zacha, E., and Paquin, A. J., *New Engl. J. Med.*, 1962, 266, 1287.

SIR,—In an interesting and valuable paper on this subject by Dr. Jean Smellie and her co-workers (14 November, p. 1222) there is a bacteriological point on which they do not comment but which I feel deserves attention; this is the finding that of their 19 cases of urinary infection by proteus, all were caused by *Proteus vulgaris*.

This is surprising, since it is well known that the majority of proteus infections are due to *Pr. mirabilis*, and that infections with *Pr. vulgaris* are comparatively rare. However, before discussing the matter further it would be of interest to know the criteria used to

identify these strains as belonging to the species *Pr. vulgaris*.—I am, etc.,

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Reading.

SIR,—In their important article on pyelonephritis in childhood (14 November, p. 1222) Dr. Jean M. Smellie and her co-workers give figures that suggest that a high proportion of affected children may acquire their infection in the neonatal period and remark on the difficulty of making this diagnosis in the newborn infant. A physical sign that I have found very useful in this connexion is the presence of palpably enlarged kidneys. This sign is often present before the baby is obviously ill and before pus appears in the urine and is often associated with a positive blood culture and jaundice: with treatment it regresses in a few days. When I have done an intravenous pyelogram subsequently no definite abnormality has been demonstrable, and in a baby who died of congenital heart disease, after regression with treatment, the kidneys were essentially normal in architecture though 50% heavier than expected. The nature of the swelling is not clear: renal-vein thrombosis, acute inflammation, and adrenal haemorrhage are possible causes. On a number of occasions the presence of this physical sign has enabled us to make an early diagnosis of neonatal septicaemia and to institute treatment before a baby became seriously ill.—I am, etc.,

J. A. DAVIS.

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Institute of Child Health,
Hammersmith Hospital,
London W.12.**Lymphocytic Transformation**

SIR,—The recent preliminary communication of Drs. M. W. Elves, S. Roath, and M. C. G. Israels (24 October, p. 1051) reports their observation that the percentage transformation, after exposure to phytohaemagglutinin (P.H.A.), of lymphocytes from one patient with primary hypogammaglobulinaemia and six patients with hypogammaglobulinaemia secondary to chronic lymphatic leukaemia was significantly low. From this they speculated widely on the physiology of immune mechanisms. The finding in primary hypogammaglobulinaemia is contrary to two previous reports^{1,2} of normal transformation to P.H.A. (although immuno-fluorescence studies did not detect

γ -globulin production in the transformed cells).

Schrek and Rabinowitz¹ and Quaglino² found deficiency of response in some patients with chronic lymphatic leukaemia, though they did not give data of correlation with γ -globulin levels, as did Elves and his colleagues, who suggest that the low γ levels in these patients (and in primary hypogammaglobulinaemia) might result from lymphocyte hyporesponsiveness. Before such a correlation could be regarded as a causative one other independent assessments of severity of the underlying disease would be needed. Also, from the technical standpoint, quantitative deductions from percentage trans-

Pre-treatment Serum Immunoglobulin Levels, and % Lymphocytes Transformation Following Exposure to Two Non-specific Stimulants, and to Antigens to which the Patients were Believed to be Exposed, in Five Patients with Primary Hypogammaglobulinaemia

Patient	Age (yrs.)	Sex	Pre-treatment Serum Immunoglobulins			% Lymphocyte Transformation									
						Control	Non-specific		Antigens						
			IgG mg./100 ml.	IgA % of Standard "Normal" Serum	IgM		P.H.A.	Staph. Filtrate	P.P.D.	Strep- tolysin	Tetanus Toxoid	Diph- theria T.A.F.	Smallpox Vaccine (Lister)	T.A.B.	<i>E. coli.</i>
A1	40	M	80	1	9	<0.1	61	—	<0.1	<0.1	—	—	<0.1	—	—
A2	40	M	80	1	9	<0.1	56	37	3	—	—	2	2	<0.1	—
B	5	F	7.5	0	3	<0.1	80	47	—	0.25	—	—	1	—	—
C	62	F	120	0	14	1	64	48	3	5	—	—	0.5	—	1.5
D	29	M	2.5	0	25	0.2	85	24	4	—	—	—	1	—	—
F	2	M	0.3	0	1	<0.1	35	—	<0.1	—	<0.1	—	—	—	—
47 healthy adults						<0.1-0.5	21-92	11-84	Range for immunized individuals approximately 1-8						

— = Test not performed.