SIR,—Thank you for printing the three illuminating articles under the general heading "Are Medical Books Too Dear?" (26 July, p. 227) in which your contributors hit firmly the heads of a number of controversial nails. Of course medical books are dear, but so too are other necessities such as food and housing.

Today a "solid" scientific book, that is, a book which is not the product of the whims and fancies of a single author, but one which has been produced by a team of investigators able to call for assistance on trained researchers into existing clinical literature, and on chemical, biochemical, pathological, and pharmaceutical laboratories for current data, must necessarily be expensive. After all, the capital value of the equipment used to produce material for its compilation will run into hundreds of thousands of pounds. If, for example, someone were rash enough to decide to produce from scratch a new formulary or pharmacopoeia, and, being a conscientious individual, felt it necessary to check the accuracy of all published information—chemical and physical tests, assay processes, indications and contraindications, doses and formulations, methods of sterilization, storage requirements, and so on—his publishers would have to sell, at a rough estimate, at least 5,000 copies at £50 a time in order to cover costs.

In my experience British medical books are priced lower than those of any other country. Despite this, British doctors and pharmacists do not seem to buy many books. I have seen copies of "Osler" 50 years old in doctors' surgeries and some pharmacists still rely on *Squire's Companion*, the last edition of which was published in 1916. On the other hand I know practitioners in Holland who spend £70 to £100 a year on new books and journals.

Perhaps, in the rapidly expanding field of medical science, the book is, or is rapidly becoming, out of date. Perhaps information on new drugs pertinent to 5 p.m. on a Friday should be available to practitioners on the following Monday. Perhaps photostat copies of data sheets should replace Caxton's letterpress. They might be more up to date, but I don't think they would be cheaper.—I am, etc.,

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SIR,—The unhappiness of two of the contributors to your middle articles (26 July, p. 227) is shared by medical librarians. We have an obligation to provide for our readers any published matter that they require for their work, whether in research or practice, but it is increasingly difficult to do so with the limited budgets at the disposal of most of us. The library of the private society, supported by a proportion of the annual subscriptions of members, has to scrutinize its expenditure with extreme care, a fact which may not be generally realized by its users.

Already most librarians can afford to buy only one copy of very expensive books, which are kept solely for reference, with the result that would-be borrowers who live at too great a distance from the library to visit it are penalized. Their problem is solved by the librarian's investment in a corporate sub-

scription to Messrs. H. K. Lewis's invaluable lending library, from where copies of expensive, ephemeral, or temporarily popular books may be obtained to supplement the library's stock and to be reissued to the readers. Similarly, a personal subscription to Lewis's library must be the chosen solution of many medical workers desirous of keeping in touch with new specialist publications.

The question of conference reports cannot be thus solved, since few are included at Lewis's library. Unless all librarians "stand firm" in refusing to purchase such works at exorbitant prices, the pioneers in rebellion will find, on capitulating as they are bound ultimately to do when their readers insist on seeing this material, that it is no longer in print, for the editions of works of limited appeal are small and prompt ordering is vital if copies are to be secured.

The cost of journals causes librarians no less concern than the cost of books. Even in an organization which produces a journal of sufficient prestige to be in demand for exchange arrangements with like periodicals, more than half of the annual expenditure of the library must be reserved for periodical literature. An iniquity which is perpetrated by some publishers is to impose a higher subscription rate upon libraries, research establishments, and multiple-reader institutions. No dental library could be without at least one copy of *Archives of Oral Biology*, one of the main British research journals; this library includes two copies, one to be bound and kept for reference use, the other to be circulated on loan to members. For this periodical Pergamon Press charges private individuals an annual subscription of £5 5s. (\$15.00); for libraries, research establishments, and all other multiple-reader institutions the annual cost is £40 (\$100.00). Here is an example of a medical publisher extorting a huge subscription from the defenceless library for a specialist journal which it is impelled to include. Clearly an examination of publishers' methods in the production and marketing of journals as well as books is desirable.—I am, etc.,

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SIR,—Your timely leading article on the cost of medical publications (26 July, p. 189) and the contributions of Drs. David Pyke, William Havard, and Raymond Greene on this contemporary theme (26 July, p. 227) makes one wonder whether it is not high time for the B.M.A. to press for more generous income-tax allowances for the purchase of medical publications.—I am, etc.,

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Cystic Fibrosis and Fertility

SIR,—Slightly over a year ago (8 June 1968, p. 576) one of your leading articles dealt with cystic fibrosis and fertility. Attention was called to the paradoxical situation where females with cystic fibrosis are known to be fertile,¹ whereas males are infertile and have complete azoospermia.² At

the time of your article the cause of this azoospermia was not known. Postulates suggested were some genetic abnormality of spermatogenesis, deficiencies of vitamin A or E, and a defect in transport of the spermatozoa owing to diminished water and electrolyte secretion.

We have recently demonstrated that the aetiology is a specific anatomical defect preventing the transport of spermatozoa from the testes to the urethra.³ The efferent ductules of the head of the epididymis end blindly, the body and tail of the epididymis are missing or rudimentary, and the vas deferens is absent. In most cases the seminal vesicle is absent, or if present is only a dilated cystic structure. Our original data have now been extended to include 30 consecutive males with cystic fibrosis, aged 17 to 38 who are azoospermic. The anatomical defect described above has been confirmed in 23 consecutive necropsies and in 12 of 13 surgical explorations for hernia repair or orchiopexy. This anatomic absence is present as early as one month of age and would appear to be a failure in development, as to date we have been unable to demonstrate evidence of inspissation, inflammation, or atresia. It is tempting to speculate that this adult finding may have an intrauterine origin, since in the male these structures—namely, epididymis, vas deferens, and seminal vesicle—are all of a common Wolffian duct origin from the foetal mesonephros. In the female these structures become vestigial, and their Müllerian duct counterparts develop normally into the oviduct and uterus. This may well explain the observed difference in fertility.—I am, etc.,

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Contraceptives and Cervical Carcinoma

SIR,—In their paper on "Prevalence Rates of Uterine Cervical Carcinoma" Dr. Myron R. Melamed and others (26 July, p. 195) show a statistically significant difference between the population choosing and using the diaphragm as compared with those using oral steroids for contraception. It is, however, rather puzzling to note that relatively few Jewish women attended their centres and were not separately identified. This is all the more curious since this ethnic group in New York City comprises several million people, and raises the question whether Jewish women did in fact attend, but for various reasons were not recognized as such.

Their attendance is important, since many writers^{1,2} have shown an extremely low frequency of cancer of the cervix in Jewish women, and have demonstrated that this could possibly be due to the absence of a foreskin in their husbands, since this low incidence is also paralleled among Moslem women whose husbands are also circumcised. It might possibly be, therefore, that the use of the diaphragm by preventing contact

between the smegma and the cervix may be exerting a beneficial effect in this respect.

It would seem important, therefore, that the authors should again attempt to identify those women whose husbands are circumcised, and if this proves impossible in the present series it could perhaps be evaluated in the future. If indeed the incidence of uncircumcised husbands remains the same in all ethnic groups examined and the statistical difference between diaphragm and steroid methods remains the same, it would seem that the diaphragm acting as a barrier against smegma might possibly be one of the explanations for this difference.—I am, etc.,

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Sudden Death in a Young Asthmatic

SIR,—We should like to reply to some of your correspondents who have commented on our report of the sudden death of a young asthmatic (5 April, p. 29). One of the main reasons which prompted us to publish the case report in detail was that it illustrated a problem in the management of asthma which we believe is a not uncommon one—that of a patient whose symptoms are suppressed by a maintenance dose of corticosteroids but in whom there is evidence of persistent airways obstruction.

We were interested by the letter from Dr. N. Macdonald and others (3 May, p. 312) in which they discuss the place of bronchial lavage. As they point out, the difficulty is to know when this procedure is indicated. In our patient, eight weeks before his fatal attack, a severe episode of asthma had occurred in which he had an epileptiform convulsion, presumably due to hypoxia, and he was taken to another hospital. That episode was unlike typical status asthmaticus, since he recovered and was allowed home within a few hours. When he was seen by us a week later we decided to stop corticosteroids and to substitute prednisone, initially in high dosage. We confidently anticipated that he would respond to a resumption of corticosteroids. Our dilemma arose two weeks later, when it was clear that, despite considerable symptomatic improvement, his peak expiratory flow (P.E.F.) had not risen to the values which had been obtained when he was previously taking betamethasone. While bronchial lavage may have great value in status asthmaticus, as reported by Drs. P. E. Walker and M. Marshall (5 July, p. 31), we wonder whether it would have been of any benefit in our patient so long after an episode of severe asthma.

We have no personal experience in the use of potassium iodide, which was recommended by Dr. H. Herxheimer (26 April, p. 246) and Dr. Erik Ask-Upmark (21 June, p. 762). Dr. Herxheimer appears to have assumed that the mucus which was found in the bronchi at necropsy had been present ever since the previous severe episode of asthma. While this may have been the case, we were careful to point out that Professor Lynne Reid was able to state only that this mucus had probably been present

for several days before death. It seems possible that other factors than mucous plugging contributed to the persistent airways obstruction in our patient. It is also possible that the major cause of his sudden collapse from hypoxia in the terminal episode was intense bronchial muscle constriction.

Dr. Monica K. McAllen (26 April, p. 246) has drawn attention to the possibility that disodium cromoglycate may mask symptoms which might give warning of an impending relapse. It has been shown¹ that disodium cromoglycate is able to give protection against exercise-induced asthma, and this may explain why our patient was able to take strenuous exercise without distress.

We reject Dr. Arend Bouhuys's contention (5 July, p. 53) that peak expiratory flow is an unreliable test for following the progress of asthmatic patients. He himself admits that our measurements of P.E.F. gave evidence of persistent airways obstruction, since he asserts that we did not accord due importance to its presence in our clinical management. He suggests that our patient was inadequately treated, since he should have been admitted for bronchoscopy and "active physiotherapy." We doubt whether either of these measures would have been of benefit. In any case it is clearly impractical to carry out bronchoscopy in every patient in whom tests disclose a suboptimal level of ventilatory capacity, particularly when, as in our patient, he has no symptoms and can play a vigorous game of football without distress. Apart from the much less practical convenience of tests which require a spirometer for their performance, we doubt whether either of the tests which he recommends (F.E.V. 1 second or M.M.E.F.R.) would have given us any more reliable information. In fact, there was a close correspondence between the values of P.E.F. and F.E.V.₁ in our patient. Nevertheless, we should have been interested to learn from Dr. Bouhuys what values of either F.E.V.₁ or M.M.E.F.R. for a boy aged 14 and 64 in. (1 m. 60 cm.) tall would have led him to take such measures as he would regard as being more adequate treatment.

While it is both impractical and probably unnecessary to subject every patient with suboptimal ventilatory capacity to procedures additional to an increase in dosage of steroids, nevertheless it seems clear that special consideration needs to be given to patients aged 10 to 14 years (since it is in this age group that the largest increase in deaths from asthma has occurred²), particularly if serial measurements of ventilatory function disclose persistent airways obstruction after a recent episode of severe asthma or status asthmaticus.—We are, etc.,

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Outpatient Management of Diabetic Children

SIR,—In the article by Dr. G. W. Chance (24 May, p. 493) we read that the prevailing trend at present is to admit every new patient with juvenile diabetes to the hospital, and to keep him there, both for initial treatment of

the disease as well as for an initial educational programme prepared for both the patient and his parents.

In our area diabetes is generally recognized in the early stages, so that we have encountered neither ketoacidosis nor coma as the presenting symptom in juvenile diabetes. Furthermore, a study carried out by us on the rehabilitation of the juvenile diabetic¹ revealed the marked psychological disturbances present in the juvenile diabetic and their families, partly owing to the prolonged hospitalization. We therefore introduced into our clinic a programme of initial treatment and education on an outpatient basis. Before treatment is instituted insulin reserve is measured,² by one or all of the following tests: intravenous arginine infusion; intravenous tolbutamide; and oral glucose tolerance. All of these tests are performed ambulatorily. The patient is taught to test urine for sugar with Benedict's solution, or Clinitest tablets, and to register the results three times a day. Insulin injections are first administered by a nurse, who comes to the home until the patient or one of the patients is able to do it by himself. In the meantime the patient and his family are seen several times a week in our clinic by a team consisting of a doctor, nurse, and dietitian, who direct the medical and dietary management. Psychological and psychiatric counselling is also begun at this stage.

We have found this approach to be very rewarding to the patients and their families, as well as for the treating team.—We are, etc.,

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Hand and Wrist

SIR,—I was pleased to see that Dr. V. Wright in his interesting article (19 July, p. 155) touched on the surgical treatment of rheumatoid arthritis as it affects the hand and wrist. It is not always appreciated that certain simple measures can give pleasing functional as well as cosmetic results—operative relief of compression of the median nerve and of trigger finger phenomenon in particular. It is even less well known that rebalance of the extensor mechanism of the finger can be achieved surgically if done at an early stage in mallet and boutonnière deformities—by division of the central slip in the former, and of the distal attachment of the tendon in the latter. One should also mention, of course, that the intrinsic release procedure gives a satisfactory result in swan neck deformity if performed early on, and before secondary proximal-interphalangeal joint stiffness has occurred.

Surgical synovectomy should certainly be considered, particularly when synovitis is persistent in the metacarpophalangeal joints; in more advanced cases realignment of the extensor tendons is often called for, and in the later stages, as Dr. Wright mentions, excision