It is strange that Dr Forsythe should ask why it takes the secretary of state a year to determine an appeal under section 190 when the issues are so much weightier. Disciplinary proceedings may arise from a clash of personalities.² Whatever the result of the current deliberations between the DHSS and the Joint Consultants Committee, the HM(61)112 or similar procedure would lose some of its unfairness if regional health authorities were stripped of their responsibilities, if only because they do not follow the fundamental principles of natural justice in which the accused consultant is told who his accuser is.

FELIX WEALE

Shorne,
Kent

1 Dawson J. The Savage case: the wider issues. *Br Med J* 1986;292:944-5.

2 Anonymous. The lessons from the Savage inquiry. *Br Med J* 1986;293:285-6.

AUTHORS' REPLY.—Some of the issues in Mr Weale's letter relate to a specific case, and it would be inappropriate to make any comment on the details of an individual matter about which Mr Weale appears to have knowledge.

I remain of the opinion that it would be difficult not to follow the procedure laid down in HM(61)112 in cases involving professional conduct or competence, or both, where the complaints are of a serious nature and could lead to dismissal or a final warning. The procedure set out in paragraphs 8-15 is formal, legalistic, and costly, and the associated expenses will be incurred by any employer invoking the process regardless of his efficiency. The question of who holds the contract is therefore irrelevant. In comparison with that procedure the secretary of state's appeal is informal and straightforward, and it is a matter of concern to authorities that, after delays in setting up the hearing, it can take so long for the secretary of state to promulgate his decision.

I cannot accept Mr Weale's contention that the existing procedure is unfair in that the employer is not bound to identify the person who makes the original complaint. The rules of natural justice provide that the individual should know the exact nature of the charge against him and what he has been called on to answer. The existing procedure does that. Many prosecutions are brought in the criminal courts against people who are convicted as a result of the evidence, but the original informant is never named or identified.

J M FORSYTHE

South East Thames Regional Health Authority,
Bexhill on Sea,
Sussex TN39 3NQ

Abdominal pain and disorder of coagulation

Dr V Roy and colleagues (21 May, p 1460) rightly emphasise the importance of a non-invasive technique such as ultrasonography as an aid to diagnosis in patients presenting with acute abdominal pain.

We recently treated a 53 year old woman with end stage renal failure secondary to glomerulonephritis who was currently receiving continuous ambulatory peritoneal dialysis. She presented with acute abdominal pain and haemorrhagic peritoneal dialysis fluid. She had had amenorrhoea for more than 30 years. During the past year she had had a few transient ischaemic attacks secondary to atrial fibrillation and had therefore been treated with warfarin, which was closely monitored and kept in the therapeutic range. On examination she had noticeable abdominal tenderness in the left upper quadrant, but no mass was palpable. Rectal and vaginal examination showed no abnormalities, and the peritoneal dialysis fluid was sterile. On the left

straight leg raising was not only limited but painful. Her prothrombin time was not unusually prolonged and was reported to be 2.7 times the control value, and within 24 hours after admission her haemoglobin concentration dropped from 77 to 62 g/l; a diagnosis of retroperitoneal haemorrhage was considered. A computed tomogram showed a retroperitoneal haematoma on the left side measuring 8×11 cm. She was, however, treated conservatively: warfarin was stopped and she continued with dialysis. On an outpatient basis the resolution of her haematoma was monitored by ultrasonography and she remained well.

We conclude that in diagnosing and managing acute abdominal pain a close liaison between the physician, surgeon, and radiologist is mandatory.

MUHAMMAD YAQOOB

R AHMAD

Regional Renal Unit,
Royal Liverpool Hospital,
Liverpool L8 8XP

Vocational training in general practice

Following the recent action by the Joint Committee on Postgraduate Training for General Practice (7 May, p 1320) the regional adviser and chairman of the general practitioner subcommittee in the North East Thames region have written to the chairman of the joint committee informing her of a resolution which was passed at the annual meeting of the executive council of the association of course organisers by 52 votes to 12.

The association of course organisers expressed concern about the apparently unforeseen consequences of the unique action taken by the committee to enforce its stated standards in the North East Thames region. The damage to the reputations and prospects of trainees (past, present, and future) in the region, the disastrous effect on recruitment to vocational training in the region, and the resulting implications for the standards of general practice, particularly in deprived inner city areas, are of major concern.

The association has urged the committee to withdraw its sanctions in order to allow more appropriate action to be taken to resolve the situation.

PAUL SACKIN

Alconbury,
Huntingdon,
Cambridgeshire PE17 5EQ

Surgical closure of the back lesion in open neural tube defects

The time is ripe for a new controlled trial of closure of myelomeningocele,¹ but I doubt whether the recent report by Messrs G T Deans and V E Boston (21 May, p 1441) sheds much light on the subject. The authors argue against the need for closure on the basis that in 109 babies with lesions above L2 born between 1964 and 1971 and undergoing early closure the cumulative survival to 1 year was 0.51 compared with 0.50 in 105 similar babies born between 1978 and 1985 whose lesions were not closed.

McLone *et al* found 0.95 survival to 1 year in 200 unselected patients born since 1975 and operated on for myelomeningocele, of whom 35% had lesions at or above L1.² Even if the fatalities had come from this subset the difference between the resulting (approximately) 0.85 survival and Messrs Deans and Boston's 0.50 is significant ($p < 0.001$). Charney *et al* found 0.92 or better survival to 10 months in infants with myelomeningoceles whether or not the back was closed early.³ These differences indicate that there was some factor

common to all the babies in Messrs Deans and Boston's series which, as late as 1985, determined a heavy mortality not experienced in the United States. Within this excess mortality—which needs explanation—differences due to closure or non-closure might pass unnoticed.

I agree that surgical policy may have little influence on the eventual development of hydrocephalus and the need for a shunt, but the authors do not discuss the important late complications of scoliosis and neurological deterioration due to a tethered spinal cord, against which early operation may be an important preventive measure.⁴

A NORMAN GUTHKELCH

Section of Neurosurgery,
University of Arizona,
Arizona 85724

1 Guthkelch AN. Aspects of the surgical management of myelomeningocele: a review. *Dev Med Child Neurol* 1986;28:525-32.

2 McLone DG, Dias L, Kaplan WE, *et al*. Concepts in the management of spina bifida. *Concepts in Pediatric Neurosurgery* 1985;5:97-106.

3 Charney EB, Sutton LN, Bruce DA, *et al*. Myelomeningocele newborn management: time for parental decision. *Z Kinderchir* 1983;38:90-3.

4 Reigel DH, McLone DG. Myelomeningocele: operative treatment and results—1987. *Concepts in Pediatric Neurosurgery* 1988;8:41-50.

Antidepressant drugs in the elderly

Dr Anthony J Duncan and Professor A John Campbell (30 April, p 1230) have studied elderly patients on long term antidepressant treatment in a general practice. They found that patients who were taking antidepressants had an equal health state with those who were not, and there appeared to be no unwanted effects. They then made the inference that these people were being kept on antidepressants for too long.

It could be said that these patients are in their current state of health because of the use of antidepressants. The only patients who showed a reduced health state were those who were receiving antidepressants for a previous definite depressive illness. If anything this adds to the alternative hypothesis as we know that not all people respond to treatment.

The answers that the authors seek would come from prolonged study with the addition of patients who had been taking long term antidepressants and came off them and patients who should have taken antidepressants but did not. The development of measures of health state will allow us to do more of these studies in the future, and our understanding of depression in the elderly will then be enhanced.

T D S SEDDON

Ormiston Health Centre,
Tauranga,
New Zealand

Euthanasia

Dr Roger Higgs (14 May, p 1348) touches on a point that I mentioned in the council debate on euthanasia, but unfortunately this point did not appear in your report on the debate (14 May, p 1408).

Dr Higgs identifies as a "disturbing feature of the report" that it reads as if it has been written by people who have already made up their minds before gathering evidence. This is nowhere more blatant than in the section dealing with the crucial distinction between the active and passive taking of life. The report distinguishes between "an active intervention by a doctor to terminate life" and "a decision not to prolong life." In paragraph 98 of the report this distinction is stated plainly as if it were incontrovertable, but there is no