Correspondence

Letters to the Editor should not exceed 500 words.

Family Planning Association

SIR,—By advising the Family Planning Association that in their opinion this organization should confine its activities to contraception only and should not attempt to widen the scope of its work into other fields of family planning, the General Medical Services Committee (as reported in your issue of April 24, Supplement, p. 142) has in effect delivered a snub to the F.P.A. on behalf of the general practitioners of the country. However, before coming to this conclusion the G.M.S.C. would have been well advised to have asked themselves what facilities exist under the National Health Service to help those unfortunate couples who want help or advice on their failure to achieve a family or on the sexual or psychosexual problems of marriage. They would have been forced to appreciate that these facilities are extremely rudimentary or non-existent in most parts of the country.

The vast majority of general practitioners are so overwhelmed with trivial illness that they have neither the time nor the specialized knowledge to help these people themselves, and outside the largest centres of population there are no specialized hospital clinics to which they can be referred.

As its name implies, the Family Planning Association is an organization which specializes in helping people to plan their families. This should include positive planning to start a family by childless couples as well as planning to prevent more than the

desired number of children. In view of the failure of the Health Service to provide these facilities a private organization has every right to try to fill this gap, particularly since all the F.P.A. clinic doctors are fully qualified and registered medical practitioners.

Recently there has been some correspondence in this journal on the subject of work for married women doctors, and the F.P.A. does excellent service in providing part-time work for married women. The work of these doctors would be made very much more interesting and worth while if it included not only the latest techniques of oral and intra-uterine contraception but also more comprehensive investigation of childless couples and giving advice and treatment in cases of sexual problems in marriage (which are very common but require more time than the average general practitioner can spare).

As registered medical practitioners there is no reason, ethical or otherwise, why they should not do clinical work (though not, agreed, in "illness in general"), and why they should not become recognized specialists in all aspects of human fertility and marital medical problems to whom general practitioners could refer patients.

As such they would render invaluable service both to the general population and to the overworked general practitioners.—I am, etc.,

Chipperfield Common, ROBERT NEWILL.
Near King's Langley, Herts.

Treatment in Depressive Illness

SIR,—Dr. E. H. Hare's letter (24 April, p. 1125) suggests that not every feature of clinical assessment made by the observers in the recent M.R.C. trial of treatment in depressive illness was necessarily included in the published report (3 April, p. 881). We note with interest that the observers recorded height and weight; but no mention is made of any other information concerning physical constitution. We wonder whether any other such information was collected—and perhaps discarded; in particular a record of skinfold thickness, using Harpenden (M.R.C.) skinfold callipers for the purpose. Our interest in this arises from the fact that we published evidence¹ in 1962 from a study of 570 men and 898 women that physical constitution can be a significant prognostic indicator for depression. But the M.R.C. report states that "evaluation of demographic, social, and clinical characteristics revealed disappointingly little basis as reliable prognostic indicators." We are not told, however, whether the designers of the M.R.C. trial considered the body-build of their patients in their assessment and if so whether it was in terms of modern somatometry. The use of "simplified

somatotypes"^{2,3}—involving the taking of only skinfold thickness in addition to height and weight—would have enabled them to compare the response to treatment of the various physical phenotypes which their sample no doubt comprised. It could have provided an excellent opportunity to obtain data which might tend to confirm or refute our findings.—We are, etc.,

Birmingham 23.
Winchester, Hants.

R. W. PARNELL.
IAN SKOTTOWE.

REFERENCES

- ¹ Parnell, R. W., and Skottowe, I., *Proc. roy. Soc. Med.*, 1962, 55, 707.
- ² ———, *J. psychosom. Res.*, 1964, 8, 311.
- ³ ———, *Human Body Composition*, 1965, edited by J. Brozek, p. 61. Pergamon Press, Oxford.

Corticosteroid Treatment for Acute Meningoencephalitis

SIR,—I read the account of the analysis of cases of encephalitis in Norway by Professor Bøe and his colleagues (24 April, p. 1094) with considerable astonishment. Not only because their conclusions run completely counter to my own 13 years' first-hand experi-

ence of the steroids in the acute infections, including meningoencephalitis,¹ but because of the unprecedented case-fatality rates at which they have arrived.

And one might have expected a more critical approach. The value of steroid treatment in such cases is governed by three considerations, any of which may play a vital part: (1) the severity of the reaction which it is hoped to arrest; (2) the dosage and route of administration; and (3) the stage at which treatment is begun. These factors are dismissed by the authors in a sentence, "77 patients received corticosteroid therapy, the daily doses ranging between 75 and 300 mg." Since two-thirds of their patients were adults this dosage would seem quite inadequate; 75 mg. cortisone would have no effect on a patient weighing 12 st. (75 kg.) in coma with encephalitis, and 300 mg. would not greatly affect the issue. Such a patient admitted to this hospital would receive 200 mg. hydrocortisone succinate intravenously at once (3 mg./kg.) and at the same time 25 mg. prednisone four-hourly through an intra-gastric tube (2 mg./kg. per day). Thus he would receive in terms of hydrocortisone double their maximum dosage in the first 24 hours, and heavier patients would receive proportionately more. If there were no perceptible effect in 12 to 24 hours the intravenous hydrocortisone would be repeated, and the prednisone would be repeated and continued for two or three more days depending on the response, after which it would be tailed off rapidly within six or seven days. If massive doses at the outset fail to halt the reaction prolonged administration is unlikely to be effective.

In a patient coming under treatment within the first three or four days spectacular results may be expected, especially following the intravenous administration of steroids, which appears to be by much the most effective route. The longer the reaction has endured the more slowly it will yield to treatment and the more the likelihood that irreversible changes may have occurred. To wait—as some do—until the patient is moribund before administering steroids is to court and probably to experience failure.

Let us compare their findings with our results. Since 1957, 63 cases of meningoencephalitis have been admitted to this hospital. Of these, 35 of the most severe cases received steroids, 11 due to measles, 4 to rubella, 3 to vaccinia, 1 to herpes simplex, 1 to monkey B virus, and 1 to Coxsackie B2. In 13 no cause was discovered. If Professor Bøe and his colleagues' statistics be valid we should have had a 50% case-fatality rate in this group, that is to say, 17 or 18 deaths; in fact there was not a single one. Of 28 cases not treated with steroids, 6 were due to measles, 5 to mumps, 1 to chicken-pox, and 1 to vaccinia. Here again from their figures we should have had 5 or 6 deaths, but again there were none. In fact there has not been a death from meningoencephalitis at this hospital since 1957.

I cannot by any stretch of the imagination reconcile my own experience with the deductions of Professor Bøe and his colleagues from

their statistics. In any event, retrospective analysis even of one's own material is difficult enough, but when dealing with the material of others it must be highly unsatisfactory. May I suggest to the authors that they try the steroids for themselves along the lines I have indicated? I have not the slightest doubt that they would be agreeably surprised.—I am, etc.,

G. E. BREEN,
Physician Superintendent.
South Middlesex Hospital,
Isleworth, Middlesex.

REFERENCE

- ¹ Breen, G. E., and Talukdar, P. K., *Lancet*, 1965, 1, 158.

Autoimmunity in Myasthenia Gravis

SIR,—I am not very concerned with priorities of ideas; nevertheless, since Dr. A. J. L. Strauss (8 May, p. 1245) has called attention to the contemporaneous suggestions made in October 1960 that myasthenia gravis might be a disease with an autoimmune aetiology, may I recall that I also made this suggestion in the Robert Knox lecture in May 1958.¹ Dr. Henry Kaplan and I referred to it again in an article on tumour versus host reactions in Hodgkin's disease.²

My interest lay in associations between the thymus, certain tumours, particularly lymphomas, and autoimmune reactions. I was influenced by similarities of lymphoid hyperplasia in Hashimoto's disease and myasthenia gravis described by B. Castleman.³

There has been much more interesting evidence connecting the thymus and its tumours with autoimmune phenomena since the suggestion that myasthenia gravis might be in this category was first made.—I am, etc.,

D. W. SMITHERS.

Radiotherapy Department,
The Royal Marsden Hospital,
London S.W.3.

REFERENCES

- ¹ Smithers, D. W., *J. Fac. Radiol.*, 1959, 10, 3.
² Kaplan, H., and Smithers, D. W., *Lancet*, 1959, 2, 1.
³ Castleman, B., *Tumors of the Thymus Gland. Atlas of Tumor Pathology*, 1955, Sect. 5, Fasc. 19. Armed Forces Institute of Pathology, Washington.

Figlu Test in Diagnosis of Malabsorption

SIR,—I should like to compliment Dr. D. P. Rose on his interesting paper (17 April, p. 1031) on the use of the Figlu test as a method of assessing function of the small intestine. The validity of the test is based on the existence of folic-acid deficiency, though this may not be accompanied by clinical signs. Such a deficiency could arise from an abnormal state of the jejunum—the site of absorption of folic acid from the bowel. If the jejunum is functioning normally and not contributing to the malabsorption syndrome, one would expect the result of the Figlu test to be normal. It is noteworthy that among Dr. Rose's five patients who were suffering from regional enteritis the Figlu test gave an abnormal result in one only, and in this patient the diagnosis was jejuno-ileitis. In pancreatic steatorrhoea a normal Figlu test is to be

expected; I have confirmed this in the solitary case which I have so far been able to study.

Recently I have compared the 5 g. D-xylose urinary excretion and the urinary output of urocanic acid and Figlu in 37 patients suffering from neoplastic disease—a condition in which an abnormal jejunal mucosa may occur.^{1,2} The results of the two tests are shown in the accompanying Tables.

TABLE I.—Urinary Output of Urocanic Acid and Figlu in 37 Patients with Neoplastic Disease

Normal Result 0–25 mg.	Abnormal Result 26 mg. +
18	19

TABLE II.—Urinary Excretion of D-Xylose Following a 5 g. Load

D-Xylose Output	
Normal Result 1.2–2.5 g.	Abnormal Result less than 1.2 g.
22	15

TABLE III

	Normal Xylose	Abnormal Xylose
Normal Figlu	12	6
Abnormal Figlu	10	9

In a direct comparison of the two tests, twelve patients had both a normal Figlu test and normal xylose excretion; and nine patients showed abnormal results in both. However, of the remaining sixteen patients ten had an abnormal Figlu test with normal xylose excretion, a finding which might be expected if the Figlu test were more sensitive than the xylose excretion test. In six patients an abnormal xylose test was found in association with a normal Figlu test, but in three of these six patients the blood-urea level was raised.

These data lend support to Dr. Rose's conclusion that in the diagnosis of intestinal malabsorption it is wise to study the results of the Figlu test alongside those of the xylose test.—I am, etc.,

IAIN W. DYMCK.

Department of Materia
Medica and Therapeutics,
The University,
Glasgow W.2.

REFERENCES

- ¹ Creamer, B., *Brit. med. J.*, 1964, 2, 1435.
² Dymock, I. W., unpublished data.

Intersex

SIR,—I apologize to my colleagues in general practice for my attempt to oversimplify the problems of intersex. I agree that cytological sex is not necessarily the same as genetic sex. It was indeed tactless to use the phrase "pseudo-scientists." I am, however, intrigued by the only two letters written in criticism of my two articles on elective surgery (3 and 10 April, pp. 909 and 973).

Scottish paediatricians, anatomists, geneticists, and gynaecologists (who all have regular access to my wards) will be grateful to Dr. J. E. Gray, Dr. R. R. Gordon, and Mr. C. J. Dewhurst (1 May, p. 1192) for their expert advice on the advantages of the early diagnosis of intersex.

In Glasgow, parents have relatives and neighbours. I would be glad to learn from Dr. Gray how *he* advises parents "who . . . have evidence before their very eyes that all is not right sexually" on the naming of their child?

Fortunately, the adreno-genital syndrome is less lethal in Glasgow than it appears to be in Newcastle and Sheffield. Because of his extensive personal experience in the successful treatment of the adreno-genital syndrome in early infancy I would be glad to learn from Mr. Dewhurst details of his personal experience in the technique of construction of a vagina in a growing child. Despite our abysmal ignorance, this is becoming an increasingly common problem in Glasgow. I would be glad to learn from Mr. Dewhurst the late results following vaginal construction before puberty.—I am, etc.,

WALLACE M. DENNISON.

Royal Hospital for Sick
Children,
Glasgow C.3.

Lightning Seizures and Fits in Childhood

SIR,—In your leader on lightning seizures (1 May, p. 1139) you rightly draw attention to a condition which is not uncommon in infants. The literature on the subject is extensive and the terminology rather confused. One of the best recent publications is that by Peter Jeavons and Brian Bower—*Infantile Spasms*, published by W. Heinemann (1964) as a supplement No. 15 from the Spastics Society. These authors have made a deliberate effort to sort out the terminology, and it is a pity that your leader seems to add to the confusion. Although you do not mention the common term of "infantile spasms" which is usually accepted in the English literature, you make a distinction, for example, between "lightning major convulsions," "petit mal," and later "jack-knifing" and "drop attacks." These are all descriptive terms which have a precise meaning only for the person using them, but might be interchangeable for other people. If your leader had explained the differences, it would have done a service to the readers. The impression given is that of a selection of quotations from various authors without recognizable link. In relation to "jack-knifing" it is said that any posture is maintained for only a fraction of a second and there appears to be a momentary muscular relaxation and loss of tone . . . characteristically attacks come at intervals between 1 and 5 seconds . . . they come during inattention . . . and may be found also at any time in later childhood. All these points are certainly not part of the most common features of this peculiar condition. Although grateful to your leader for quoting some of my work, I regret to point out that what is described really belongs to another paper on "Involuntary Movements in Subacute Sclerosing Encephalitis" in the same paediatric journal.

Another leader on "Fits in Childhood" (17 April, p. 1012) also adds to the terminological tangles and gives rather odd information. For example, your leader writer appears to be able to use the E.E.G. "to distinguish between genuine 'febrile convulsions' and recurrent epileptic attacks triggered off by a high temperature." It also mentions that